| DEPARTMENT | OF | HEALTH / | AND | HUMAN SERVICES | |
|------------|-----|----------|------|-----------------|--|
| | OF. | | 1110 | HUMAN BEAVILLED | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

| MEDI | CARE/MEDICAID | CERTIFICATION | N AND TRANSMITTAL |
|------|---------------|---------------|-------------------|
| DIDT | | | |

ID: JM4C

| | | PART I | - TO BE COMP | LETED BY T | HE STAT | E SURVEY | AGENCY | | Facility ID: 00593 |
|---|--|---|--|---------------------------------------|-------------------------------|---|---|--|--|
| I. MEDICARE/MEDICAI (L1) 245483 2.STATE VENDOR OR MI (L2) 940220900 1000000000000000000000000000000000000 | |). | NAME AND AI (L3) THE NORT (L4) 7700 GRAN (L5) DULUTH, M | H SHORE ESTA D AVENUE | | | i) 55807 | TYPE OF ACTION Initial Termination Validation | Recertification CHOW Complaint |
| 5. EFFECTIVE DATE CH (L9) 07/14/2016 | ANGE OF OWNE | RSHIP | 7. PROVIDER/SU 01 Hospital | PPLIER CATEGO | RY 09 ESRD | <u>02</u> (L 13 PTIP | 7) 22 CLIA | 7. On-Site Visit 8. Full Survey After | 9. Other Complaint |
| DATE OF SURVEY ACCREDITATION STA 0 Unaccredited 2 AOA | 01/21/202 ATUS: 1 TJC 3 Other | 20 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | | FISCAL YEAR ENDI | NG DATE: (L35) |
| 11LTC PERIOD OF CER From (a) : To (b) : | TIFICATION | | Complian | | : | 2. T 3. 2 | roved Waivers Of Th 'echnical Personnel 4 Hour RN -Day RN (Rural SNF | te Following Requirements 6. Scope of S 7. Medical D 7) 8. Patient Ro | ervices Limit irector |
| 12.Total Facility Beds 13.Total Certified Beds | | 70 (L18)70 (L17) | B. Not in Co | mpliance with Progrand/or Applied Wai | | 5. L | ife Safety Code | 7) 8. Patient Ro 9. Beds/Roor (L12) | |
| 14. LTC CERTIFIED BED | DDEAVDOUD | | Requirements | and or Applied wat | | * Code: 15. FACILIT | A | (1212) | |
| 18 SNF | 18/19 SNF 70 | 19 SNF | ICF | IID | | | or 1861 (j) (1): | (L15) | |
| (L37) | (L38) | (L39) | (L42) | (L43) | | | | | |
| 16. STATE SURVEY AGE 17. SURVEYOR SIGNAT | | (IF APPLICABL | E SHOW LTC CANCE | ELLATION DATE |): | 18. STATE S | URVEY AGENCY A | APPROVAL | Date: |
| Kimberly Se | ettergren, | HFE NE | <u> </u> | 01/21/2020 | (L19) | Melissa Poepping, Enforcement Specialist 01/21/2020 | | | |
| | PAR | T II - TO BE | COMPLETED | BY HCFA RH | EGIONAI | OFFICE O | R SINGLE ST | ATE AGENCY | |
| 19. DETERMINATION O 1. Facility i 2. Facility | s Eligible to Partic | ipate (L21) | | IPLIANCE WITH GHTS ACT: | CIVIL | 2. | | ncial Solvency (HCFA-257)l Interest Disclosure Stmt (: : | |
| 22. ORIGINAL DATE | 2 | 3. LTC AGREEM | IENT 2 | 4. LTC AGREEM | ENT | 26. TERMIN | VATION ACTION: | | (L30) |
| OF PARTICIPATION 05/01/1987 | | BEGINNING | DATE | ENDING DAT | E | <u>VOLUNTARY</u> 01-Merger, Clo | osure | 05-Fail to | NTARY Meet Health/Safety |
| (L24) | | (L41) | | (L25) | | | ion W/ Reimburseme | | Meet Agreement |
| 25. LTC EXTENSION D | ATE: 2 | 7. ALTERNATI | VE SANCTIONS | (1.44) | | | oluntary Termination | OTHER | er Status Change |
| | (L27) | B. Rescind Sus | pension Date: | (L44) (L45) | | | | | |
| 28. TERMINATION DAT | E: | 29 | . INTERMEDIARY/ | CARRIER NO. | | 30. REMARK | s | | |
| | | | 04201 | | | | | | |
| | | (L28) | 06201 | | (L31) | | | | |
| 31. RO RECEIPT OF CMS | S-1539 | 32 | . DETERMINATION | | ATE | | | | |
| | | | 01/14/2020 | OF ALL ROVAL D | AIE | | | | |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 21, 2020

CMS Certification Number (CCN): 245483

Administrator The North Shore Estates LLC 7700 Grand Avenue Duluth, MN 55807

Dear Administrator:

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 January 3, 2020 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mighing

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 21, 2020

Administrator The North Shore Estates Llc 7700 Grand Avenue Duluth, MN 55807

RE: CCN: 245483 Cycle Start Date: November 21, 2019

Dear Administrator:

On January 21, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Mi Pig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

| DEPARTMENT OF HE | | | CEDTIFICATION | | EDICARE & MEDICAID SERVICES |
|--|---------------------|--------------------------------------|--|--|---|
| | | | | N AND TRANSMITTAL ATE SURVEY AGENCY | ID: JM4C Facility ID: 00593 |
| | | | | ATE SURVET AGENCT | |
| 1. MEDICARE/MEDICAID PR | OVIDER NO. | 3. NAME AND ADD | RESS OF FACILITY SHORE ESTATES L | I.C. | 4. TYPE OF ACTION: $2(L8)$ |
| (L1) 245483 | | (L4) 7700 GRAND | | | 1. Initial 2. Recertification |
| 2.STATE VENDOR OR MEDICA (L2) 940220900 | AID NO. | | | (L6) 55807 | 3. Termination 4. CHOW |
| (E2) 940220900 | | (L5) DULUTH, MN | | (L0) 5300 7 | 5. Validation 6. Complaint 7. On-Site Visit 9. Other |
| 5. EFFECTIVE DATE CHANGE | E OF OWNERSHIP | 7. PROVIDER/SUPP | LIER CATEGORY | <u>02</u> (L7) | |
| (L9) 07/14/2016 | | 01 Hospital | 05 HHA 09 ESR | D 13 PTIP 22 CLIA | 8. Full Survey After Complaint |
| 6. DATE OF SURVEY | 11/21/2019 (L34) | 02 SNF/NF/Dual | 06 PRTF 10 NF | 14 CORF | |
| 8. ACCREDITATION STATUS | : (L10) | 03 SNF/NF/Distinct | 07 X-Ray 11 ICF/ | ID 15 ASC | FISCAL YEAR ENDING DATE: (L35) |
| | TJC | 04 SNF | 08 OPT/SP 12 RHC | 16 HOSPICE | 12/31 |
| 2 AOA 3 | Other | | | | |
| 11LTC PERIOD OF CERTIFIC | ATION | 10.THE FACILITY IS | CERTIFIED AS: | | |
| From (a): | | A. In Compliance | e With | And/Or Approved Waivers Of Th | • • |
| To (b) : | | Program Rec Compliance | | 2. Technical Personnel | 6. Scope of Services Limit |
| | | Compnance | Based Oll. | 3. 24 Hour RN | 7. Medical Director |
| 12.Total Facility Beds | 70 (L18) | 1. Acc | ceptable POC | 4. 7-Day RN (Rural SNI | F) 8. Patient Room Size |
| - | | V.D. Maria | 1 | 5. Life Safety Code | 9. Beds/Room |
| 13.Total Certified Beds | 70 (L17) | X B. Not in Comp Requirements and | liance with Program | * Code: B * | (L12) |
| | | requirements une | a of Applied Walters. | 15. FACILITY MEETS | (212) |
| 14. LTC CERTIFIED BED BRE | | 100 | | | ([15) |
| | 9 SNF 19 SNF | ICF | IID | 1861 (e) (1) or 1861 (j) (1): | (L15) |
| | 70 | | | | |
| (L37) (L | .38) (L39) | (L42) | (L43) | | |
| 17. SURVEYOR SIGNATURE | | Date : | 0.0010 | 18. STATE SURVEY AGENCY | APPROVAL Date: |
| Kimberly Setterg | | | (L19) | | · (L20) |
| | PART II - TO B | E COMPLETED B | Y HCFA REGION | AL OFFICE OR SINGLE ST | CATE AGENCY |
| 19. DETERMINATION OF ELI | GIBILITY | | LIANCE WITH CIVIL | | ncial Solvency (HCFA-2572) |
| X 1. Facility is Elig | ible to Participate | RIGH | ITS ACT: | Ownership/Control Both of the Above | ol Interest Disclosure Stmt (HCFA-1513) e : |
| 2. Facility is not | - | | | | |
| 2. Fuenty is not | (L21) | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREEN | MENT 24. | LTC AGREEMENT | 26. TERMINATION ACTION: | (L30) |
| OF PARTICIPATION | BEGINNING | 6 DATE | ENDING DATE | VOLUNTARY 00 | 0 INVOLUNTARY |
| 05/01/1987 | | | | 01-Merger, Closure | 05-Fail to Meet Health/Safety |
| | (1.41) | | (1.25) | 02-Dissatisfaction W/ Reimbursem | - |
| (L24) | (L41) | | (L25) | 03-Risk of Involuntary Termination | - - |
| 25. LTC EXTENSION DATE: | | IVE SANCTIONS | | 04-Other Reason for Withdrawal | OTHER |
| | A. Suspensio | on of Admissions: | 7.1 0 | | 07-Provider Status Change 00-Active |
| (L | 27) B. Resaind St | spension Date: | (L44) | | 00-Active |
| | B. Reselled St | ispension Date. | | | |
| | | | (L45) | | |
| 28. TERMINATION DATE: | 2 | 9. INTERMEDIARY/CA | RRIER NO. | 30. REMARKS | |
| | | 06201 | | | |
| | (L28) | | (L31) | | |
| | | | | | |
| 31. RO RECEIPT OF CMS-1539 | 9 3 | 2. DETERMINATION OF | APPROVAL DATE | | |
| | (L32) | | (L33) | DETERMINATION APPR | POVAL |
| | (202) | | (255) | DETERMINATION APPR | 10 M AL |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 11, 2019

Administrator The North Shore Estates Llc 7700 Grand Avenue Duluth, MN 55807

RE: CCN: 245483 Cycle Start Date: November 21, 2019

Dear Administrator:

On November 21, 2019, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The North Shore Estates Llc December 11, 2019 Page 2

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

The North Shore Estates Llc December 11, 2019 Page 3

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

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

If substantial compliance with the regulations is not verified by February 21, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 21, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

The North Shore Estates Llc December 11, 2019 Page 4

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,

M. Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | I | | APPROVED |
|--------------------------|--|--|---------------------|--|----------|----------------------------|
| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | C | MB NO | . 0938-0391 |
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | COM | E SURVEY |
| | | 245483 | B. WING _ | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | · [| STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| THE NOP | RTH SHORE ESTATES | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E 00 | 00 | | |
| F 000 | Emergency Prepare conducted on 11/17 a recertification sur | | F 00 | 00 | | |
| | survey was conduc complaint investiga facility was found n federal requiremen Requirements for L | gh 11/21/19, a standard ted at your facility. A tion was also conducted. Your ot to be in compliance with the ts of 42 CFR 483, Subpart B, ong Term Care Facilities. | | | | |
| | The following comp substantiated: H548 | plaint was found to be 83040C | | | | |
| | as your allegation of Department's accept enrolled in ePOC, y at the bottom of the | f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. | | | | |
| F 550 | on-site revisit of you validate that substa regulations has bee your verification. | acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with ercise of Rights | F 55 | 50 | | 1/3/20 |
| SS=D | CFR(s): 483.10(a)(§483.10(a) Resider | 1)(2)(b)(1)(2) | | | | 10120 |
| | | and communication with and | | | | |
| | | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | | (X6) DATE |
| Electron | ically Signed | | | | | 12/19/2019 |

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.

| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | [| ST | TREET ADDRESS, CITY, STATE, ZIP CODE | <u>,</u> | |
| THE NOP | RTH SHORE ESTATES | 3 LLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 550 | Continued From pa | ige 1 | F f | 550 | | | |
| | | and services inside and including those specified in | | | | | |
| | with respect and dig resident in a manne promotes maintena her quality of life, re | cility must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's cility must protect and of the resident. | | | | | |
| | access to quality ca severity of condition must establish and practices regarding provision of service | facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. | | | | | |
| | | e right to exercise his or her of the facility and as a citizen | | | | | |
| | resident can exerci | facility must ensure that the se his or her rights without ion, discrimination, or reprisal | | | | | |
| | free of interference, reprisal from the fac- rights and to be sup exercise of his or he subpart. | resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this | | | | | |
| | by: | NT is not met as evidenced tion, interview, and document | | | Immediate Corrective Action: | | |

Facility ID: 00593

If continuation sheet Page 2 of 68

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | O | | APPROVEI 0938-039 |
|--------------------------|---|---|--------------------|-----|---|--|---------------------------|
| TATEMEN | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245492 | B. WING | | | | C |
| | | 245483 | B. WING | | TREET ADDRESS, CITY, STATE, ZIP CODE | 11/2 | 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | | 700 GRAND AVENUE | | |
| THE NO | RTH SHORE ESTATE | S LLC | | | DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 550 | review, the facility f drainage bag and in public view for 1 of dignity. In addition, resident was offere upon request for 1 for dignity. Findings include: R27's Face Sheet p diagnoses included history of urinary tra R27's annual Minin 9/19/19, indicated and required exten transfers, dressing R27's care plan da | printed 11/20/19, indicated d chronic kidney disease, and act infection. hum Data Set (MDS) dated R27 was cognitively intact, sive assist with mobility, | F 5 | 550 | Resident #27 was provided a urinal drainage bag cover to utilized wher and wheelchair. Resident #53 s N who was caring for him received education regarding proper process follow when a resident asks to use bathroom. Corrective Action as it applies to oth The Policy and Procedure for Quali Life-Dignity remains current. The nurses and NARs will be re-ed on the Quality of Life-Dignity Policy regards to need to keep urinary dra bags covered per resident s prefe and to provide toileting assistance of resident states that they need to us bathroom by 1/3/2019. All residents who have urinary drain bags will be reviewed to ensure tha have a urinary drainage bag cover | in in bed AR s to the hers: ity of lucated with ainage rence when a se the nage at they | |
| | infection (UTI) relation On 11/19/19, at 7:3 laying in her bed with catheter bag was ethallway. R27's cather yellow urine in the form On 11/20/19, at 3:4 laying in her bed with catheter bag was her visible from the hall bright clear yellow to On 11/20/19, at 3:3 (NA)-E confirmed Form not in a privacy bag | ted to altercation in elimination. a1 a.m. R27 was observed ith door open. R27's Foley exposed and visible from the heter bag had bright clear | | | is their preference. All others will be planned that they don □t wish to har drainage bag covered. Date of Compliance 1/3/2019 Recurrence will be prevented by: Audits of 5 residents who have urin drainage bags will be conducted we 4 and then monthly x 2 months to a that bags are covered to provide for resident privacy. Audits of 5 reside receiving toileting cares will be con- weekly x4 and the monthly x 2 month The results will be shared with the for QAPI committee for input on the ne- increase, decrease or discontinue to audits. | e care ve hary eekly x assure r ents ducted oths. facility eed to | |

Facility ID: 00593

If continuation sheet Page 3 of 68

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 550 | should be in privacy, dignity and privacy, would be especially preferred to have he On 11/20/19, at 3:50 (LPN)-E confirmed not in a privacy bag hallway. LPN-E ind were to be in privacy On 11/20/19, at 4:30 (DON) was interview catheter bag was to order to maintain he The facility policy Q | y bags to ensure the resident's NA-E further stated this important for R27, since R27 er door open at all times. 2 p.m. licensed practical nurse R27's Foley catheter bag was and was visible from the icated Foley catheter bags y bags for dignity purposes. 9 p.m. the director of nursing we and verified R27's to be placed in a privacy bag in er dignity. uality of Life-Dignity revised for a re to promote, maintain and | F | 550 | Corrections will be monitored by: DON/ADON/Nurse Managers | | |
| | indicated R53's diag disease. R53's quarterly MD R53 was cognitively assistance with toile toileting program. R53's Care Area As 8/19/19, indicated F of urine. The CAA be care planned for | ecord printed 11/20/19, gnoses included Parkinson's S dated 11/5/19, indicated v intact, required extensive eting, and was not on a esessment (CAA) dated R53 was frequently incontinent indicated toileting needs would R53 to continue to offer d change every two hours. | | | | | |

Facility ID: 00593

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | : 01/09/2020 APPROVED . 0938-0391 |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | E CONSTRUCTION | (X3) DAT COM | E SURVEY IPLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 550 | R53's care plan data alteration in elimina urinary tract infection impaired mobility, a and bladder. R53's dry, odor free, and t symptoms of UTI. assistance of two a with toileting needs clothing adjustment R53's nursing assis 11/17/19, indicated required two assist R53's Bladder Evalt indicated R53 was ib bladder, did not info occasionally would had already voided R53 required assist Hoyer for transfers, management, and p toileting, check, and R53 was able to ma understand others. On 11/17/19, at 1:10 in his pants becaus bathroom, and wou on his own. During observation R53 had verbalized morning cares. Nur instructed R53 to "p was wearing an inco NA-A if R53 had a u | ed 8/26/19, indicated R53 had tion related to a history of ons (UTI), urinary retention, nd was incontinent of bowel goal was to remain clean, to be free from signs and R53 interventions included nd a Hoyer (mechanical lift) including pericare, pad, and s. tant care guide dated R53 was incontinent, and and a Hoyer with toileting. uation dated 9/20/19, incontinent of bowel and orm staff of need to void, and ask staff for a urinal, but R53 and did not void in a urinal. ance with toileting including a | F 5 | 550 | | | |

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| | - | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|----|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE | E SURVEY |
| | | | A. BUILDIN | NG | | | C |
| | | 245483 | B. WING _ | | | 11/2 | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOF | RTH SHORE ESTATES | 3 LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 550 | change his brief and was done. On 11/19/19, 11:24 (LPN)-B confirmed | d get him cleaned up when he a.m. licensed practical nurse she overheard R53 state he | F 5 | 50 | | | |
| | had to urinate, and ahead and pee in h wearing an incontin had planned to talk comment because resident to urinate in dignity concern for that was the first tim had to go to the bat be incontinent of bo further stated R53 w maybe would be ab assistance. LPN-B offered to use the u verified R53 did not | heard NA-A instruct R53 to go is pants because he was nent brief. LPN- B stated she with NA-A about that it was not acceptable to tell a in their pants, it would be a that resident. LPN-B stated ne she had heard R53 say he throom, and had known R53 to owel and bladder. LPN-B was getting stronger, and ole to use a urinal with a stated R53 should have been urinal or to be toileted. LPN-B t have a urinal in his room. | | | | | |
| | prefer to use the ba pants. R53 stated s the bathroom or off staff came into his r | 50 p.m. R53 stated he would athroom and not urinate in his staff don't offer to take him to fer a urinal. R53 stated when room, R53 would say he had aff would often tell him to just | | | | | |
| | residents should be | 0 p.m. the ADON stated e offered to be toileted and not heir pants, and that it would be hat resident. | | | | | |
| | resident was able to the resident should program. A toileting | 39 p.m. the DON stated if a o verbalize they had to urinate, be on a bowel and bladder g log would be initiated to t's urinary patterns to promote | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|---|----------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 245483 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | · | STREET ADDRESS, CITY, STATE, ZIP CODE | <u>.</u> | |
| THE NOF | RTH SHORE ESTATES | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 550 | highest bladder fun | ctioning. | F 55 | 50 | | |
| | Toileting Plans for L 10/10, directed a re plan to assess for a resident. Conduct a resident and his or factors that may ha decline in urinary in and evaluate inform bladder habits, and Assess the resident behavioral program incontinence. | ehavioral Programs and Jrinary Incontinence dated view of the resident's care ny special needs of the a thorough assessment of the her environment to determine ve contributed to any recent continence. Monitor, record, nation about the resident's continence or incontinence. t for appropriateness of s which promote urinary | | | | |
| F 585 SS=D | CFR(s): 483.10(j)(1 §483.10(j) Grievano §483.10(j)(1) The re grievances to the fa that hears grievano reprisal and without reprisal. Such grievano respect to care and furnished as well as furnished, the beha residents, and other facility stay. §483.10(j)(2) The re facility must make p resolve grievances accordance with thi §483.10(j)(3) The fa | ces. esident has the right to voice incility or other agency or entity es without discrimination or fear of discrimination or ances include those with treatment which has been that which has not been vior of staff and of other r concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in | F 58 | 85 | | 1/3/20 |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|---------------|--------------------------|---|---------------|------|---|------|-----------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE | | | E SURVEY |
| AND PLAN O | FCORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
| | | 245483 | B. WING | | | | C |
| NAME OF F | PROVIDER OR SUPPLIER | 243403 | <u> </u> | S | IREET ADDRESS, CITY, STATE, ZIP CODE | 11/2 | 21/2019 |
| | | | | | 700 GRAND AVENUE | | |
| | RTH SHORE ESTATES | | | D | ULUTH, MN 55807 | | |
| (X4) ID | | | ID | , | | | (X5) COMPLETION |
| PREFIX TAG | | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | DATE |
| | | | | | DEFICIENCY) | | |
| F 585 | Continued From no | ao 7 | | | | | |
| 1 303 | Continued From pa | ye / | F 58 | 50 | | | |
| | §483.10(j)(4) The fa | acility must establish a | | | | | |
| | | ensure the prompt resolution | | | | | |
| | | garding the residents' rights ragraph. Upon request, the | | | | | |
| | | a copy of the grievance policy | | | | | |
| | to the resident. The | grievance policy must | | | | | |
| | include: | t individually or through | | | | | |
| | | ent locations throughout the | | | | | |
| | facility of the right to | o file grievances orally | | | | | |
| | | or in writing; the right to file | | | | | |
| | | ously; the contact information icial with whom a grievance | | | | | |
| | | his or her name, business | | | | | |
| | address (mailing an | nd email) and business phone | | | | | |
| | | ble expected time frame for ew of the grievance; the right | | | | | |
| | | lecision regarding his or her | | | | | |
| | grievance; and the | contact information of | | | | | |
| | | s with whom grievances may | | | | | |
| | | pertinent State agency, nt Organization, State Survey | | | | | |
| | | ong-Term Care Ombudsman | | | | | |
| | | on and advocacy system; | | | | | |
| | | evance Official who is rseeing the grievance process, | | | | | |
| | • | ng grievances through to their | | | | | |
| | conclusions; leading | g any necessary investigations | | | | | |
| | | taining the confidentiality of all ted with grievances, for | | | | | |
| | | ty of the resident for those | | | | | |
| | grievances submitte | ed anonymously, issuing | | | | | |
| | | ecisions to the resident; and | | | | | |
| | | ate and federal agencies as f specific allegations; | | | | | |
| | | aking immediate action to | | | | | |
| | | ential violations of any resident | | | | | |

Facility ID: 00593

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|--|---|---------------------|----|---|------------------------|-------------------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE SU COMPLE | |
| | | 245483 | B. WING | | | | _ 21/2019 |
| NAME OF F | ROVIDER OR SUPPLIER | L | · [| ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOR | TH SHORE ESTATES | SLLC | | | 00 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 585 | Continued From pa | ge 8 | F 5 | 85 | | | |
| | investigated; | ed violation is being | | | | | |
| | reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statement the steps taken to i summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropria accordance with St of the residents' rig or if an outside entit the State Survey Ag Organization, or loo confirms a violation rights within its area (vii) Maintaining evit result of all grievant | §483.12(c)(1), immediately d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and e law; I written grievance decisions e grievance was received, a t of the resident's grievance, nvestigate the grievance, a rtinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not rective action taken or to be as a result of the grievance, itten decision was issued; ate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance | | | | | |
| | by: Based on interview facility failed to ens | NT is not met as evidenced and document review, the ure a written response to a residents (R12) reviewed for | | | Resident #12 had a grievance forn out with regards to missing shorts. Replacement shorts were ordered 12/19/19.Grievance form was put ir | on | |
| | Findings include: | | | | Action as it applies to others: | | |

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|--|--|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 7 | 700 GRAND AVENUE | | |
| | RTH SHORE ESTATES | | | D | ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 585 | R12's Admission Reindicated R12's diagonated R12's diagonated R12's diagonated R12's diagonated R12's quarterly Min 9/10/19, indicated R12 displaying the store of the deficit, was able to understood, and unindicated R12 displaying to the shorts of the sh | ecord printed 11/20/19, gnoses included unspecified es, and unspecified es). imum Data Set (MDS) dated R12 had a moderate cognitive speak clearly, was derstood others. R12's MDS ayed no behaviors, no signs or im or psychosis, and had no iated 4/20/17, indicated R12 ct, was able to understand be understood by others, and unicate needs effectively. es dated 10/23/19 through between the facility looked for was told after she asked, the to find them. R12 stated she he lady who did the laundry. a written response in regards ing. 0 a.m. laundry aide (LA)-A en missing two purple shorts LA-A stated she has looked and was unable to find them. amily knew about it. | F | 585 | The Grievance Policy and Procedu reviewed and remains current. Grievance/Concern Form has been updated to reflect facility□s offer of of the written resolution. All staff will be educated on the Grie Policy and Procedure by 1/3/2019. Resident Counsel meeting on 12/18 was held and Grievance Procedure reviewed. Date of completion: 1/3/2019 Recurrence will be prevented by: 3 resident interviews regarding any grievances will be held weekly x4, t monthly x2 months, on various unit assure concerns are documented a followed through with resolutions an they were aware who to contact. T results of these interview audits will reviewed monthly at the facility QAF committee meeting for input on the to increase, decrease or discontinu audits. Grievances will continue to discussed at the monthly Resident Counsel meetings and will be repor monthly on an ongoing basis to the QAPI committee. The correction will be monitored by Administrator/Social Services Director/Designee | hen s to and hd that he be red facility | |
| | On 11/20/19, at 2:4 | 0 p.m. social services director | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | PLE CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | i | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 585 | (SS)-A stated she h missing clothing. S family gets updated grievance investiga written response. On 11/20/19, at 2:4 director (SS)-B stat occurred some time administrator was s shorts, but the re w appropriate size. S not provide a writter resident representa keep the grievance R12's grievance for provided. The facility policy C Procedure dated 9/ to be completed, ar as soon as reasona complaint had beer would provide a ver summary was requilater than 5 busines grievance. If the gri grievance officer was Grievance officer was Grievance and notifit the proposed action resolved, it would b Directors and the B summary to the cor no later than 30 day grievance. All com | ad not heard about R12's S-A stated the resident or with the results of the tion, but they do not provide a 3 p.m. social services regional ed R12's missing shorts ago. SS-B stated the upposed to purchase new as a problem finding the S-B confirmed the facility did n response to R12 or the tive. SS-B stated they would | F | 585 | | | |

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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE | 0938-039 E SURVEY |
|--------------------------|--|---|---------------------|---|-----------|---------------------------|
| AND PLAN C | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 3 | | PLETED |
| | | 245483 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 585 | - | ge 11 | F 58 | 5 | | |
| F 609 SS=D | years. Reporting of Allege CFR(s): 483.12(c)(| | F 609 | 9 | | 1/3/20 |
| | | onse to allegations of abuse, n, or mistreatment, the facility | | | | |
| | must: §483.12(c)(1) Ensur involving abuse, neg mistreatment, includ source and misappr are reported immed hours after the alleg that cause the alleg serious bodily injury, the events that cause abuse and do not re the administrator of officials (including to adult protective serv for jurisdiction in lon | re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established | | | | |
| | designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct | ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced | | | | |
| | Based on interview facility failed to repo | v and document review, the ort bruises of unknown origin v within 2 hours for 1 of 3 iewed for abuse. | | Immediate Corrective Action: Resident #21 s bruising to right ar thumb have resolved. The nurse w not report the incident to the admin | ho did | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 | |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | (X3) DATE | E SURVEY PLETED | |
| | | 245483 | B. WING | | | | C 21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CO | | | | | |
| | TH SHORE ESTATES | | | 77 | 00 GRAND AVENUE | | | |
| | | | | DI | ULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 609 | Continued From par Findings include: R21's Admission Re indicated R21's diag dementia with beha cerebral infarction (R21's quarterly Min 9/19/19, indicated F impairment, display psychosis, no beha period, and required activities of daily livit R21's care plan initi was unable to remo due to physical and directed staff to obs changes in vulneral staff to provide physical and mobility, indicated staff to provide physical staff to provide physical and mobility, indicated staff to provide physical staff to provide physical and mobility, indicated staff to provide physical and mobility, indicated staff to provide physical staff to give space, demonstrating agita | ge 12 ecord printed 11/20/19, gnoses included vascular vioral disturbance, and stroke). imum Data Set (MDS) dated &21 had a severe cognitive ed no symptoms of delirium or viors during the assessment d extensive assistance with all | F 60 | 09 | | on ng of hers: s tion ries of y r last any wed up VA eports thly x2 in has orting. hared r input | | |
| | R21's Order Summ | ary Report with active orders uded a chewable 81 milligram | | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|--|--------------------|---|---|-------|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | PLE CONSTRUCTION G | | (X3) DATE | E SURVEY PLETED |
| | | 245483 | B. WING | | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ; | STREET ADDRESS, CITY, STATE, ZIP COD | E | | 21/2013 |
| | RTH SHORE ESTATES | | | | 7700 GRAND AVENUE | | | |
| | TH SHOKE ESTATES | | | I | DULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD | BE | (X5) COMPLETION DATE |
| F 609 | Continued From pa (mg) aspirin daily. I any orders for antic medications. R21's progress note a.m. indicated staff of R21's hands at th the right thumb brui (cm) by 1.0 cm, and cm x 4.0 cm. The to being black and blu questions of how sh were being hurt. Th was updated on the R21's progress note indicated the interdi 10/31/19, to review 10/30/19. The IDT grab at staff and str refuse medications to place Tubigrips to elbows for protection R21's progress note specific event that I lacked indication the reported to the Stat R21's physician visi R21 resisted exami increased behaviors | ge 13 R21's orders did not include oagulant or steroid es dated 10/31/19, at 12:19 had reported bruises to both he base of the thumbs, with se measuring 2.0 centimeters d the left thumb measuring 3.8 oruises were documented as e. R21 did not respond to he got the bruises, or if she he oncoming licensed nurse bruises. es dated 11/1/19, at 9:55 a.m. sciplinary team (IDT) met on R21's bruises noted on noted R21 would frequently ike out with her hands, and and treatments. IDT decided both arms from knuckles to on as R21 allowed. es lacked indication of a ed to R21's bruises, and at R21's bruises were e Agency. it note dated 11/4/19, indicated nation, and was seen for s and refusal behaviors the 21's physician note lacked | F | | DEFICIENCY) | | | |
| | (DON) stated staff stime of the incident | 2 p.m. the director of nursing should have been asked at the for possible causes of one knew how it could have | | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|--|---------------------|---|------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ì í | IPLE CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING _ | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 609 F 623 SS=B | happened, it should state agency within The facility policy for Prevention/Vulneral directed staff to imr who was then to att of the injury of unkr the administrator of and suspected abus state agency no late the suspicion. Notice Requiremen CFR(s): 483.15(c)(3) §483.15(c)(3) Notic Before a facility trar resident, the facility (i) Notify the resider representative(s) of the reasons for the language and mann facility must send a representative of th Long-Term Care Or (ii) Record the reas discharge in the resider | have been reported to the 2 hours, as a potential abuse. In Abuse ble Adult Plan dated 12/18, nediately notify the unit nurse, empt to determine the cause nown origin, immediately notify an injury of unknown origin, se would be reported to the er than 2 hours after forming ts Before Transfer/Discharge B)-(6)(8) e before transfer. nsfers or discharges a must- nt and the resident's the transfer or discharge and move in writing and in a her they understand. The copy of the notice to a e Office of the State | F 60 |)9 | | 12/19/19 |
| | (iii) Include in the no paragraph (c)(5) of §483.15(c)(4) Timir (i) Except as specifi (c)(8) of this section discharge required | ng of the notice. Ted in paragraphs (c)(4)(ii) and n, the notice of transfer or under this section must be at least 30 days before the | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ``` | | PLE CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 623 | before transfer or d (A) The safety of ind be endangered und this section; (B) The health of ind be endangered, und this section; (C) The resident's h allow a more immed under paragraph (c) (D) An immediate tr required by the resident under paragraph (c) (E) A resident has r days. §483.15(c)(5) Content notice specified in p must include the fol (i) The reason for t (ii) The effective dat (iii) The location to v transferred or disch (iv) A statement of t including the name, and telephone num receives such reque to obtain an appeal completing the form hearing request; (v) The name, addre telephone number of Long-Term Care Or (vi) For nursing faci and developmental disabilities, the mail | nade as soon as practicable ischarge when- dividuals in the facility would er paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of ealth improves sufficiently to diate transfer or discharge, 0(1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, 0(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written baragraph (c)(3) of this section lowing: ransfer or discharge; te of transfer or discharge; which the resident is arged; he resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in a and submitting the appeal ess (mailing and email) and of the Office of the State | F | 523 | 3 | | |

| | - | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|-------|---|--|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TIPLE | E CONSTRUCTION | (X3) DATE | E SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | ING _ | | | PLETED C |
| | | 245483 | B. WING | | | | 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE 200 GRAND AVENUE | | |
| THE NO | RTH SHORE ESTATES | S LLC | | | ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 623 | the protection and a developmental disa C of the Developmental and Bill of Rights Ac codified at 42 U.S.C (vii) For nursing fac disorder or related email address and agency responsible advocacy of individue established under the for Mentally III Indiv §483.15(c)(6) Chan If the information in effecting the transfer must update the real as practicable once becomes available. §483.15(c)(8) Notice In the case of facilite the administrator of written notification p to the State Survey State Long-Term Ca the facility, and the well as the plan for relocation of the real 483.70(I). This REQUIREMEN by: Based on interview facility failed to ensu- | advocacy of individuals with bilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder he Protection and Advocacy iduals Act. the notice changes prior to er or discharge, the facility cipients of the notice as soon the updated information | F 6 | 23 | Resident #19 and Resident #50 bo completed bed-holds, including nar resident, transfer location/hospital r date of transfer, and reason for trar Resident #19 signed her own bed h Resident #50 left from an appointm straight to the ER and thus a phone | ne of name, nsfer. iold. ent | |

Facility ID: 00593

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FC | DRM / | 01/09/2020 APPROVED 0938-0391 | |
|--------------------------|---|---|--------------------|----|---|--------------------------------------|-------------------------------------|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 · · | | E CONSTRUCTION (X3 | COMF | E SURVEY PLETED | |
| | | 245483 | B. WING | | | C 11/21/2019 | | |
| NAME OF PF | ROVIDER OR SUPPLIER | | <u> </u> | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE NOR | TH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | (X5) COMPLETION DATE | |
| | indicated R19's diag chronic kidney diser failure. R19's hospital disch 9/25/19, indicated F hospital on 9/23/19, R19's medical reco notice for transfer w writing to R19 and/o R19's progress note R19 had a fall and w room for evaluation facility on 10/20/19. evidence a written r provided in writing t representative. R50's Admission Re indicated R50's diag kidney disease, dial cognitive impairmer R50's progress note indicated R50 was a 5/1/19, for Influenza lacked evidence a w provided in writing t representative. R50's Interagency F indicated R50 was a | ecord printed 11/20/19, gnoses included anemia, ase, and congestive heart harge paperwork dated R19 was admitted to the for evaluation after a fall. rd lacked evidence a written vas obtained and provided in or R19's representative. e dated 10/20/19, indicated was sent to the emergency and returned back to the R19's medical record lacked notice for transfer was o R19 and/or R19's ecord printed 11/20/19, gnoses included chronic betes type 2, and had a mild | F6 | 23 | the residents representative was completed and documented on the for Considering the above information, the facility is going to copmlete an IDR as does not appear there is defient practic The facility does have a current policy written notice of transfers/bedholds wh remains current. Policy remains current, facility will educated all nurses on completing not of transfer/bedhold when resident is be sent to hospital/ER/going on a leave. A nurses will be trained by 1//2019 | e it ce. on iich iich | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | | |
| | | | | | 0(5) | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 623 | Continued From pa | ge 18 | F 6 | 623 | | | |
| | services stated whe hospital from the fa- signed bed hold and transfer from the re- able to sign for ther verbal from the resi- written Bed-Hold No Therapeutic Leave representative, and document in the res- written was provide resident representative (LPN)-A stated if a for from the facility, the hold form including resident was unable would be obtained for representative over the resident's medic completed form was and the director of re person or by email for | 0 p.m. licensed practical nurse resident goes into the hospital resident would sign a bed reason for transfer, and if the to sign, a verbal consent from the resident's the phone and documented in cal record. LPN-A stated the s put into the resident's chart, nursing (DON) was notified in of the hospitalization. | | | | | |
| | | | | | | | |
| F 677 SS=D | written notice of tran ADL Care Provided | for Dependent Residents | F 6 | 677 | | | 1/3/20 |
| | | ident who is unable to carry | | | | | |

Facility ID: 00593

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| | | AND HUMAN SERVICES | | | | PRINTED: 01/09/2 FORM APPROV OMB NO. 0938-03 | /ED |
|--|--|---|-------------------|-----|--|---|-----|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 · · | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 245483 | B. WING | ; | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | | • | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLET | |
| F 677 | services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility for reviewed for 1 of 4 reviewed for activiti Findings include: R41's Face Sheet p R41's diagnoses in anxiety, schizoaffed R41's annual Minim 10/14/19, indicated and required extens which included groot R41's Care Area As dated 10/15/19, indicated grooming, and prefeshaved. On 11/17/19, indicated grooming, and prefeshaved. On 11/18/19, at 9:2 the facial hair rema R41 stated she was twice a week, which | y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced tion, interview, and document ailed to ensure facial hair was dependent residents (R41) es of daily living (ADLs). printed 11/20/19, indicated cluded Parkinson's disease, ctive disorder, and bipolar. num Data Set (MDS) dated R41 was cognitively intact, sive assistance for ADLs, printg. seessment (CAA) Summary icated R41 required extensive | | 677 | Immediate Corrective Action: Resident #41 received assistance removal of her facial hair. Corrective Action as it applies to The Policy and Procedure on AD assistance was reviewed and removed assistance was reviewed and removed and residents will be revealed as preference for removal of facial her be reflected on the care plan and care sheets. Date of Compliance: 1/3/2019 Recurrence will be prevented by Audits of 5 random residents will completed weekly x 4 then month months to assure timely assistant provided for removal of facial had results of these audits will be shat the facility QAPI committee for in the need to increase, decrease of discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/De | others: L mains ducated ce Policy acial hair. d their hair will t NAR be hly x 2 ice is ir. The ared with uput on or | |

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|---|--|--|--------------------|-----|--|------------------|-------------------------------------|
| STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF PROVIDER OR SL | JPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NORTH SHORE E | STATES | SLLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| PREFIX (EACH DE | FICIENC | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| shaving. R4 bothered hei hair removed On 11/19/19 remained. R assistance v On 11/19/19 (NA)-A state ADLs includ assistance v cares, but di NA-A state ADLs includ assistance v cares, but di NA-A further morning, and been preser R41's nursin dependent of have facial h On 11/20/19 (DON) state required assist that was the resident's plip preferred to expect staff The DON fur resident that removed wa The facility p 2/18, indicat cleanliness a resident. Th residents' ca needs of the | depend 1 furth r, and s d. 41 stat vith sha vas pro id not o stated d it app at for se on staff hair rem at 4:3 d she v sistance reside an of ca have fa to follor ther stat t prefer is a dig policy S ed the and to p ne polic are plan e reside | ded on staff to assist with er stated having facial hair she preferred to have her facial 0 p.m. R41's facial hair ed staff did not offer to aving during morning cares. 6 p.m. nursing assistant was dependent on staff for all ving. NA-A stated grooming vided for R41 during morning ffer to assist R41 with shaving. facial hair was noted that eared R41 facial hair had everal days. NA-A verified guide indicated R41 was for grooming, and preferred to noved. 9 p.m. the director of nursing vould expect a resident that e with shaving to be shaved if nt's desire. DON stated if a are included a resident acial hair removed, she would w the resident preferences. ated the lack of grooming for a red to have facial hair | F | 577 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|---|---------------------|---|--|----------------------------|
| | | | PLE CONSTRUCTION G | (X3) DATE COM | E SURVEY PLETED | |
| | | 245483 | B. WING _ | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOF | TH SHORE ESTATES | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 SS=D | CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re- that residents recein accordance with pro- practice, the compri- care plan, and the ri- This REQUIREMEN by: Based on observative review, the facility fave weights as ordered medical condition for reviewed for unnece Findings include: R29's Admission Re- indicated R29's diag embolism (blood clear arteries in the lungs respiratory failure, wheart failure (CHF), R29's care plan initive was at risk for falls including CHF, eder R29's care plan ind psychotropic medic obtain a monthly or R29's care plan ide diagnoses and cond | fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered esidents' choices. NT is not met as evidenced ion, interview, and document ailed to ensure monitoring of by a physician regarding a or 1 of 6 residents (R29) essary medications. ecord printed 11/19/19, gnoses included pulmonary of in one of the pulmonary of in one of the pulmonary of, acute and chronic 'ascular dementia, congestive and edema. ated 8/24/18, indicated R29 related to medical conditions, ma, and vascular dementia. icated R29 was taking ations, and directed nursing to thostatic blood pressure. ntified R29's cardiovascular ditions, including CHF and | F 68 | 4 Immediate Corrective Action: Resident #29 continues to have ord check daily weights and has specifi parameters on when to call Heart C to update. Resident s diagnosis of remains stable. Corrective Action as it applies to oth The Heart Failure-Clinical Protocol remains current. All nurses will be re-educated by 1// on the Heart Failure-Clinical Protocol Policy with regards to the need to for physician recommendations/param on when to notify physician for furth direction. All residents with multiple day of we weights will be reviewed to ensure to they have specific parameters on w notify MD. Date of Compliance: 1/3/2019 Recurrence will be prevented by: | c Center CHF ners: Policy 3/2019 ol ollow eters ier eek that then to | 1/3/20 |
| | Lasix (diuretic), but | with medications that included lacked direction for daily ition of provider of increase of | | Audits of 5 residents with multiple d week weights will be completed we 4 then monthly x 2 months to assur | ekly x | |

Facility ID: 00593

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------------------|-------------------------------------|
| | | | ` ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 | Continued From pa | ge 22 | F6 | 684 | | | |
| | 3 pounds overnight | or 5 pounds weekly. | | | weights are being done per physici | | |
| | weights and weight of the physician. | cked direction to obtain daily gain guidelines for notification | | | parameters. The results of the audi be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue t audits. | | |
| | as of 11/19/19, inclu- check vital signs d -daily weights every weight gain of 3 por one week. Call he breath, orthopnea, 9/30/19. -Monthly orthostatic and standing) the 2 order date 8/26/18. -Lasix (diuretic) 40 CHF. Order start d -Melatonin 3 mg at manifestations. -Metoprolol succina extended release 2 -Sertraline HCL (an bedtime. Order star -Olanzapine (antips for bipolar disorder. | aily. Order 9/17/19. / day shift, call Heart Center if unds overnight or 5 pounds in art center of shortness of edema or bloating. Order date c blood pressure (lying, sitting, 24th of every month. Nursing milligrams (mg) twice daily for ate 10/23/19. bedtime for difficulty sleeping ate (for blood pressure) 4 hour; 25 mg in the a.m. tidepressant) 50 mg at | | | Corrections will be monitored by: DON/ADON/Nurse Managers/Desi | gnee | |
| | 9/27/19, indicated F from 9/5/19, throug intestinal bleed, en damage, or malfund further indicated R2 hospital with orders and referral to the h R29's Treatment Ac | R29 had been hospitalized h 9/17/19, with CHF, potential icphalopathy (brain disease, ction). R29's NP visit note 29 was discharged from the for Lasix and daily weights, | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED |
|--|---|---|--------------------|-----|--|----------|--------------------------------|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIF | PLE CONSTRUCTION | | <u>. 0938-0391</u> E SURVEY |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. | | A. BUILD | INC | G | COMPLETED | | |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 684 | completed only on 9 weekly weights. R29's Physician Visi included signed NP to call the heart cer overnight or 5 poun symptoms of shortr edema or bloating. R29's NP visit notes R29 had been hosp 9/17/19, with a GI b and CHF. R29 was daily weights, Lasix failure clinic. R29's TAR for 10/1 indicated R29's dail daily starting 10/1/1 were not obtained 1 10/17/19, and 10/22 2019 indicated R29 pounds. R29's TAF indicated R29's pre 9/25/19. R29's TAR for 11/1/ indicated R29's dail 11/3/19, or 11/14/19 had more than a 3 11/11/19, and 11/13 notification of the pl increase of greater | 9/18/19, and 9/19/19, then bit Record dated 9/30/19, orders for daily weights, and atter if weight gain of 3 pounds ds in one week, and if ness of breath, orthopnea, s dated 10/11/19, indicated bitalized 9/5/19 through leed, acute encephalopathy, a discharged with orders for and a referral to the heart /19, through 10/31/19, y weight was to be obtained 9, and R29's daily weights 10/1/19, 10/2/19, 10/10/19, 2/19. R29's TAR for October 's weight on 10/3/19, was 180 R for September 2019, vious weight was 171.5 on /19, through 11/20/19, y weight was not obtained on 0. R29's TAR indicated R29 pound weight gain from 9, and it increased slightly R29's progress notes dated 0/19, lacked documentation of hysician regarding the weight than 3 pounds, and lacked nonitoring of symptoms of | Fθ | 684 | | | |

Facility ID: 00593

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|---|--------------------|-----|---|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ``` | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | TH SHORE ESTATES | 3 LLC | | | 700 GRAND AVENUE | | |
| | | | | D | OULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 | through 11/20/19, ir | Vitals summary for 9/21/19, ndicated R29 had missed daily | Fe | 684 | | | |
| | 10/17/19, 10/18/19, 11/14/19. | 19, through 10/3/19, 10/10/19, 10/22/19, 11/3/19, and rd indicated R29 had a weight | | | | | |
| | gain of 8.5 pounds t weights were record | from 9/25,/19 to 10/3/19. No ded in R29's medical record nd 10/3/19. R29's progress | | | | | |
| | was reported to the | 9, indicated the weight gain physician, though lacked | | | | | |
| | increased edema a | ring for symptoms of CHF, nd respiratory status. | | | | | |
| | gain of 4 pounds fro | d indicated R29 had a weight om 10/5/19, to 10/6/19. R29's ked documentation of | | | | | |
| | notification of physic symptoms of CHF, | cian, monitoring for signs and respiratory status, or | | | | | |
| | - R29's weight reco | elated to R29's weight gain. rd indicated R29 had a weight om 10/9/19, through 10/11/19, | | | | | |
| | with no weight reco | rded on 10/10/19. Progress nentation of notification of | | | | | |
| | physician, monitorir | ng for signs and symptoms of atus, or increased edema, | | | | | |
| | | d indicated R29 had a weight | | | | | |
| | but had not obtaine | from 10/16/19, to 10/19/19, d a weight on 10/17/19, or s notes lacked documentation | | | | | |
| | of notification of phy | ysician, monitoring for signs HF, respiratory status, or | | | | | |
| | increased edema, r R29's progress note | elated to R29's weight gain. es dated 10/23/19, indicated s Lasix for 3 days, following a | | | | | |
| | | d indicated R29 had a weight | | | | | |
| | | s from 10/29/19, to 10/30/19. rd indicated R29 went to the | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|---|---|---------------|-----|---|------|--------------------------------|
| | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MI II | TIP | PLE CONSTRUCTION | | <u>. 0938-0391</u> E SURVEY |
| | | ` ´ | | G | COMPLETED | | |
| | | | _ | | | | С |
| | | 245483 | B. WING | | | 11/ | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SUC | | | 7700 GRAND AVENUE | | |
| | | | | | DULUTH, MN 55807 | | |
| (X4) ID | | | ID | | PROVIDER'S PLAN OF CORRECTIO | | (X5) COMPLETION |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | х | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | | DATE |
| | | | | | DEFICIENCY) | | |
| | | | 1 | | | | |
| F 684 | • | • | F 6 | 82 | 4 | | |
| | | and daily weights were | | | | | |
| | ordered. R29's me | dical record lacked | | | | | |
| | | ema and respiratory status. | | | | | |
| | | d indicated R29 had a weight | | | | | |
| | | from 11/11/19, to 11/12/19. | | | | | |
| | | rd lacked evidence of | | | | | |
| | | hysician or heart clinic of ked documentation of | | | | | |
| | | otoms of CHF, increased | | | | | |
| | edema and respirat | | | | | | |
| | | d indicated R29 had a weight | | | | | |
| | | from 11/17/19, to 11/18/19, | | | | | |
| | previous day. | t loss of 6.5 pounds the | | | | | |
| | previous day. | | | | | | |
| | | oner (NP) visit notes dated | | | | | |
| | | R29's Lasix had been | | | | | |
| | | prior, and R29's weight was | | | | | |
| | | ong with decreased edema, was prior to R29's weight that | | | | | |
| | same day. | | | | | | |
| | - | | | | | | |
| | | 7 a.m. R29's resident | | | | | |
| | R29's weight is not |)-F expressed concern that | | | | | |
| | | checked daily. | | | | | |
| | On 11/20/19, at 4:2 | 8 p.m. director of nursing | | | | | |
| | | sing weights and lack of | | | | | |
| | • | hysician. DON stated nursing | | | | | |
| | | symptoms of CHF with DON verified nursing should | | | | | |
| | | eart center and monitored R29 | | | | | |
| | | weight. DON also verified | | | | | |
| | orthostatic BP's sho | buld be obtained for monitoring | | | | | |
| | | dications and should be | | | | | |
| | documented. | | | | | | |
| | The facility policy H | eart Failure-Clinical Protocol | | | | | |

If continuation sheet Page 26 of 68

| | | AND HUMAN SERVICES | | | FORM | : 01/09/202 1 APPROVE | |
|--|---|---|---------------------|---|--|------------------------------------|--|
| TATEMENT | RS FOR MEDICARE | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3) DA | . 0938-039 TE SURVEY MPLETED | |
| | | 245483 | B. WING _ | | 11 | C / 21/2019 | |
| IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| THE NOF | RTH SHORE ESTATES | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE | |
| F 684 | Continued From pa | ige 26 | F 68 | 34 | | | |
| F 686 SS=D | symptoms of CHF, monitoring and man notification of physi Treatment/Svcs to | Prevent/Heal Pressure Ulcer | F 68 | 36 | | 1/3/20 | |
| | resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that (ii) A resident with p necessary treatment with professional st promote healing, pu new ulcers from de This REQUIREMEN by: Based on observat review, the facility f wound assessment pressure ulcers and treatment for 2 of 4 for pressure ulcers Findings include: National Pressure I | sure ulcers. prehensive assessment of a must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and pressure ulcers receives int and services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced tion, interview, and document ailed to ensure consistent t to prevent worsening of d evaluate the effectiveness of residents (R5, R50) reviewed njury Advisory Panel staging sure injuries (pressure ulcers) | | Immediate Corrective Act Resident #5 s pressure u reassessed by ADON. Are be stable and wound conti followed by wound clinic o basis. Resident #50 s pr was reassessed by ADON continues to be followed b on a routine basis. ADON on need to complete a we assessment of pressure u Corrective Action as it app | Icer was ta continues to nues to be n a routine essure ulcer . Area y wound clinic was educated ekly Icers. | | |

Event ID: JM4C11

Facility ID: 00593

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| | OF DEFICIENCIES | A MEDICAID SERVICES | (X2) MI II TI | PLE CONSTRUCTION | OMB NO. | E SURVEY |
|------------------------------|--|---|---------------------|---|--|----------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | | G | | PLETED |
| | | | | | | C |
| | | 245483 | B. WING | | 11/2 | 21/2019 |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RTH SHORE ESTATE | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIOI DATE |
| F 686 | appear differently i Presence of blanch sensation, tempera visual changes. Co purple or maroon of indicate deep tissu Stage 2 Pressure I loss with exposed skin with exposed viable, pink or red, as an intact or rupt Adipose (fat) is not not visible. Granula are not present. Th from adverse micro over the pelvis and should not be used associated skin da incontinence associ intertriginous derm related skin injury ((skin tears, burns, Stage 3 Pressure I Full-thickness loss is visible in the ulco epibole (rolled wou Slough and/or escl of tissue damage v areas of significant wounds. Undermin Fascia, muscle, ter and/or bone are no obscures the exter Unstageable Press Stage 4 Pressure I tissue loss Full-thic with exposed or dir | n darkly pigmented skin. hable erythema or changes in ature, or firmness may precede olor changes do not include discoloration; these may e pressure injury. njury: Partial-thickness skin dermis Partial-thickness loss of dermis. The wound bed is moist, and may also present ured serum-filled blister. t visible and deeper tissues are ation tissue, slough and eschar hese injuries commonly result oclimate and shear in the skin I shear in the heel. This stage I to describe moisture mage (MASD) including ciated dermatitis (IAD), atitis (ITD), medical adhesive (MARSI), or traumatic wounds abrasions). njury: Full-thickness skin loss of skin, in which adipose (fat) er and granulation tissue and and edges) are often present. har may be visible. The depth varies by anatomical location; t adiposity can develop deep ing and tunneling may occur. hoon, ligament, cartilage ot exposed. If slough or eschar ht of tissue loss this is an | F 684 | was reviewed and remains current All nursing staff will be re-educate 1/3/2019 on the Skin Assessment Wound Management Policy inclurneed to document on pressure ul- weekly. All residents with pressure ulcerss reviewed to ensure that they have skin assessments documented. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of all residents with pressure will be completed weekly x 4 ther x 2 months to assure pressure ul- being documented on weekly. The of the audits will be shared with the QAPI committee for input on the increase, decrease or discontinue audits. Corrections will be monitored by: DON/ADON/Nurse Managers/De | ed by t and ding the cers will be e weekly ure ulcers a monthly cers are e results ne facility need to e the | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | THE NORTH SHORE ESTATES LLC | | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | (rolled edges), unde often occur. Depth If slough or eschar loss this is an Unsta Unstageable Press full-thickness skin a skin and tissue loss damage within the because it is obscu slough or eschar is 4 pressure injury wi (i.e. dry, adherent, i fluctuance) on the h not be softened or n R5's Admission Rea indicated R20's diag neuropathy, pressu non-pressure relate anemia, edema, an damage, disorder, o R5's annual Minimu 8/27/19, indicated F impairment, had no assessment period assistance of two s nonambulatory. R5's MDS further in pressure ulcer with yellow/creamy/grey eschar (dead thick, wound bed) presen R5's Care Area Ass Ulcer/Injury dated 8 | ermining and/or tunneling varies by anatomical location. obscures the extent of tissue ageable Pressure Injury. ure Injury: Obscured and tissue loss Full-thickness in which the extent of tissue ulcer cannot be confirmed red by slough or eschar. If removed, a Stage 3 or Stage II be revealed. Stable eschar ntact without erythema or neel or ischemic limb should removed cord printed 11/20/19, gnoses included diabetes with re ulcer of right heel, ed chronic ulcer of left foot, d encephalopathy (brain or disease). Im Data Set (MDS) dated R5 had a severe cognitive rejection of cares during the , required extensive taff for bed mobility, total taff for transfers, and was indicated R5 was at risk for d had an unstageable slough (dead ish tissue in a wound bed) or leathery, black tissue in a | F6 | \$86 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | (X3) DATE | E SURVEY PLETED |
| | | 245483 | B. WING | | · | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | | | 7700 GRAND AVENUE | | |
| | | | | 1 | DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| TAG F 686 | Continued From par R5 allowed. R5's physician apporindicated R5 had a base of the right he the wound, and tend documentation india not appear to be ac R5's care plan initia a mobility impairme reposition every 2 h refused repositionin indicated R5 had a including pressure of directed nursing to hours. Interventions was followed by hos R5's Weekly Skin Ir indicated there were and R5 continued to pressure area to the R5's Weekly Press dated 9/11/19, indic ulcer measured 3.8 and was unstageab pressure ulcer was unchanged. R5's Weekly Press | ge 29 bintment dated 9/4/19, large pressure ulcer at the el with dark tissue overlying der to touch. Physician cated R5's pressure ulcer did utely infected at that time. ted 10/3/18, indicated R5 had nt, and directed staff to iours, and noted R5 frequently ig. R5's care plan further history of skin breakdown, ulcers to bilateral heels, and offer repositioning every 2 is dated 11/14/19, indicated R5 spital wound care. | F 6 | | DEFICIENCY) | IATE | DATE |
| | ulcer measured 3.4 unstageable with 20 10% granulation (ne and moderate server mixed with the bloo | cm x 5.0 cm and was 0% eschar, 70% slough and ew connective tissue) tissue, sanguineous (clear liquid d) drainage with odor. R5's documented as ongoing and | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|----|--|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | | A. BUILDIN | NG | | | C |
| | | 245483 | B. WING | | | 11/2 | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | Continued From par improved. R5's Weekly Skin Ir indicated there were and continued to ha area to the right hee Skin inspection sind R5's Weekly Skin Ir indicated R5 had no continued unstagea heel. R5's Weekly Presse 10/3/19, indicated F measured 3.2 cm x with 25% granulation amount of serosang odor. R5's pressure ongoing and decline registered nurse as 9/17/19, and 10/3/1 worsened during the R5's Weekly Presse 10/8/19, indicated F measured 4.0 cm x was 10% granulation moderate brownish R5's pressure ulcer and improved, thou had increased with In addition, the right previously been door | ge 30 hspection dated 9/24/19, e no new areas of concern, ave an unstageable pressure el. R5 had not had a Weekly be 9/11/19. hspection dated 10/1/19, o new areas of concern, and able pressure area to right ure Wound Evaluation dated R5's left heel pressure ulcer 4.5 cm, and was unstageable on, 75% slough, and moderate guineous drainage with an e area was documented as ed. R5 had not had a sess the wound between 9, and the wound had | F 68 | 86 | DEFICIENCY) | | |
| | R5's progress notes R5 went to wound o | s dated 10/14/19, indicated clinic | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM |): 01/09/2020 // APPROVED). 0938-0391 |
|--------------------------|---|--|--------------------|------|--|---------|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | E CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 245483 | B. WING | | | 11 | C / 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOF | TH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 686 | indicated R5 contin pressure area to the right great toe and the had not had a week 10/1/19. R5's Weekly Press 10/17/19, indicated measured 3.5 cm x with 75% granulation moderate serosang odor. R5's pressure improved. In additivi indicted R5 had a s left toe that had heat R5's progress notes antibiotic was order R5's progress notes and a new order for a wound infection w 11/1/19. R5's progr indicated R5 had go treatment orders had left medial fifth toe, and water and a vir | A spection dated 10/15/19, ued to have an unstageable eright heel, outer aspect of top of right second toe. R5 ty skin inspection since ure Wound Evaluation dated R5's right heel pressure ulcer 3.0 cm and was unstageable on, and 25% slough, and uineous drainage with no e ulcer was documented as on, R5's wound evaluation tage one pressure area on his aled. a dated 10/22/19, indicated a h orders for an antibiotic, a follow up appointment for a er with possible infection. a dated 10/23/19, indicated an ed for a wound infection. a indicated R5 had a wound moderate amount of inosa (bacteria organism). a dated 10/26/19, indicated R5 a change in antibiotic to treat <i>i</i> th pseudomonas until ress notes, the same day one to wound dare and ad changed to right heel and including cleansing with soap pegar solution. | F | \$86 | | | |
| | R5's Weekly Skin Ir | nspection dated 10/29/19, | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FO | ED: 01/09/2020 RM APPROVED NO. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | E CONSTRUCTION | (X3) [| DATE SURVEY COMPLETED |
| | | 245483 | B. WING | | | | C 11/21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE VULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 686 | indicated R5 contin pressure ulcer to th right great toe, and with a superficial ul- R5 had not had a w 10/15/19. R5's Braden Scale J determining risk for 11/7/19, indicated R breakdown. R5's progress notes refused to go to wo appointment was ref R5's Weekly Skin Ir indicated R5 contin pressure ulcer, alor right great toe and t superficial ulcer bet had not had a week 10/29/19. R5's Weekly Press 11/14/19, indicated measured 3.3 cm x with 25% granulatio moderate amount of with no odor. R5's documented as imp had increased, the decreased and slou not had an RN asse at the facility since treated for a worser infection. | ued to have unstageable e right heel, outer aspect of top of right second toe, along cer between 4th and 5th toes. eekly skin inspection since Assessment (a tool to assist in skin breakdown), dated 85 was at risk for skin a dated 11/8/19, indicated R5 und care appointment and escheduled for 11/22/19. Inspection dated 11/12/19, ued to have a right heel ag with the outer aspect of the tope of right second toe, and ween 4th and 5th toes. R5 ty skin inspection since ure Wound Evaluation dated R5's right heel pressure ulcer 5.2 cm and was unstageable on and 75% slough with a of serosanguineous drainage | F | \$86 | | | |

Facility ID: 00593

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| | - | AND HUMAN SERVICES | | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | ` ' | | E CONSTRUCTION | (X3) DATI | E SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | | | pleted C |
| | | 245483 | B. WING _ | | | | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOF | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | R5's right heel ulcer 0.3 cm with a minim On 11/19/19, at 10:: of nursing (ADON) pressure ulcer on th goes to wound care ADON stated R5's p and they have a goo On 11/20/19, at 8:44 (LPN)-A looked at F had showered. R5' edges, light slough, On 11/20/19, at 9:45 wound looked bette drainage. LPN-A st an infection in the ri On 11/20/19, at 1:5 nurse (RN)-F, soak pressure ulcers in v LPN-A sanitized han the right heel press 0.3 cm. LPN-A use to remove some slo sanitized hands, glo as ordered. LPN-A | s dated 11/20/19, indicated r measured 5 cm x 3.5 cm x hal amount of tan drainage. 58 a.m. the assistant director stated R5 had an unstageable he right heel. ADON stated R5 e, but R5 was non-compliant. pressure ulcer was improving od treatment for it. 4 a.m. licensed practical nurse R5's right heel wound after he is right heel ulcer had regular and was unstageable. 5 a.m. LPN-A stated R5's er, with some slough and some tated R5 had previously had | F 68 | 86 | | | |
| | (DON) verified wou | 4 p.m. director of nursing nd assessments were not ad a wound infection, and | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPL | E CONSTRUCTION | (X3) DAT | E SURVEY |
| AND PLAN C | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING | | | IPLETED C |
| | | 245483 | B. WING | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NORTH SHORE ESTATES LLC | | | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | weekly. The facility policy fo Wound Manageme weekly skin inspect licensed staff, docu the Pressure Woun | ge 34 ssments would be done or Skin Assessment and nt dated 12/18, directed a ion would be completed by ment skin condition weekly on d Evaluation, and review skin rdisciplinary team at least | F 6 | 86 | | | |
| | indicated diagnoses non-pressure right I diabetes, anemia, a R50's quarterly MD R50 had a severe of extensive assistant toileting, and was to hygiene. MDS furth unstageable pressu R50's physician ord ulcer with soap and amount of lososorb wrap with kerlix and every 2 days. Wea post-op boot while i R50's care plan upo had a wound to right | ers directed to wash left heel water, dry, smear a small on Xeroform (yellow gauze), I place surgilast, and change r heel boot while in bed, | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245483 | B. WING_ | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | IREET ADDRESS, CITY, STATE, ZIP CODE 700 GRAND AVENUE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 F 690 SS=D | physician orders. R50's medical reco Wound Evaluations 6/27/19-9/6/19, and On 11/20/19, at 2:10 left heel pressure u The ADON verified wound assessment 11/19/19. The ADC dressing was chang did not coordinate v dressing was chang wound evaluation. important to complet assessments to mo wound. On 11/20/19, at 4:30 would expect wound completed weekly. Bowel/Bladder Inco CFR(s): 483.25(e)(1) §483.25(e)(1) The f resident who is con admission receives maintain continence condition is or beco not possible to main §483.25(e)(2)For a incontinence, based comprehensive ass ensure that- (i) A resident who e | rd lacked Weekly Pressure from 5/23/19-6/12/19, 10/22/19-11/19/19. 0 p.m. the ADON stated R50's leer was identified on 3/29/19. she did not complete weekly s for R50 from 10/22/19, to on stated at that time, R50's ged every three days, and she with the nurses when the ged to complete the weekly The ADON stated it was bete weekly wound initor the progress of the 0 p.m. the DON, stated she d assessments to be ntinence, Catheter, UTI 1)-(3) ence. facility must ensure that tinent of bladder and bowel on services and assistance to a unless his or her clinical mes such that continence is ntain. resident with urinary | F 6 | | | 1/3/20 |

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| | | AND HUMAN SERVICES | | | FC | ORM A | 01/09/2020 APPROVED 0938-0391 | |
|--------------------------|---|--|-------------------|-----|---|------------------------------------|-------------------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | LE CONSTRUCTION (X3 | (X3) DATE SURVEY COMPLETED C | | |
| | | 245483 | B. WING | ÷ | | | , 1/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 690 | resident's clinical co catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that o and (iii) A resident who if receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For a incontinence, based comprehensive ass ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review, the facility fa to prevent incontine reviewed for incontine reviewed for incontine failed to assess and to maintain continen of 2 residents (R53) Findings include: R29's Admission Re indicated R29's diag embolism (blood cli- | ondition demonstrates that necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder e treatment and services to at infections and to restore extent possible. A resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel e treatment and services to armal bowel function as NT is not met as evidenced tion, interview, and document ailed to ensure timely toileting ence for 1 of 2 residents (R29) inence. In addition, the facility d develop a toileting program nce of bowel and bladder for 1) reviewed for incontinence. | F | 690 | Immediate Corrective Action: Resident #29 was provided toileting by NAR. Care plan and NAR care sheets were updated to reflect the same information. A toileting log was initiated resident #53 to reassess for an appropriate toileting program. Corrective Action as it applies to other The Policy and Procedure for ADL Assistance and was reviewed and remains current as it pertains to assistance with toileting. The Urinary Continence and Incontine Policy remains current. All residents needing assistance with | d for rs: | | |

Facility ID: 00593

If continuation sheet Page 37 of 68

| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 | |
|--------------------------|--|---|--------------------|-----|---|---|-------------------------------------|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
| | | 245483 | B. WING | | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | 1 | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 | | |
| THE NOP | TH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| F 690 | 10/2/19, indicated F no resistive behavior mood symptoms du R29's MDS further incontinent of bowe extensive assistance cares, and received R29's undated Care Urinary Incontinence completed for annu- date of 9/23/19, indi- assistance with toile incontinent of blade hospitalized with a R29's CAA indicate every 2 hours and a transferred using a not always alert sta R29 received Lasix for urgency and fre- indicated R29 was R29's care plan rev was able to commu- by others, and coul conversation. R29' frequently incontine directed staff to toil necessary. R29's care guide/pe 11/17/19, indicated directed staff to pro- awake. | nge 37 num Data Set (MDS) dated R29 was cognitively intact with brs, delirium, psychosis or uring the assessment period. indicated R29 was frequently and bladder, required ce of two staff for toileting d a diuretic on a regular basis. e Area Assessment (CAA) for ce and Indwelling Catheter, hal MDS with the reference icated R29 required eting cares, was frequently der, and had recently been urinary tract infection (UTI). d R29 was offered toileting as needed, and was stand-aide assist lift. R29 did ff to the need to use the toilet. , which could increase the risk quency. R29's CAA further able to communicate needs. rised 10/2/19, indicated R29 unicate needs, was understood d usually understand simple 's care plan indicated R29 was ent of bowel and bladder, and et every 2 hours and as | Fé | 590 | toileting will be provided this assist per care plan/care sheet details. All nurses and NARs will be re-edu on the ADL Assistance Policy by 1/ The education will include the need timely toileting per care plan. All residents who are incontinent we reassessed to determine whether at toileting program is appropriate. All nurses and NARs will be re-edu on the Urinary Continence and Incontinence Policy by 1/3/2019 as pertains to completion of a toileting determine whether a toileting progra appropriate. Date of Compliance: 1/3/2019 Recurrence will be prevented by: Audits of 5 incontinent residents we completed weekly x 4 then monthly months to assure toileting needs h been addressed and care planned that residents are being toileted ind care plan. The results of the audits shared with the facility QAPI comm for input on the need to increase, decrease or discontinue the audits Corrections will be monitored by: DON/ADON/Nurse Managers/Des | icated (3/2019. d for vill be a ucated a it g log to ram is ill be y x 2 ave and dividual s will be hittee | | |
| | | ary Report for Active Orders uded orders for Lasix (diuretic | | | | | | |

If continuation sheet Page 38 of 68

| | - | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|---------------|---|--|---------------|------|---|------|-----------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | ripl | | | E SURVEY |
| | F CORRECTION | IDENTIFICATION NUMBER: | ` ´ | | 3 | | PLETED |
| | | | | | | (| C |
| | | 245483 | B. WING | | | 11/2 | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (| (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | COMPLETION DATE |
| 1/10 | | , | | | DEFICIENCY) | | |
| | | | 1 | | | | |
| F 690 | - 1 | - | F 69 | 90 | | | |
| | medication) 40 milli | grams (mg) twice daily. | | | | | |
| | R29's progress not | es dated 10/21/19, through | | | | | |
| | | R29 had not had incidents of | | | | | |
| | refusing toileting ca | res. | | | | | |
| | $O_{\rm P}$ 11/19/10 at 0.4 | 7 a m. regident representative | | | | | |
| | | 7 a.m. resident representative wed and expressed concern | | | | | |
| | | t toileted frequently enough. | | | | | |
| | | | | | | | |
| | | observations from 7:25 a.m. R29 was in her room watching | | | | | |
| | | her hearing aide, visited with | | | | | |
| | RR-F, and ate brea | kfast. Staff had not entered | | | | | |
| | | F arrived at 8:05 a.m., and | | | | | |
| | | d toilet use since 7:25 a.m. talked to R29 about going to | | | | | |
| | | ned on the call light, and told | | | | | |
| | R29 she would be b | back 10 minutes prior to her | | | | | |
| | | hat morning. Before RR-F left red R29's room and RR-F | | | | | |
| | | would like to go to exercise | | | | | |
| | group and then she | would come back before the | | | | | |
| | | tated R29 would need to be | | | | | |
| | toileted prior to the offer toilet use prior | appointment. Staff did not | | | | | |
| | | took R29 downstairs to | | | | | |
| | exercise group. | | | | | | |
| | | eturned from exercise group | | | | | |
| | and the nurse chan | ge R29's oxygen. prought R29 down to her room. | | | | | |
| | | | | | | | |
| | | 1 a.m. R29 stated she had not | | | | | |
| | | m yet, and had just put on her | | | | | |
| | | o. Staff entered the room and had to go to the bathroom. | | | | | |
| | | | | | | | |
| | | 55 a.m. nursing assistant 9's room with the stand-assist | | | | | |

| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|--|--|---------------|----|---|------|--------------------|
| | | & MEDICAID SERVICES | | | | | 0938-0391 |
| | OF DEFICIENCIES | IDENTIFICATION NUMBER: | ` ´ | | | | E SURVEY PLETED |
| | | | | | | | c |
| | | 245483 | B. WING | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RTH SHORE ESTATES | | | 7 | 7700 GRAND AVENUE | | |
| | TH SHOKE ESTATES | | | D | DULUTH, MN 55807 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | X | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | COMPLETION DATE |
| | | , | | | DEFICIENCY) | | |
| | | | 1 | | | | |
| F 690 | Continued From pa | ge 39 | F 6 | 90 | 1 | | |
| | | her to the commode. R29 | | | | | |
| | | ode. NA-F verified R29's | | | | | |
| | | s a little damp. NA-F stated | | | | | |
| | usually was to be tolle | ted at least every 2 hours, but | | | | | |
| | usually was tolleted | per ner request. | | | | | |
| | On 11/19/19, at 10: | 26 a.m. NA-G stated R29 | | | | | |
| | | nd tell them when she had to | | | | | |
| | | , and they would answer | | | | | |
| | | me, NA-H verified the care | | | | | |
| | | t use every hour for R29. ould check on her and R29 | | | | | |
| | | ied staff should offer. | | | | | |
| | fround don, but form | | | | | | |
| | | 04 a.m. the assistant director | | | | | |
| | | stated nursing assistants | | | | | |
| | | e according to the care guide | | | | | |
| | | ed R29's family had wanted our for awhile when R29 was | | | | | |
| | | equently, and stated the care | | | | | |
| | | 2 hours and as needed. | | | | | |
| | | care guide sheets were not | | | | | |
| | changed when the | care plan was changed. | | | | | |
| | The facility policy for | ADL (activition of daily living) | | | | | |
| | | or ADL (activities of daily living) e Plan revised 5/20/19, | | | | | |
| | | ADL assistance to all | | | | | |
| | | the assessment and care | | | | | |
| | plan. Incontinent re | esidents were to be checked | | | | | |
| | and toileted accord | ing to the care plan. | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | R53's Admission Re | ecord printed 11/20/19, | | | | | |
| | | gnoses included Parkinson's | | | | | |
| | | esity, and a gastrostomy tube | | | | | |
| | (a tube inserted through a tub | ough the belly that brings the stomach). | | | | | |

If continuation sheet Page 40 of 68

| | - | AND HUMAN SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|--|---------------------|-----|--|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | | A. BUILDIN | NG. | | | C |
| | | 245483 | B. WING | | | 11/2 | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOF | RTH SHORE ESTATES | 3 LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 690 | Continued From pa | ge 40 | F 69 | 90 | | | |
| | R53 was cognitively | S dated 11/5/19, indicated y intact, and required ce with toileting, and was not am. | | | | | |
| | frequently incontine indicated toileting n for R53 to continue | /19/19, indicated R53 was ent of urine. The CAA leeds would be care planned to offer toileting, check, and nours, and overall goal was to ontinence. | | | | | |
| | alteration in elimina urinary tract infection impaired mobility, a and bladder. R53's dry, odor free, and t symptoms of UTI. I assistance of two a | ted 8/26/19, indicated R53 had attion related to a history or ons (UTI), urinary retention, and was incontinent of bowel a goal was to remain clean, to be free from signs and R53 interventions included and a Hoyer (mechanical lift) including peri care, pad, and ts. | | | | | |
| | indicated R53 was in bladder, did not info occasionally would had already voided R53 required two as Hoyer for transfers, management, and p toileting, check, and | uation dated 9/20/19, incontinent of bowel and orm staff of need to void, and ask staff for a urinal but R53 and did not void in a urinal. ssists with toileting including a , clothing and pad peri care. Staff was to offer d change every two hours. ake needs known and | | | | | |
| | 11/17/19, indicated | stant care guide sheet dated R53 was incontinent and and a Hoyer with toileting. | | | | | |

| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|-----------------------|--|--------------|------|---|------|-----------------------|
| | | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPI | O | | 0938-0391 E SURVEY |
| | F CORRECTION | IDENTIFICATION NUMBER: | · / | | | | PLETED |
| | | | | | | (| C |
| | | 245483 | B. WING | | | 11/2 | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID | | | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) COMPLETION |
| PREFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | X | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI | | DATE |
| | | | | | DEFICIENCY) | | |
| F 690 | Continued From pa | ge 41 | F 6 | 90 | | | |
| | | | | | | | |
| | | 6 p.m. R53 stated he urinated e he was unable to use the | | | | | |
| | | Id be unable to use the urinal | | | | | |
| | on his own. | | | | | | |
| | During observation | on 11/19/19, at 10:07 a.m. | | | | | |
| | | he had to "pee" during | | | | | |
| | morning cares. NA | -A instructed R53 just to "pee" | | | | | |
| | | e he was wearing an A-B asked NA-A if R53 had a | | | | | |
| | | R53 did not have urinal, and | | | | | |
| | told R53 that NA-A | would change and get him | | | | | |
| | cleaned up when he | e was done. | | | | | |
| | On 11/19/19. 11:24 | a.m. licensed practical nurse | | | | | |
| | (LPN)-B confirmed | R53 was incontinent of bowel | | | | | |
| | | ated R53 was getting stronger | | | | | |
| | | e able to use a urinal with stated R53 should be | | | | | |
| | assessed for a toile | ting program, and should be | | | | | |
| | offered to use the u | rinal or to be toileted. | | | | | |
| | On 11/19/19, at 12: | 50 p.m. R53 stated he would | | | | | |
| | prefer to use the ba | throom and not "pee" in his | | | | | |
| | | staff did not offer to take him offer a urinal. R53 stated | | | | | |
| | | ome into his room, R53 would | | | | | |
| | | and the staff was used to him | | | | | |
| | going in his pants. | | | | | | |
| | On 11/20/19, at 2.1 | 0 p.m. the ADON stated bowel | | | | | |
| | and bladder assess | ments were completed upon | | | | | |
| | | /, and with any resident | | | | | |
| | | N stated if a resident showed ay be able to be continent of | | | | | |
| | | ne resident would be started | | | | | |
| | on a toileting progra | | | | | | |
| | | | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | APPROVED 0938-0391 |
|--|---|--|---------------------|--|-------------------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 245483 | B. WING | | | C 21/2019 |
| NAME OF PROVIDER OR SUPPLIER THE NORTH SHORE ESTATES LLC | | SLLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 690 F 732 SS=C | On 11/20/19, at 4:30 resident was able to the resident should program. A toileting assess the resident highest bladder fun The facility policy B Toileting Plans for U 10/10, directed a re plan to assess for a resident. Conduct a resident and his or factors that may ha decline in urinary in and evaluate inform bladder habits, and Assess the resident behavioral program incontinence. Posted Nurse Staffi CFR(s): 483.35(g)(1) §483.35(g) Nurse S §483.35(g)(1) Data must post the follow basis: (i) Facility name. (ii) The current data (iii) The total numbe by the following catu unlicensed nursing resident care per sh (A) Registered nursi | 9 p.m. the DON stated if a overbalize they had to urinate, be on a bowel and bladder g log would be initiated to 's urinary patterns to promote ctioning. ehavioral Programs and Jrinary Incontinence dated view of the residents care iny special needs of the a thorough assessment of the her environment to determine ve contributed to any recent continence. Monitor, record, nation about the resident's continence or incontinence. t for appropriateness of s which promote urinary ng Information 1)-(4) staffing Information. requirements. The facility ving information on a daily e. er and the actual hours worked egories of licensed and staff directly responsible for nift: less. cal nurses or licensed as defined under State law). aides. | F 6 | | | 1/3/20 |

Facility ID: 00593

If continuation sheet Page 43 of 68

| | | AND HUMAN SERVICES | | | F | ORM APPROVED |) |
|-------------------|---|---|--------------|--|---------------|-----------------------------|---|
| | OF DEFICIENCIES | | | | | 3 NO. 0938-0391 | Т |
| | F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | 3) DATE SURVEY COMPLETED | |
| | | | | | | С | |
| | | 245483 | B. WING _ | | | 11/21/2019 | |
| NAME OF F | ME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | IP CODE | | |
| | NORTH SHORE ESTATES LLC | | | 7700 GRAND AVENUE | | | |
| | | | | DULUTH, MN 55807 | | | _ |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT | | (X5) COMPLETION | |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO T DEFICIENC | | TE DATE | |
| | 1 | | 1 | | • / | | - |
| F 732 | Continued From pa | ae 43 | F 73 | 12 | | | |
| | Continuou i rom pu | 90 10 | 170 | | | | |
| | §483.35(g)(2) Posti | ng requirements. | | | | | |
| | | post the nurse staffing data | | | | | |
| | | uph (g)(1) of this section on a ginning of each shift. | | | | | |
| | (ii) Data must be po | | | | | | |
| | (A) Clear and reada | able format. | | | | | |
| | | place readily accessible to | | | | | |
| | residents and visito | rs. | | | | | |
| | §483.35(g)(3) Publi | c access to posted nurse | | | | | |
| | | acility must, upon oral or | | | | | |
| | | ke nurse staffing data lic for review at a cost not to | | | | | |
| | exceed the commu | | | | | | |
| | | | | | | | |
| | §483.35(g)(4) Facili | | | | | | |
| | | facility must maintain the staffing data for a minimum of | | | | | |
| | | quired by State law, whichever | | | | | |
| | is greater. | | | | | | |
| | | NT is not met as evidenced | | | | | |
| | by: Based on interview | , and document review, the | | Immediate Corrective A | ction: | | |
| | | ure the required nurse staffing | | Nursing Staffing Informat | | ted | |
| | | sted daily. This had the | | in facility. | | | |
| | the facility. | l 65 residents who resided in | | Corrective Action as it ap | nlies to othe | re · | |
| | and raolinty. | | | The Nursing Hours Posti | | | |
| | Findings include: | | | remains current. | | | |
| | On 11/17/10 at 11. | 20 a.m. upon ontaring the | | Management nurses and | | | |
| | | 30 a.m. upon entering the irvey no staff posting and | | were re-educated on nee information is posted dai | | | |
| | | visible. Registered nurse | | reflect changes for each | | | |
| | | ne staff posting was to be | | Date of Compliance: 1/3/ | /2019 | | |
| | located on the first to the nurse's station | floor on the bulletin board next | | Recurrence will be preve | anted by: | | |
| | | 11. | | Audits of the nursing stat | | ion | |
| | On 11/17/19, at 11:4 | 40 a.m. RN-B working on the | | sheet will be completed v | | | |

Facility ID: 00593

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| | | AND HUMAN SERVICES | | | FORM | : 01/09/2020 APPROVED . 0938-0391 | |
|--------------------------|---|---|---------------------|---|-------------------------------------|---|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | CON | E SURVEY IPLETED | |
| | | 245483 | B. WING _ | | C 11/21/2019 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE NO | RTH SHORE ESTATES | S LLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F 732 | first floor confirmed place which identifie census. On 11/17/19, at 2:0 census was noted to located directly acro The posting dated of staffing. On 11/17/19, at 2:1 the staff posting way updated and posted on 11/20/19, at 2:4 interviewed and staff changes. The DON not posted 11/17/19, had entered the fact The facility form title Staff Directly Respondated 11/17/19, directly had entered the fact The facility form title Staff Directly Respondated 11/17/19, directly information is requiparticipating in Med Drug Regimen is Fin CFR(s): 483.45(d) Unnece Each resident's dru unnecessary drugs drug when used- | there was not a posting in ed the staffing and facility 6 p.m. facility staff posting and to be posted on first floor wall one posted on first floor wall poss from the nurse's station. 11/17/19, indicated census and 7 p.m. the administrator stated as not completed, and was d after the surveyors entered director of nursing (DON). 4 p.m. the DON was ted she was responsible for d census forms for the are to be updating with 1 stated the staff posting was 0, until after the survey team cility on 11/17/19. ed Hours Report of Nursing possible for Resident Care exced, "The posting of this red for nursing homes licare and Medicaid." ree from Unnecessary Drugs-General. g regimen must be free from . An unnecessary drug is any cessive dose (including | F 73 | monthly x 2 months to assure inf is being posted daily. The results audits will be shared with the fac committee for input on the need increase, decrease or discontinu audits. Corrections will be monitored by Administrator/DON/ADON/Nurse Managers/Designee | of the ility QAPI to e the | 1/3/20 | |

Facility ID: 00593

If continuation sheet Page 45 of 68

| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED <u>0938-0391</u> | |
|--------------------------|---|--|---------------------|-----|--|----------------------------------|--|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 245483 | B. WING | | | C 11/21/2019 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | <u> </u> | STR | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE NOP | TH SHORE ESTATES | SLLC | | | 0 GRAND AVENUE LUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| F 757 | Continued From pa | ige 45 | F 7 | 57 | | | | |
| | §483.45(d)(2) For e | excessive duration; or | | | | | | |
| | §483.45(d)(3) With | out adequate monitoring; or | | | | | | |
| | §483.45(d)(4) With use; or | out adequate indications for its | | | | | | |
| | | e presence of adverse ch indicate the dose should be nued; or | | | | | | |
| | stated in paragraph section. | combinations of the reasons is (d)(1) through (5) of this NT is not met as evidenced | | | | | | |
| | Based on interview facility failed to ens pressures for moni related psychotropi for 3 of 6 residents | v and document review, the ure orthostatic blood toring of potential side effects c medications were completed (R29, R39, R3) reviewed for cations. In addition, the facility | | | Immediate corrective action: Resident # 29s orthostatic BP s w completed. Residents #39 has discharged from facility. Resident #3 s orthostatic BP s w | n | | |
| | failed to ensure app medications for 1 o for unnecessary me | propriate diagnoses for use of f 6 residents (R39) reviewed edications. In addition, the | | | completed. Resident⊡s daily weigh continue to be monitored. | | | |
| | ordered by a physic | ure monitoring of weights as cian regarding a medical residents (R29) reviewed for cations. | | | Action as it applies to others: The Policy and Procedure for Antipsychotic medication use, inclu orthostatic BP□s, requirements for | MĎ | | |
| | Findings include: | | | 1 | orders on duration of use and need targeted behaviors remains curren All residents taking psychotropic m | t. | | |
| | indicated R29's dia embolism (blood cl arteries in the lungs respiratory failure, v | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive , edema, bipolar disorder, and | | | were reviewed to assure that ortho BPs are being completed as appro and that appropriate diagnosis are utilized. All residents with multiple day of we weights will be reviewed to ensure | static priate being eek | | |

Facility ID: 00593

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | F ⁱ | ORM A | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|---------------------------------------|--|---|-------------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | E CONSTRUCTION (X3 | COMF | SURVEY PLETED |
| | | 245483 | B. WING | | | C 11/2 | , 1/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | · | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATE | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| F 757 | was at risk for falls including CHF, ede vascular dementia. R29 was taking psy and behavior alterin nursing to obtain a pressure. R29's Order Summas of 11/19/19, incl -check vital signs d -Monthly psychotro side effects, update the 24th, monthly. Sertraline HCL (ar bedtime. Order sta -Olanzapine (antips for bipolar disorder R29's progress not R29 refused an ort progress notes lact attempts to re-appr blood pressure. R29's Treatment Ac indicated R29's ort not completed. R29's Weights and lacked documentat pressure. | tiated 8/24/18, indicated R29 related to medical conditions, ema, bipolar disorder, and R29's care plan indicated ychotropic medications (mood ng medications), and directed monthly orthostatic blood hary Report with Active Orders uded orders for: laily. Order 9/17/19. pic side effect monitoring, if e physician. Every day shift on htidepressant) 50 mg at | F 7 | 57 | they have specific parameters on when notify MD. All nurses will be re-educated on the Antipsychotic Medication Policy, includ orthostatic BP□s (if appropriate) and t appropriate diagnoses need to be utili for antipsychotic meds by 1/3/2019. All nurses will be re-educated by 1/3/2 on the Heart Failure-Clinical Protocol Policy with regards to the need to folic physician recommendations/parameters on when to notify physician for further direction. Date of completion: 1/3/2019 Recurrence will be prevented by: 3 residents receiving psychotropic medication will be reviewed weekly on various units x4 then monthly x2 to as orthostatic BPs are being completed a appropriate and that appropriate diagrare being utilized. The results of these audits will be reviewed by the facility C Committee monthly for input on the neet to increase, decrease or discontinue t audits. Audits of 5 residents with multiple day week weights will be completed weekly the facility C Committee for input on the neet to increase, decrease or discontinue t audits. The correction will be monitored by: | ding that ized 2019 ow ers ssure as nosis e QAPI eed the c) of ly x will | |
| | orthostatic blood pr | ober 2019, indicated R29's ressures for monitoring of cations were obtained on | | | The correction will be monitored by: DON/ADON/Nurse Managers/Designe | ee | |

Facility ID: 00593

| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|--------------------------------|---|---------------|-----|---|---------------------------------------|--------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPI | | OMB NO. 0938-0391 (X3) DATE SURVEY | |
| | OF CORRECTION | IDENTIFICATION NUMBER: | · / | | | COMPLETED | |
| | | | | | | (| C |
| | | 245483 | B. WING | | | 11/2 | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (| (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | COMPLETION DATE |
| | | | | | DEFICIENCY) | | |
| | | | 1 | | | | |
| F 757 | • | - | F 7 | 57 | | | |
| | | d documentation of orthostatic | | | | | |
| | blood pressure resu | uits. | | | | | |
| | | es dated 10/24/19, lacked | | | | | |
| | | 29's orthostatic blood | | | | | |
| | pressure results. | | | | | | |
| | R29's Weights and | Vitals Summary for 10/24/19, | | | | | |
| | | ion of an orthostatic blood | | | | | |
| | pressure. | | | | | | |
| | R29's TAR for Nove | ember 2019, indicated R29's | | | | | |
| | orthostatic blood pr | essure had not yet been | | | | | |
| | | eduled for 11/24/19. R29's | | | | | |
| | | was to be monitored monthly le effect monitoring monthly on | | | | | |
| | the 24th. | ie encountering montally on | | | | | |
| | | | | | | | |
| | | Vitals Summary dated /20/19, indicated no | | | | | |
| | | essures were obtained or | | | | | |
| | recorded for R29. | | | | | | |
| | $O_{\rm P} = 11/20/40$ at 4.20 | 9 n.m. director of nursing | | | | | |
| | | 8 p.m. director of nursing ostatic BP's should be | | | | | |
| | | ring of psychotropic | | | | | |
| | medications. | | | | | | |
| | R30's Admission P | ecord printed 11/20/19, | | | | | |
| | | gnoses included CHF, mild | | | | | |
| | cognitive impairmer | nt, encephalopathy (brain | | | | | |
| | . | or malfunction), major | | | | | |
| | depressive disorder | r, anu msomma. | | | | | |
| | | ary Report for active orders as | | | | | |
| | of 11/20/19, include | | | | | | |
| | | /chotic medication) 50 pedtime for primary insomnia, | | | | | |
| | order dated 10/29/1 | | | | | | |

If continuation sheet Page 48 of 68

| | | AND HUMAN SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|----|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | LE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | <u> </u> | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOR | RTH SHORE ESTATES | 3 LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 757 | -Sertraline (antidep tablet; take 2 tabs of dated 10/29/19 In addition, R39's of medications without medications: -Pregabalin Capsul -Slow Mag tablet Di- -Metoprolol Tartrate pressure) -Melatonin (hormon -Lisinopril (for high failure) -Furosemide (diure -Atorvastatin Calciu -Diltiazem CD ER 2 and heart failure) -cholestyramine ligh -cholecalciferol (vita -Budesonide capsu Crohn's or ulcerativ - Aspirin R39's order summa monitoring of psych effects, and orthost monitoring of psych R39's care plan init received psychotrop risk for adverse side directed nursing to reactions and obtai pressures. R39's Consultant P | Arressant medication) 100 mg daily for depression, order anders included the following th diagnoses for use of the le (nerve pain medication) R (magnesium supplement) e (for chest pain or high blood me used for sleep) blood pressure and heart ttic) um (for high cholesterol) 24 hour (high blood pressure ht packet (for high cholesterol) amin D supplement) le DR (anti-inflammatory for ve colitis) ary lacked direction for notropic medication side tatic blood pressures for notropic medications. tiated 8/29/19, indicated R39 pic medications and was at e effects. R29's care plan monitor for adverse drug n monthly orthostatic blood | F 7 | 57 | | | |
| | | /19, recommendations g of antipsychotics including | | | | | |

If continuation sheet Page 49 of 68

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORI | M APPROVED D. 0938-0391 |
|--------------------------|---|---|----------------------|-----|--|---------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) Mul A. Build | | PLE CONSTRUCTION G | (X3) DA | ATE SURVEY DMPLETED |
| | | 245483 | B. WING | i | | 1' | C 1/21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 757 | orthostatic blood pri target behaviors. N recommendation as R39's Medication A for September 2019 quetiapine fumarate through 9/12/19, me and sertraline for de included directives monitoring monthly completed on 9/6/11 R39's Treatment Ac September 2019, d lying and sitting (ort to antipsychotic me orthostatic blood pri done, but without re R39's progress note documentation of o results or attempts orthostatic blood pri R39's Weights and 9/6/29, lacked docu blood pressure. R39's MAR for Octor received quetiapine depression, and set melatonin for insom directives for antips monthly and was do 10/6/19. R39's TAR for Octor | essures, side effects, and lursing signed s completed on 8/12/19. dministration Record (MAR) 9, indicated R39 received e for insomnia on 9/10/19 elatonin daily for insomnia, epression daily. R39's MAR for antipsychotic side effect and was documented as 9. dministration Record (TAR) for irected nursing to obtain a chostatic) blood pressure due dication monthly. R39's essure was documented as esults. es dated 9/619, lacked rthostatic blood pressure to reapproach for the | F | 757 | 7 | | |

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ``` | | | (X3) DATE COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | - | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 757 | to antipsychotic me an orthostatic blood 10/6/19, but lacked R39's Weights and indicated R39's orth completed, and ind hypotension (drop i in position from lyin R39's MAR for Nov received melatonin insomnia, and sertr MAR lacked direction medication side effer R39's TAR for Nove to obtain orthostatic to psychotropic meet R39's Weights and readmission on 10/2 blood pressures ha R39's progress note 10/29/19, lacked do blood pressures, or use of quetiapine of R39's Target Behav 11/14/19. R39's NP visit note had received quetia nursing reported not | dication. R39's TAR indicated d pressure was obtained on documentation of results. Vitals Summary for 10/6/19, nostatic blood pressure was icated no orthostatic n blood pressure) with change g to sitting. ember 2019, indicated R39, quetiapine fumarate for aline for depression. R39's on to monitor for antipsychotic ects. ember 2019, lacked direction blood pressures monthly due dications. vitals Summary since 29/19, indicated no orthostatic | F | 757 | | | |

If continuation sheet Page 51 of 68

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED . 0938-0391 |
|--------------------------|---|---|----------------------|-----|---|-----------------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | LE CONSTRUCTION | (X3) DAT COM | E SURVEY IPLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 757 | quetiapine was pres quetiapine and star R39's progress note had not been sleep the physician had d that had helped her R39's progress note R39's progress note recurred since quet reordered quetiapin R39's progress note insomnia was not a quetiapine. R39's Consultant P Review dated 9/12/ regarding quetiapin sleep was not an ap quetiapine and reco assessment of the R39, and if the diag use of quetiapine. changing R39's diag depression. R39's physician visi indicated R39 had s physician on 9/9/19 should restart queti been restarted. R39's progress note R39's diagnosis for depression. R39's Consultant P | es dated 9/8/19, indicated R39 ing well and was concerned iscontinued the quetiapine sleep good previously. es dated 9/9/19, indicated physician sated insomnia had iapine was discontinued, so | F7 | 757 | | | |

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PRINTED: 01/09/2020

| | FORM | APPROVED 0938-0391 | | | | | |
|--------------------------|--|---|---------------------|------|--|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TIPL | LE CONSTRUCTION | (X3) DATE | E SURVEY |
| AND PLAN C | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | ING | | | PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| THE NOP | RTH SHORE ESTATES | 3 LLC | | | 7700 GRAND AVENUE | | |
| | | | | | DULUTH, MN 55807 | | 0.(-) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 757 | Continued From pa | ge 52 | F 7 | 57 | | | |
| | | The pharmacist indicated on | | | | | |
| | | ot showing signs of agitation discontinued. Resident then | | | | | |
| | complained of not b | peing able to sleep and | | | | | |
| | | ted with a diagnosis of sleep to a diagnosis of depression. | | | | | |
| | The consultant pha | rmacist recommended | | | | | |
| | | e quetiapine and starting a uld target sleep, such as | | | | | |
| | trazodone or mirtaz | apine that would also help | | | | | |
| | | 39's physician addressed the mendation by ordering | | | | | |
| | trazodone in place | | | | | | |
| | R39 had been read | tes dated 11/4/19, indicated mitted from a hospital stay | | | | | |
| | | 10/29/19, for heart failure 's physician visit notes | | | | | |
| | indicated medicatio | ns were reviewed, but | | | | | |
| | | t provided for use of icked diagnoses for psychosis | | | | | |
| | or psychotic behavi | ors. R39's physician visit | | | | | |
| | notes further indicated behavioral changes | ted R39 had not significant | | | | | |
| | - | | | | | | |
| | | s dated 11/11/19, lacked cations received by R39 per | | | | | |
| | | visit notes indicated R39's | | | | | |
| | | nd had no significant | | | | | |
| | | R39's NP visit notes further ived quetiapine for chronic | | | | | |
| | | plan was to continue the | | | | | |
| | | | | | | | |
| | | oner (NP) visit notes dated orthostatic blood pressures | | | | | |
| | had not been check | ked between 11/19/19 and | | | | | |
| | 11/21/19, and lacke received by R39 pe | ed diagnoses for medications er orders. | | | | | |

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| | MENT OF HEALTH | | FORM | APPROVED 0938-0391 | | | |
|--------------------------|---|---|---------------------|-----------------------|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 0.15.100 | | NG_ | | | C |
| | PROVIDER OR SUPPLIER | 245483 | B. WING | 61 | IREET ADDRESS, CITY, STATE, ZIP CODE | 11/2 | 21/2019 |
| | | | | | 700 GRAND AVENUE | | |
| THE NOF | RTH SHORE ESTATES | SLLC | | | ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 757 | Continued From pa | ge 53 | F 7 | 57 | | | |
| | | 2 p.m. R39 stated she felt her elpful and she had not de effects. | | | | | |
| | (DON) stated she w pressures to be dor any psychotropic m quetiapine is not an sleep and verified F pressures were not side effect monitorin following R39's hos been done. DON v had seen R39 since and nursing should diagnoses of medic verified R39's Psych | 9 p.m. director of nursing yould expect orthostatic blood he when a resident is receiving edication. DON verified appropriate medication for R39's orthostatic blood completed and antipsychotic ng was not on the TAR pital return and should have erified the NP and physician have put in a request for sations at that time. DON hotropic Medication review leted as dated for 10/10/19, r Form was not completed for | | | | | |
| | revised 12/16, direct receive antipsychot necessary to treat st they are indicated a policy and procedur physician to identify symptoms that may antipsychotic medic specific condition for medications are ner based on a compre Antipsychotic media only symptoms wer | ntipsychotic Medication Use sted residents would "only ic medications when specific conditions for which and effective." The facility re further directed the r, evaluate and document r warrant the use of cations, and the diagnosis of a or which the antipsychotic cessary to treat would be hensive assessment. ations would not be used if the e one or more of symptoms ess, insomnia, nervousness, or | | | | | |

If continuation sheet Page 54 of 68

| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|--|--|---------------|------|---|------|--------------------|
| | CS FOR MEDICARE | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | | ONSTRUCTION | | 0938-0391 |
| | F CORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
| | | 045400 | | | | | С |
| | PROVIDER OR SUPPLIER | 245483 | B. WING | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | 11/2 | 21/2019 |
| | | | | | GRAND AVENUE | | |
| THE NOP | RTH SHORE ESTATES | 5 LLC | | DUL | UTH, MN 55807 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL | ID | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION |
| PREFIX TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | 1 | | DEFICIENCY) | | |
| F 757 | Continued From pa | ae 54 | F 75 | 57 | | | |
| _ | Continuou i rom pu | 9001 | 1 / C | 01 | | | |
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| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | cord dated 11/20/19, indicated | | | | | |
| | R3's diagnoses incl disorder and anxiet | uded major depressive | | | | | |
| | | y disorder. | | | | | |
| | | dated 8/21/19, identified R3 | | | | | |
| | also identified she | paired cognition. R3's MDS | | | | | |
| | | dication for seven days, during | | | | | |
| | | back period, and had two or | | | | | |
| | more falls without ir | ijury. | | | | | |
| | | ry Report dated 11/20/19, | | | | | |
| | - | rdered orthostatic blood | | | | | |
| | | ng due to psychotropic on the 10th day of every | | | | | |
| | month. Further, R3 | 3 was ordered fluoxetine | | | | | |
| | (antidepressant) 20 8/30/19. | mg daily for depression on | | | | | |
| | 0/30/19. | | | | | | |
| | R3's care plan date | d 3/14/19, indicated R3 had | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|------|--|----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
| | | 245483 | B. WING | NG _ | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE | | |
| | | TEMENT OF DEFICIENCIES | | U | PULUTH, MN 55807 PROVIDER'S PLAN OF CORRECTION | .1 | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 757 | potential for psycho related to fluoxetine Interventions includ drug reactions. R3's November 201 orthostatic blood pre Review of R3's weig 12/2/19, lacked indi pressures were rec 11/21/19. On 11/20/19, at 10:: conducted with regi confirmed she was blood pressures in l stated staff were ex a process for leavin results was being p | tropic adverse drug reactions medication usage. ed monitoring for adverse 19 TAR lacked indication essures were taken. ghts and vitals summary dated cation orthostatic blood orded from 8/1/19, to 34 a.m. an interview was stered nurse (RN)-E. RN-E unable to locate orthostatic R3's medical record. RN-E spected to follow the order and a progress notes with | F 7 | 57 | | | |
| | conducted with the expected staff were | DON. The DON stated she e to complete full sets of essures as indicated, and | | | | | |
| F 760 SS=D | revised 12/16, direct document, and report the attending physic hypotension." Residents are Free | ntipsychotic Medication Use sted nursing staff to observe, ort adverse consequences to cian such as "orthostatic of Significant Med Errors | F 7 | 60 | | | 1/3/20 |
| | The facility must en §483.45(f)(2) Resid medication errors. | sure that its- lents are free of any significant | | | | | |

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | r – | | | | APPROVE 0938-039 | |
|--------------------------|---|--|---------------------------------------|----|--|------------------------------|----------------------------|--|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | COMI | E SURVEY PLETED | |
| | | 245483 | B. WING | | | (11/2 | C 21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | 21/2013 | |
| THE NO | RTH SHORE ESTATES | SLLC | 7700 GRAND AVENUE DULUTH, MN 55807 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 760 | Continued From pa | ige 56 | F 7 | 60 | | | | |
| | by: | NT is not met as evidenced | | | | | | |
| | review, the facility | tion, interview, and document ailed to ensure a correct ic pain medication was if 8 residents (R52) reviewed | | | Immediate Corrective Action: Resident #52 s Narco was disconti on 11/26/19. The licensed nurses who administer incorrect doses of Narco to resident | red the | | |
| | Findings include: | | | | were re-educated on completing the appropriate checks including checki medication label to MD order on MA | ng | | |
| | indicated R52's dia | ecord dated 11/19/19, gnoses included humerus f upper arm) and mild cognitive | | | before administering medication. Corrective Action as it applies to oth The Policy and Procedure regarding Medication Administration remains | | | |
| | 10/28/19, identified R52's MDS further needed pain medic | inimum Data Set (MDS) dated R52 had intact cognition. identified he received as ation, had occasional pain, pain medication for seven | | | All residents were reviewed to ensure all medication cards are current with is on the EMAR and that there are no current medication errors. All nurses will be re-educated the pr procedure for medication administration | n what io roper | | |
| | indicated R52 was pain medication) 10 six hours as needed | hary Report dated 11/19/19, prescribed Norco (a narcotic 0-325 milligrams (mg) every d for pain rated six or greater n scale. The order was placed | | | including checking medication label order on MAR before administering medications by 1/3/2019 Date of Compliance: 1/3/2019 Recurrence will be prevented by: | | | |
| | R52's care plan dat not wish to self-adn a mild cognitive imp further indicated R5 | ted 11/1/19, indicated R58 did ninister medications, and had pairment. The care plan 58 would be administered ysician orders and by a | | | Audits of 3 nurses per week will be completed weekly x 4 then monthly months to assure medications are b appropriate passed per policy. The i of these audits will be shared with th facility QAPI committee for input on need to increase, decrease or disco the audits. | eing results ne the | | |
| | Record (MAR) print | 018 Medication Administration ted 11/19/19, indicated R58 Irocodone-acetaminophen | | | Corrections will be monitored by: DON/ADON/Nurse Managers/Desig | jnee | | |

Facility ID: 00593

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|-------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | LE CONSTRUCTION | (X3) DATE COMI | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 760 | (Norco) 5-325 mg. every four hours as two tablets as need numeric pain scale. R58 was administe p.m. and 11/14/19, started on 11/6/19, R52's November 20 indicated R58 was R58 was to take on needed, for pain rat needed, for pain rat scale. The MAR fu administered Norco and 11/17/19, at 8:2 on 11/15/19, and di On 11/17/19, at 7:1 nurse (LPN)-C and administering medic LPN-C and LPN-E medication. LPN-C labeled Norco 10-3: a locked compartm LPN-C compared th electronic medicatio (eMAR) and verbalic card label did not m LPN-C did not adm requested LPN-E to located in R58's pa verified six doses o dispensed from the nurse (RN)-E walke informed LPN-C the | R58 was to take one tablet needed for pain rated 4-7, or ed for pain rated 8-10 on the The MAR further identified red Norco 11/12/19, at 4:39 at 1:06 a.m. The order was and discontinued on 11/15/19. D18 MAR printed 11/19/19, prescribed Norco 5-325 mg. e tablet every six hours, as ted 4-7 or two tablets, as ted 8-10 on the numeric pain rther identified R58 was o on 11/16/19, at 6:31 a.m., 46 a.m. The order was started scontinued on 11/18/19. 7 p.m., licensed practical LPN-E were observed cations. R58 approached and stated he needed pain cremoved a medication card 25 mg, belonging to R58, from ent within the medication cart. the medication card label to the on administration record ized the dosage on medication patch the physicians order. inister the Norco and o check the physicians order. inister the Norco and o check the physicians order per medical record. LPN-C f Norco 10-325 mg had been medication card. Registered ed to the medication cart and e physician order indicated the s Norco 5-325, and stated she | F | 760 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | : 01/09/2020 APPROVED . 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|-----------------|---|
| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DAT COM | E SURVEY IPLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 760 | On 11/17/19, at 7:2 conducted with RN- medical record, and was updated in the verbalized the Nord from every four hou the dosage of 5-329 RN-E stated the ord according to the wr error occurred as si medication label ag ensure accuracy. To observed, and RN- incorrectly administ was documented at A Medication Error 11/17/19, indicated, 10-325 administered to pharmacy but no 11/12/19." The Med Form further indication was administered a reached the patient harm." On 11/20/19, at 3:3 conducted with the The DON stated the medication labels a prior to administrati adverse consequer of opioid pain media and constipation. The facility policy A revised 4/19, direct administering the m | 7 p.m., an interview was E. RN-E audited R58's d stated R58's Norco order eMAR on 11/15/19. RN-E to frequency was changed its to every six hours however, 5 mg remained the same. der transcription was accurate, itten physician order, and the taff had failed to verify the ainst the medication order to The medication card was again E confirmed six doses were ered. The medication card is filled on 11/12/19. Reconciliation Form dated "Dose sent from pharmacy d total of 6 times. Escript sent t facility for updated dose on dication Error Reconciliation ted the wrong drug/dosage and "an error occurred that but did not cause patient 6 p.m. an interview was director of nursing (DON). e nurses were to check gainst the medication orders on. The DON further stated nees of receiving double doses cation could include confusion | F | 760 | | | |

If continuation sheet Page 59 of 68

| | | AND HUMAN SERVICES | | | | FORM | 01/09/202 APPROVE |
|--------------------------|--|---|--------------------|-----|--|-----------------------------------|--------------------------------|
| TATEMENT | RS FOR MEDICARE OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | CONSTRUCTION | (X3) DAT COM | 0938-039 E SURVEY PLETED |
| | | 245483 | B. WING | i | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | TH SHORE ESTATES | S LLC | | | 0 GRAND AVENUE LUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE |
| F 760 | Continued From pa | ige 59 | F 7 | 760 | | | |
| | | osage, right time and right administration before giving the | | | | | |
| | Food Procurement, CFR(s): 483.60(i)(1 | Store/Prepare/Serve-Sanitary)(2) | F٤ | 312 | | | 1/3/20 |
| | §483.60(i) Food sa The facility must - | fety requirements. | | | | | |
| | approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision d facilities from using gardens, subject to safe growing and fo (iii) This provision of | e food items obtained directly rs, subject to applicable State | | | | | |
| | serve food in accor standards for food This REQUIREMEN by: | NT is not met as evidenced | | | Immediate Corrective Action | | |
| | review, the facility f served at the appro- food safety and pre- had a potential to a | tion, interview, and document ailed to ensure food was opriate temperature to ensure event food borne illness. This ffect 63 of 65 residents who n the facility kitchen. | | | Immediate Corrective Action: Food temps were checked to e were at appropriate temp. Corrective Action as it applies t The Food Preparation and Serv was reviewed and remains curr All culinary staff will be re-educ | o others: vice Policy rent. | |
| | Findings include: On 11/17/19, at 5:3 | 4 p.m. review of the facility | | | need to take and document for temperatures in the kitchen prio meal being served by 1/3/2019 | od or to each | |
| | | og for November 2019, | | | Date of Compliance: 1/3/2019 | | |

Facility ID: 00593

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|--|---|---------------------|--|--|-------------------|-------------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | <u> </u> | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SLLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 812 | Continued From pa | age 60 | F 8 | 12 | | | |
| | revealed temperatu following meals: | | | | Recurrence will be prevented by: Random audits will be conducted a | at 4 | |
| | Breakfast food tem 11/9, 11/13, and 11 | peratures for 11/4, 11/5, 11/8, /14. | | | different meals weekly x 4 then mo 2 months to assure that food temperatures are being completed | onthly x | |
| | Lunch food temper 11/9, 11/13, and 11 | atures for 11/4, 11/5, 11/8, /14. | | | recorded and are within appropriate The results of the audits will be sha with the facility QAPI committee for | e limits. ared | |
| | Supper food temper and 11/15. | temperatures for 11/2, 11/3, 11/9, on the need to increase, decrease discontinue the audits. | | | | | |
| | (DM)-A was intervie reviewed November stated this was the dietary manager. D been notified if food taken so retraining DM-A stated food s was important to en | 57 p.m. dietary manager ewed, and stated she had not er food temperature logs. DM-A responsibility of the assistant M-A stated she soul have d temperatures were not being of staff could have occurred. safety and temperature of food nsure bacterial growth does uld lead to food borne illness | | | Corrections will be monitored by: Culinary Director/Administrator/De | signee | |
| | (DON) stated taking serving food was in | 0 p.m. the director of nursing g food temperature before nportant not only for food ng food borne illness, but also | | | | | |
| | 12/16, directed coo temperatures and r temperatures are n | Culinary Department dated king foods at proper maintaining proper ecessary to prevent e producing bacteria). | | | | | |
| | undated, directed s | ood Re-Heating and Handling taff that all potentially ist be reheated to 165 degrees | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|---|--------------------|---|--|------|-------------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | CON | E SURVEY IPLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | ę | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | S LLC | | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | Fahrenheit or above hours, and held above until served to prev The facility training undated, directed k record food temper Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must ess infection prevention designed to provide comfortable environ development and tr diseases and infect §483.80(a) Infection program. The facility must ess and control prograr a minimum, the foll §483.80(a)(1) A sys reporting, investiga and communicable staff, volunteers, vis providing services to arrangement based conducted accordir accepted national s §483.80(a)(2) Writt procedures for the but are not limited to | e for 15 seconds within two ove 150 degrees Fahrenheit ent bacteria from growth. material Food Preparation itchen staff to check and ratures prior to service. n & Control 1)(2)(4)(e)(f) Control stablish and maintain an n and control program e a safe, sanitary and ment and to help prevent the ransmission of communicable tions. n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards; en standards, policies, and program, which must include, | F | | | | 1/3/20 |

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| | - | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|--|--|--------------|----|--|---------------|--------------------|
| | | & MEDICAID SERVICES | | | | | 0938-0391 |
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| | PROVIDER OR SUPPLIER | 2-10-100 | | | TREET ADDRESS, CITY, STATE, ZIP CODE | T1/4 | 21/2019 |
| | | | | | 700 GRAND AVENUE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | ULUTH, MN 55807 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | X | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | | COMPLETION DATE |
| IAG | | | 170 | | DEFICIENCY) | () () <u></u> | |
| | | | 1 | 1 | | | |
| F 880 | Continued From pa | ge 62 | F 8 | 80 | | | |
| | | ey can spread to other | | | | | |
| | persons in the facili | | | | | | |
| | | om possible incidents of ase or infections should be | | | | | |
| | reported; | | | | | | |
| | | ansmission-based precautions | | | | | |
| | | event spread of infections; | | | | | |
| | resident; including t | solation should be used for a | | | | | |
| | | uration of the isolation, | | | | | |
| | | e infectious agent or organism | | | | | |
| | involved, and | | | | | | |
| | | hat the isolation should be the sible for the resident under the | | | | | |
| | circumstances. | | | | | | |
| | | ces under which the facility | | | | | |
| | | oyees with a communicable skin lesions from direct | | | | | |
| | | nts or their food, if direct | | | | | |
| | contact will transmit | | | | | | |
| | | ne procedures to be followed | | | | | |
| | by staff involved in | direct resident contact. | | | | | |
| | \$483,80(a)(4) A svs | stem for recording incidents | | | | | |
| | | facility's IPCP and the | | | | | |
| | corrective actions ta | aken by the facility. | | | | | |
| | \$492.90/a) Linana | | | | | | |
| | §483.80(e) Linens. Personnel must har | ndle, store, process, and | | | | | |
| | | as to prevent the spread of | | | | | |
| | infection. | | | | | | |
| | \$102 00/f) Amount | oviow | | | | | |
| | §483.80(f) Annual r | eview. duct an annual review of its | | | | | |
| | | eir program, as necessary. | | | | | |
| | | NT is not met as evidenced | | | | | |
| | by: | | | | | | |
| | | ion, interview and document ailed to ensure proper hand | | | Immediate corrective action: NAR was re-educated on completir | na | |

Facility ID: 00593

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| TATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TIPLE | E CONSTRUCTION | (X3) DATE | 0938-039 | |
|--------------------------|---|--|---------------------|-------|--|-----------------------------------|---------------------------|--|
| ND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: A. BUILDING | | | | PLETED | | |
| | | 245483 | B. WING | | | C 11/21/2019 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | ľ | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE NO | RTH SHORE ESTATE | S LLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETIO DATE | |
| F 880 | Continued From pa | age 63 | F 8 | 80 | | | | |
| | toileting cares to p | use during personal cares and revent cross contamination for 29) reviewed for bowel and | | | appropriate hand hygiene and glove assisting resident⊡s with peri-care. Action as it applies to others: | | | |
| | Findings include: | Record printed 11/19/19, | | | The Handwashing/Hand Hygiene P was reviewed and remains current. All nursing assistants and nurses w re-educated on handwashing and g | ill be | | |
| | indicated R29's dia embolism (blood c arteries in the lung | agnoses included pulmonary lot in one of the pulmonary s), acute and chronic vascular dementia, congestive | | | use after completing resident cares focus on not touching other objects room before handwashing being completed. Date of completion: 1/3/2019 | with a | | |
| | completed 10/2/19 intact with no resis psychosis or mood assessment period R29 was frequently bladder, required e | num Data Set (MDS) , indicated R29 was cognitively tive behaviors, delirium, I symptoms during the d. R29's MDS further indicated y incontinent of bowel and extensive assistance of two ares, and received a diuretic on | | | Recurrence will be prevented by: Visual audits of handwashing/glove changing during ADLs will be condu 3x weekly for 3 residents on various x 4 weeks then monthly x 2 months the results shared with QAPI on the to increase, decrease, or discontinu- audits. | ucted s units and e need | | |
| | R29's undated Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, completed for annual MDS with the reference date of 9/23/19, indicated R29 required assistance with toileting cares, was frequently incontinent of bladder, and had recently been hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix (diuretic), which could increase the risk for urinary urgency and | | | | The correction will be monitored by DON/ADON/Designee | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | | E CONSTRUCTION | (X3) DATI COM | E SURVEY PLETED |
| | | 245483 | B. WING | | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | 3 LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 880 | Continued From pa | ge 64 | F٤ | 380 | | | |
| | was able to commu by others, and could conversation. R29' frequently incontine directed staff to toil necessary. R29's care guide/po 11/17/19, indicated | rised 10/2/19, indicated R29 inicate needs, was understood d usually understand simple s care plan indicated R29 was ent of bowel and bladder, and et every 2 hours and as ocket care plan dated R29 was incontinent, and wide bourty toileting while | | | | | |
| | directed staff to pro awake. On 11/19/19, at 9: 5 (NA)-F entered R29 lift to assist R29 wit washed her hands, curtain and shades stand-assist lift up t canvas and calf stra gloves, sanitized he performing hand hy and removed R29's R29 to a standing p lowered R29's inco to the commode. N little damp with urin gloves and sanitize moderate amount of commode. Without NA-F donned clean stand-assist lift, wip personal cleansing her soiled gloves a put on clean gloves brief on R29, move way, put the wheeld | vide hourly toileting while 55 a.m. nursing assistant b's room with the stand-assist h toileting cares. NA-F donned gloves, closed the , and positioned the to R29. NA-F hooked up the aps, and removed her soiled er hands and without rgiene donned clean gloves, s oxygen canula. NA-F raised position in the stand-assist lift, ntinent brief, and lowered R29 A-F stated R29's brief was a e. NA-F removed her soiled ed her hands, as R29 voided a of yellow urine in the t performing hand hygiene, gloves, raised R29 in the bed R29's peri area with a wipe. NA-F did not remove and perform hand hygiene, and b. NA-F put a clean incontinent d the commode out of the chair in place, lowered R29 unbuckled the canvas, | | | | | |

Facility ID: 00593

If continuation sheet Page 65 of 68

| A. BOILDING C 245483 B. WING 11/21/201 | |
|--|----------------------------|
| | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| THE NORTH SHORE ESTATES LLC 7700 GRAND AVENUE DULUTH, MN 55807 | |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | (X5) COMPLETION DATE |
| F 880 Continued From page 65 F 880 pushed the wheelchair back, and then removed her solied gloves. NA-F sanitized her hands and donned clean gloves. NA-F placed R29's oxygen canulu on R19's face. NA-F moved the stand-assist lift out of R29's room and brought it into the tub room. NA-F stated she thought she had changed gloves and sanitized following peri care, and said she should have. On 11/19/19, at 11:04 a.m. the assistant director of nursing (ADON) stated staff should remove solled gloves, sanitize or wash hands, and put clean gloves on going from dirty to clean areas and tasks. The facility Handwashing policy dated 1/08, directed handwashing should be completed when hands are visibly soiled, and when hands are not visibly soiled, to use an alcohol based hand rub. The policy further directed hand hygiene should be performed before and after contact with residents, before doing an invasive procedure, after contact with bodily fluids, before moving from contaminated body site to a clean body site during resident cares, after contact with F 947 SS=F CFR(s): 483.95(g)(1)-(4) \$483.95(g)(2) Required in-service training for nurse aides, In-service training must. \$483.95(g)(2) Required in-service training for nurse | 1/3/20 |

Facility ID: 00593

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PRINTED: 01/09/2020

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 01/09/2020 APPROVED 0938-0391 |
|--------------------------|--|---|-------------------|-----|--|---|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | | X3) DATE COMF | E SURVEY PLETED |
| | | 245483 | B. WING | | | (11/2 |) 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | }E ATE | (X5) COMPLETION DATE |
| F 947 | §483.95(g)(3) Addr determined in nurse and facility assessm address the special determined by the f §483.95(g)(4) For m to individuals with c address the care of This REQUIREMEN by: Based on interview facility failed to ensu- training, and Alzhein provided to staff du working with reside assistants (NA-I) re addition, the facility reviews were comp 9 nursing assistants employed by the fac had the potential to in the facility. Findings include: A review of staff tra assistant (NA)-I was not received abuse working with reside On 11/18/19, at 3:5 (DON) verified NA- abuse and dementi The facility policy A | at abuse prevention training. at abuse prevention training. as areas of weakness as a aides' performance reviews nent at § 483.70(e) and may needs of residents as acility staff. aurse aides providing services ognitive impairments, also the cognitively impaired. NT is not met as evidenced and document review, the ure abuse, vulnerable adult mer's/dementia training was ring orientation and prior to nts for 1 of 5 nursing viewed for staffing. In failed to ensure performance leted every 12 months for 1 of s (NA-B) who had been cility for over one year. This affect all 65 residents residing ining records indicated nursing s hired on 6/24/19, and had or dementia training prior to nts. 8 p.m. director of nursing I had not received the required a training. buse Prevention/Vulnerable | FS | 947 | Immediate corrective action: NAR who had not completed abuse, vulnerable adult training, and Alzheimer s/ Dementia training will complete the missing training sessions before beir allowed to work with residents. The NAR sperformance evaluation had not been completed was reviewed/completed with NAR. Action as it applies to others: The Abuse Prevention/Vulnerable Ac Plan Policy remains current. All staff who have been employed les than 1 year will be reviewed to ensur they have received abuse, vulnerable adult training, and Alzheimer s/dem training and will be removed from the schedule until it is completed. All management team involved in the hiring process were re-educated on to ensure that abuse, vulnerable adult training, and Alzheimer s/dementia training are completed by all new hird | ng h who dult ss re that e hentia e need ult | |
| | | 7/18, directed staff to receive | | | prior to working with residents. | | |

Facility ID: 00593

If continuation sheet Page 67 of 68

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | СОМ | E SURVEY PLETED |
|--------------------------|--|--|---------------------|--|--|---------------------------|
| | | 245483 | B. WING | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | |
| THE NO | RTH SHORE ESTATE | S LLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE |
| F 947 | • · · · · · · · · · · · · · · · · · · · | • | F 94 ⁻ | 7 | | |
| | training in new em annually. The facility Demen revised 1/18, and v admission packet, receive 8.25 hours hours worked, and thereafter. The fac training would inclu Alzheimer's, comp abuse prevention i | esident's rights, and abuse ployee orientation and taia Training Disclosure policy was provided in the resident indicated all staff would of training within their first 160 I 2 hours of training annually cility disclosure indicated ude a comprehensive view of rehensive view of dementia, in persons with dementia, and vely impaired resident. | | The personnel Records Per- current. All facility staff records will and annual performance e be completed as needed. Date of completion: 1/3/20 Recurrence will be preven Administrator will work with Resources to assure new the abuse, vulnerable adu Alzheimer⊡s/dementia tra working with residents and performance evaluations a a timely manner. This will practice reviewed monthly The correction will be mon Administrator/Human Resources/Designee | be reviewed evaluations will 19 ted by: h Human hires receive It training, and ining prior to I that annual are completed in be an ongoing by both. | |
| | | eyee Roster Report printed on sonnel record review indicated | | | | |
| | | vas 6/6/18. No annual w had been completed. | | | | |
| | consultant confirm | 39 p.m. the facility nurse ed NA-B did not have an ce review completed. | | | | |
| | | Personal Records dated erformance evaluations were to ast annually. | | | | |

If continuation sheet Page 68 of 68

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION 1 - MAIN BUILDING 01 | | TE SURVEY MPLETED |
|--------------------------|---|---|---------------------|--|----------|---------------------------|
| | | 245483 | B. WING | | 11 | /19/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STATE, ZIP CO | | 1012010 |
| | RTH SHORE ESTATES | S LLC | 0 | 00 GRAND AVENUE JLUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETIC DATE |
| K 000 | INITIAL COMMENT | ſS | K 000 | | | |
| | FIRE SAFETY | | | | | |
| | ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH | OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE. | | | | |
| | ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA | F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. | | | | |
| | Minnesota Departm Fire Marshal Divisio The North Shore Es compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F | Survey was conducted by the eent of Public Safety, State on. At the time of this survey, states was found not in requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), Health Care. | | | | |
| | IF OPTING TO USE OF THE PLAN OF (REQUIRED. PLEASE RETURN | E AN EPOC, A PAPER COPY CORRECTION IS NOT THE PLAN OF | | EPC | C | |
| | | R THE FIRE SAFETY | | | | |

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.

| | | AND HUMAN SERVICES | | | | FORM | : 12/31/2019 APPROVED . 0938-0391 |
|--------------------------|---|---|---------------------|----|---|----------|---|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DAT | E SURVEY |
| | | 245483 | B. WING | | | 11/ | 19/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 13/2013 |
| THE NOP | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE DULUTH, MN 55807 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| K 000 | Continued From pa | ge 1 | КO | 00 | | | |
| | HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510 | GHAL DIVISION TREET, SUITE 145 | | | | | |
| ÷ | By e-mail to: FM.HC.Inspections | @state.mn.us | | | | | |
| | THE PLAN OF COP DEFICIENCY MUS FOLLOWING INFO | RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: | | | | | |
| | 1. A description of w to correct the deficit | vhat has been, or will be, done ency. | | | | | |
| | 2. The actual, or pro | posed, completion date. | | | | | |
| | 3. The name and/or responsible for correpresent a reoccurre | title of the person ection and monitoring to nce of the deficiency | | | | | |
| | a full basement. The 2 different times. Th constructed in 1971 buildings are type II the original building construction type all | tates is a 2-story building with e building was constructed at e original building was with an addition in 2005. Both (111) construction. Because and the addition(s) meet the owed for existing buildings, eyed as one building, the port services only. | | | | | |
| | complete automatic facility has a comple smoke detection in t | sprinkler protected, by a fire sprinkler system. The te fire alarm system with he corridors and spaces that is monitored for | | | | | |

| | | E & MEDICAID SERVICES | 1 | OMB | NO. 0938-03 |
|--------------------------|---|---|---------------------|--|---|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION (X3 6 01 - MAIN BUILDING 01 |) DATE SURVEY COMPLETED |
| | | 245483 | B. WING | | 11/19/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| THE NO | RTH SHORE ESTATE | SLLC | | 7700 GRAND AVENUE DULUTH, MN 55807 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETI E DATE |
| K 000 | Continued From p | age 2 | K 000 | | |
| | | artment notification. | | | |
| | The facility has a l and had a census | icensed capacity of 70 beds of 65 at the time of the survey. | | | |
| | are NOT MET. | at 42 CFR Subpart 483.70(a) | | | |
| | CFR(s): NFPA 101 | - Testing and Maintenance | K 345 | 5 | 11/27/19 |
| | A fire alarm system accordance with a with the requirement Electric Code, and and Signaling Cod acceptance, maint available. 9.6.1.3, 9.6.1.5, N | - Testing and Maintenance n is tested and maintained in n approved program complying ents of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily FPA 70, NFPA 72 ENT is not met as evidenced | | | |
| | Based on staff int available documer maintained the fire maintenance docu NFPA 101 "The Life | erview and a review of the ntation, the facility has not a alarm system testing and mentation in accordance with a Safety Code" 2012 edition 1.3. This deficient practice 70 residents. | | Based on staff interview and a review the available documentation, the facili has not maintained the fire alarm syst testing and maintenance documentati in accordance with NFPA 101 "The Lif Safety Code" 2012 edition (LSC) sect 9.6.1.3. This deficient practice could a 30 of 70 residents. | ty em on ^r e ion |
| | Findings include: | | | Smoke detector located near AED on | first |
| | on 11/19/2019, ob smoke detector lo | ween 10:00 a.m. to 3:00 p.m. servations revealed that the cated in the AED room on the irses stations had a smoke | | floor replaced 11-27-19. Monitoring system in TELS in place to alert maintenance Department of need for inspection of Smoke Detector system | |

Facility ID: 00593

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | : 12/31/2019 APPROVED . 0938-0391 |
|---------------|---|---|--------------|-----|--|---|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (X3) DAT | E SURVEY IPLETED |
| | | 245483 | B. WING | | 11/ | 19/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | |
| | RTH SHORE ESTATES | S LLC | | | 700 GRAND AVENUE ULUTH, MN 55807 | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | _ | PROVIDER'S PLAN OF CORRECTION | (115) |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 345 | Continued From pa | ae 3 | КЗ | A 5 | | |
| | smoke detector bro | - | | 943 | Maintenance Director | |
| | This deficient condi Maintenance Super | tion was confirmed by a visor. | | | | |
| | Sprinkler System - CFR(s): NFPA 101 | Maintenance and Testing | КЗ | 353 | | 12/3/19 |
| | Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe maintained in a sec available. | Maintenance and Testing and standpipe systems are ind maintained in accordance dard for the Inspection, ining of Water-based Fire . Records of system design, action and testing are ure location and readily system last checked | | | | |
| | b) Who provided s | system test | | | | |
| | c) Water system s | upply source | | | | |
| | any non-required or system. 9.7.5, 9.7.7, 9.7.8, a | KS information on coverage for partial automatic sprinkler and NFPA 25 NT is not met as evidenced | | | | |
| | Based on observat automatic sprinkler maintained in accor Standard for the Ins 2010 edition. The fis system in compliant allow system being decrease in the fire | ions and staff interview, the system is not installed and dance with NFPA 13 the stallation of Sprinkler Systems ailure to maintain the sprinkler ce with NFPA 13 (10) could place out of service causing a protection system capability in ergency that could affect 70 of | | | Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the | |

Facility ID: 00593

If continuation sheet Page 4 of 5

| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 353 Continued From page 4 K 353 | URVEY ETED |
|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE NORTH SHORE ESTATES LLC 7700 GRAND AVENUE ULUTH, MN 55807 DULUTH, MN 55807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 353 Continued From page 4 | /2019 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE NORTH SHORE ESTATES LLC 7700 GRAND AVENUE ULUTH, MN 55807 DULUTH, MN 55807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C K 353 Continued From page 4 K 353 | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUED FOR ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 353 Continued From page 4 K 353 | |
| | (X5) COMPLETION DATE |
| 70 residents. 70 residents. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/19/2019, observations revealed the following deficient conditions affecting the facility's fire sprinkler neads in the kitchen around the oven located appeared to be corroded. 2. There is a painted fire sprinkler head located in the employee dining room. 3. There was a 1/4 inch gap around the fire sprinkler head escutcheon ring in the ceiling tile located inside the kitchen by the main entry. This deficient condition was confirmed by a Maintenance Supervisor. | |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 11, 2019

Administrator The North Shore Estates Llc 7700 Grand Avenue Duluth, MN 55807

Re: State Nursing Home Licensing Orders Event ID: JM4C11

Dear Administrator:

The above facility was surveyed on November 17, 2019 through November 21, 2019 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 <u>only a suggestion</u> 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</u>8.html. 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.

The North Shore Estates Llc December 11, 2019 Page 2

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 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

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.

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

| Minnesc | ota Department of He | alth | | | | |
|--------------------------|---|--|-----------------------|---|-------------------|--------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | SURVEY LETED |
| | | 00593 | B. WING | | 0 11/2 | ; 1/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | ND AVENUE MN 55807 | : | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been | | | | |
| | that may result fron orders provided tha the Department wit | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet htttp://www.health.s obul.htm | participate in the electronic nsure orders consistent with | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | | (X6) DATE 12/19/19 |

STATE FORM

If continuation sheet 1 of 68

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------------|--|-----------------------------------|-------------------------|
| | | | A. BUILDING: _ | | | |
| | | 00593 | B. WING | | C 11/21/2019 | |
| IAME OF F | ROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| | TH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | |
| | being submitted to no plan of correction Statutes/Rules, plea in the box available indicate in the elect under the heading of orders will be corre | a Department of Health orders you electronically. Although n is necessary for State ase enter the word "corrected" for text. You must then ronic State licensure process, completion date, the date your cted prior to electronically innesota Department of | | | | |
| | Department's staff the following correct Please indicate in y correction that you and identify the date | gh 11/21/19, surveyors of this visited the above provider and ction orders are issued. rour electronic plan of have reviewed these orders, e when they will be completed. 3040C was investigated and | | | | |
| | the State Licensing federal software. Ta | nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for | | | | |
| | column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow | umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. | | | | |
| | PLEASE DISREGA FOURTH COLUMN epartment of Health | NRD THE HEADING OF THE | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | E SURVEY PLETED |
|---------------|--|---|-------------------------|--|----------------|--------------------|
| | OF CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING | : | | |
| | | 00593 | B. WING | | | C 21/2019 |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| | RTH SHORE ESTATE | SHC | AND AVENU , MN 55807 | E | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | IE APPROPRIATE | COMPLE DATE |
| 2 000 | Continued From pa | age 2 | 2 000 | | | |
| | APPLIES TO FEDI | AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. | | | | |
| | PLAN OF CORRE | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | | |
| 2 280 | MN Rule 4658.010 Orientation and In- | 0 Subp. 1 Employee Service Education | 2 280 | | | 1/3/20 |
| | personnel must be of the law and the respective duties a documented. All p the policies of the r | ation and initial training. All instructed in the requirements rules pertaining to their nd the instruction must be ersonnel must be informed of nursing home, and procedure readily available to guide them a of their duties. | | | | |
| | by: Based on interview facility failed to ensi- training, and Alzhei provided to staff du working with reside assistants (NA-I) re addition, the facility reviews were comp 9 nursing assistant employed by the facility | ent is not met as evidenced and document review, the sure abuse, vulnerable adult imer's/dementia training was uring orientation and prior to ents for 1 of 5 nursing eviewed for staffing. In a failed to ensure performance oleted every 12 months for 1 of (NA-B) who had been ncility for over one year. This o affect all 65 residents residing | | Corrected | | |
| | Findings include: | | | | | |
| | | aining records indicated nursing is hired on 6/24/19, and had | 9 | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|--|-------------------------------|-------------------------|
| | | | A. BUILDING: | | | с |
| | | 00593 | B. WING | | | |
| IAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 2 280 | Continued From pa | ge 3 | 2 280 | | | |
| | not received abuse working with reside | or dementia training prior to nts. | | | | |
| | | 8 p.m. director of nursing I had not received the required a training. | | | | |
| | Adult Plan revised vulnerable adult, re | buse Prevention/Vulnerable 7/18, directed staff to receive sident's rights, and abuse loyee orientation and | | | | |
| | revised 1/18, and w admission packet, i receive 8.25 hours hours worked, and thereafter. The fac training would inclu Alzheimer's, compr abuse prevention ir | ia Training Disclosure policy vas provided in the resident ndicated all staff would of training within their first 160 2 hours of training annually ility disclosure indicated de a comprehensive view of ehensive view of dementia, n persons with dementia, and ely impaired resident. | | | | |
| | | vee Roster Report printed on onnel record review indicated | | | | |
| | | as 6/6/18. No annual v had been completed. | | | | |
| | consultant confirme | 9 p.m. the facility nurse ed NA-B did not have an e review completed. | | | | |
| | | ersonal Records dated rformance evaluations were to ast annually. | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 280 | The administrator, of designee could revisive staff training policies staff receive the ap training at orientation The DON or design appropriate staff on The DON or design system to ensure of | HOD OF CORRECTION: director of nursing (DON) or iew and/or revise the current and procedures to ensure al propriate abuse and dementia | | | | | |
| 2 302 | or related disorder | EASE OR RELATED | 2 302 | | | 1/3/20 | |
| | Alzheimer's disease or related or segregated or gene care staff | ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia | 1 | | | | |
| | (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic | of Alzheimer's disease and activities of daily living; with challenging behaviors; | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING | : | | |
| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SIIC | RAND AVENU H, MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 302 | Continued From pa | ge 5 | 2 302 | | | |
| | topics covered. | ncy of training, and the basic document compliance with | | | | |
| | by: Based on interview facility failed to ensi- training containining components was pi- orientation, and prio 1 of 5 nursing assis | ent is not met as evidenced and document review, the ure Alzheimer's/dementia g all the appropriate rovided and received during or to working with residents fo stants (NA-I) reviewed for the potential to affect all | r | Corrected | | |
| | Findings include: | | | | | |
| ; | assistant (NA)-I wa | ining records indicated nursin s hired on 6/24/19, and had or dementia training prior to nts. | g | | | |
| | (DON) verified NA- abuse and dementi immediately told sh | 8 p.m. director of nursing I had not received the require a training, and NA-I was e would not be able to work o ents that day, upon reviewing | | | | |
| | | stated NA-I was removed fror ppropriate training was | n | | | |
| | Prevention/Vulnera directed staff to rec | nd procedure for Abuse ble Adult Plan revised 7/18, eive vulnerable adult, id abuse training in new | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
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| | | | | | C 11/21/2019 | |
| | | 00593 | B. WING | B. WING | | |
| IAME OF F | PROVIDER OR SUPPLIER | | ADDRESS, CITY, S | | | |
| HE NOF | RTH SHORE ESTATES | SIIC | RAND AVENUE H, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 302 | Continued From pa | nge 6 | 2 302 | | | |
| | employee orientation | on and annually. | | | | |
| | 1/18, and was prov packet indicated all of training within the 2 hours of training a facility disclosure in a comprehensive view comprehensive view | w of dementia, abuse ons with dementia, and care c | n irs d | | | |
| | The director of nurs review and/or revisit training policies and receive the appropriate The DON or design appropriate staff or The DON or design system to ensure of TIME PERIOD FOR | THOD OF CORRECTION: sing (DON) or designee could e the current Alzheimer's d procedures to ensure all sta riate Alzheimer's training. nee could educate the n the policies/procedures. nee could develop a monitorir ingoing compliance. R CORRECTION: Twenty-on | aff | | | |
| | (21) days. | | | | | |
| 2 680 | MN Rule 4658.046 and Death: Dis. Su | 5 Subp. 1 Transfer, Discharg ummay | e, 2 680 | | | 1/3/20 |
| | a resident dies, the | rge summary at death. When nursing home must compile y that includes the date, time | а | | | |
| | This MN Requirem | ent is not met as evidenced | | | | |
| | Based on interview | | | Corrected | | |

| STATEMEN | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | E CONSTRUCTION | | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | PLETED |
| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET / | ADDRESS, CITY, S | TATE, ZIP CODE | • | |
| | RTH SHORE ESTATE | SHC | RAND AVENUE | | | |
| | | DULUT | H, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 680 | Continued From pa | age 7 | 2 680 | | | |
| | was completed for R62) reviewed for facility failed to doo | sure a recapitulation of stay 2 of 5 residents (R60, and , discharges. In addition, the cument and reconcile the ications for 1 of 5 residents discharge. | | | | |
| | Findings include: | | | | | |
| | R60's Admission Record printed 11/19/19, indicated R60 was admitted on 5/9/17, and R60's diagnoses included cancer of the prostate, heart failure, chronic atrial fibrillation, chronic kidney disease, and dementia. | | | | | |
| | at the time of death | nary Report with active orders n, indicated R60's medications trolled medications. | | | | |
| | R60's progress not R60 expired at 1:2 | tes dated 8/22/19, indicated 7 p.m. | | | | |
| | summary with a re facility. R60's med | ord lacked a discharge capitulation of R60's stay at th lical record also lacked R60's medications dispensed owing R60's death. | e | | | |
| | (DON) verified they summary or recapi find a disposition o DON stated R60's veteran's affairs (V | 58 p.m. director of nursing y could not find a discharge itulation of stay, and could not f medication form for R60. medications came from the ⁄A) and R60's spouse wanted ut the facility did not fill out a lave. | | | | |
| | Summary Recapitu | and procedure for Discharge ulation and Plan revised | | | | |
| nnesota D ATE FORI | epartment of Health | | 6899 | M4C11 | If continue | tion sheet |

| | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
| | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | | 21/2013 | |
| | | 7700 GR | | ATL, ZIF GODL | | | |
| THE NOP | RTH SHORE ESTATES | S LLC DULUTH | I, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 680 | Continued From pa | ge 8 | 2 680 | | | | |
| | 12/3/18, lacked dire stay following a dea | ectives for a recapitulation of a resident. | | | | | |
| | Medications, revise reconciliation and d following a death of and procedure did i the medication disp signature of the per | nd procedure for Discharge ed 12/16, lacked direction for locumentation of medications f a resident. The facility policy include directions to complete position record, including the rson receiving the medications using the medications for a e. | | | | | |
| | indicated R62's was 9/28/19, and include | cord printed 11/20/19, s admitted to the facility on ed the following diagnoses of ïbrillation, and had a | | | | | |
| | | e dated 9/29/19, at 9:15 a.m. sent to the emergency room esing. | | | | | |
| | indicated R62's so how long R62 was | ed dated 9/29/19, at 9:52 a.m. n declined bed hold due to going to be in the hospital was up R62's belongings that day. | | | | | |
| | | nedical record lacked evidence stay was completed. | e | | | | |
| | | 9 p.m. DON verified no ay was completed for R62 and completed. | | | | | |
| | The Director of Nur develop, review, an | HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and dent discharges and or | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|--|---|--------------------------|---|------------------------------------|-------------------------|--|
| | | 00593 | B. WING | | | <u>11/21/2019</u> | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | | AND AVENU 1, MN 55807 | E | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLET DATE | |
| 2 680 | Continued From pa | ge 9 | 2 680 | | | | |
| | appropriate staff on The DON or design | ee could educate all the policies and procedures. ee could develop monitoring ongoing compliance. | | | | | |
| 2 830 | MN Rule 4658.0520 Proper Nursing Car |) Subp. 1 Adequate and e; General | 2 830 | | | 1/3/20 | |
| | receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be ou possible unless there is a he attending physician that the in in bed or the resident bed. | d t | | | | |
| | by: Based on observati review, the facility f weights as ordered medical condition for | ent is not met as evidenced on, interview, and document ailed to ensure monitoring of by a physician regarding a or 1 of 6 residents (R29) essary medications. | | Corrected | | | |
| | indicated R29's dia embolism (blood cl arteries in the lungs | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive | 3 | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
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| | RIN SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE |
| 2 830 | Continued From pa | ge 10 | 2 830 | | | |
| | was at risk for falls including CHF, ede R29's care plan ind psychotropic medic obtain a monthly or R29's care plan ide diagnoses and com bilateral leg edema Lasix (diuretic), but weights and notifica 3 pounds overnight R29's care guide la weights and weight of the physician. R29's Order Summ as of 11/19/19, inclu- check vital signs d -daily weights every | iated 8/24/18, indicated R29 related to medical conditions, ma, and vascular dementia. icated R29 was taking ations, and directed nursing to thostatic blood pressure. ntified R29's cardiovascular ditions, including CHF and with medications that included lacked direction for daily ation of provider of increase of or 5 pounds weekly. cked direction to obtain daily gain guidelines for notification ary Report with Active Orders uded orders for: aily. Order 9/17/19. / day shift, call Heart Center if unds overnight or 5 pounds in | 1 | | | |
| | one week. Call he breath, orthopnea, 9/30/19. -Monthly orthostatic | ands overnight or 5 pounds in art center of shortness of edema or bloating. Order date blood pressure (lying, sitting, 24th of every month. Nursing | • | | | |
| | order date 8/26/18. -Lasix (diuretic) 40 CHF. Order start d -Melatonin 3 mg at | milligrams (mg) twice daily for | | | | |
| | extended release 2 | ite (for blood pressure) 4 hour; 25 mg in the a.m. tidepressant) 50 mg at | | | | |
| | bedtime. Order sta -Olanzapine (antips | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATIO | | | | (X2) MULTIPLE | ECONSTRUCTION | | E SURVEY PLETED | |
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| | OF CORRECTION | IDENTIFIC | CATION NOWBER. | A. BUILDING: | | | | |
| | | 00593 | | B. WING | | C 11/21/2019 | | |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | TH SHORE ESTATE | S LLC | | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENC) REGULATORY OR L | | FICIENCIES CEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 11 | | 2 830 | | | | |
| | R29's nurse practit 9/27/19, indicated I from 9/5/19, throug intestinal bleed, er damage, or malfun further indicated R2 hospital with orders and referral to the I | R29 had bee gh 9/17/19, w ncphalopathy nction). R29's 29 was disch s for Lasix ar | n hospitalized ith CHF, potential (brain disease, NP visit note arged from the | | | | | |
| | R29's Treatment Administration Record (TAR) for September 2019, indicated R29 had daily weights completed only on 9/18/19, and 9/19/19, then weekly weights. | | | | | | | |
| | R29's Physician Vision included signed NF to call the heart cer overnight or 5 pour symptoms of short edema or bloating. | P orders for c nter if weight nds in one we ness of brea | laily weights, and gain of 3 pounds eek, and if | | | | | |
| | R29's NP visit note R29 had been hos 9/17/19, with a GI b and CHF. R29 was daily weights, Lasix failure clinic. | pitalized 9/5/ bleed, acute s discharged | 19 through encephalopathy, with orders for | | | | | |
| | R29's TAR for 10/ indicated R29's dat daily starting 10/1/ were not obtained 10/17/19, and 10/2 2019 indicated R29 pounds. R29's TAI indicated R29's pre 9/25/19. | ily weight wa 19, and R29's 10/1/19, 10/2 2/19. R29's 9's weight on R for Septem | s to be obtained s daily weights 2/19, 10/10/19, TAR for October 10/3/19, was 180 uber 2019, | | | | | |
| | R29's TAR for 11/1 indicated R29's dai | | | | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING. | | | <u> </u> |
| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
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| 2 830 | Continued From pa | ge 12 | 2 830 | | | |
| | had more than a 3 11/11/19, to 11/12/1 again on 11/13/19. 11/12/19, and 11/13 notification of the pl increase of greater documentation of m CHF, edema or res R29's Weights and through 11/20/19, ir weights from 10/1/1 10/17/19, 10/18/19, 11/14/19. -R29's weight recor gain of 8.5 pounds weights were record between 9/25/19, a notes dated 10/4/19 was reported to the evidence of monitor increased edema a -R29's weight recor gain of 4 pounds fro Progress notes lack notification of physi symptoms of CHF, increased edema, r - R29's weight recor gain of 4 pounds fro with no weight recor gain of 4 pounds fro with no weight recor notes lacked docum physician, monitorir CHF, respiratory sta | Vitals summary for 9/21/19, ndicated R29 had missed daily 19, through 10/3/19, 10/10/19, 10/22/19, 11/3/19, and rd indicated R29 had a weight from 9/25,/19 to 10/3/19. No ded in R29's medical record nd 10/3/19. R29's progress 0, indicated the weight gain physician, though lacked ring for symptoms of CHF, nd respiratory status. rd indicated R29 had a weight om 10/5/19, to 10/6/19. R29's ked documentation of cian, monitoring for signs and respiratory status, or related to R29's weight gain. rd indicated R29 had a weight om 10/9/19, through 10/11/19, rded on 10/10/19. Progress nentation of notification of ng for signs and symptoms of atus, or increased edema, | | | | |
| | gain of 3.7 pounds but had not obtaine | from 10/16/19, to 10/19/19, d a weight on 10/17/19, or notes lacked documentation | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET / | ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | RAND AVENUE | | | |
| | | DULUT | H, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | ge 13 | 2 830 | | | |
| | and symptoms of C increased edema, r R29's progress not NP increased R29's visit. -R29's weight recor gain of 12.9 pounds R29's medical reco CHF clinic that day ordered. R29's me documentation of n CHF, increased ede -R29's weight recor gain of 3.2 pounds R29's medical reco notification of the pl weight gain and lac monitoring for symp edema and respirat -R29's weight recor gain of 7.5 pounds though had a weigh previous day. R29's nurse practiti 10/30/19, indicated increased a week p down 5 pounds, alc though the NP visit same day. | nonitoring for symptoms of ema and respiratory status. 'd indicated R29 had a weight from 11/11/19, to 11/12/19. rd lacked evidence of hysician or heart clinic of ked documentation of otoms of CHF, increased | | | | |
| | representative (RR R29's weight is not On 11/20/19, at 4:2 |)-F expressed concern that checked daily. 8 p.m. director of nursing | | | | |
| | notification to the pl | sing weights and lack of hysician. DON stated nursing symptoms of CHF with | 3 | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | | 11/ | 21/2019 |
| AME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST AND AVENUE | TATE, ZIP CODE | | |
| | TH SHORE ESTATES | SILC | I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | age 14 | 2 830 | | | |
| | have notified the he with the increased orthostatic BP's sho of psychotropic me documented. | DON verified nursing should eart center and monitored R29 weight. DON also verified ould be obtained for monitoring dications and should be leart Failure-Clinical Protocol | | | | |
| | revised 11/18, lack symptoms of CHF, | ed direction for monitoring for following physician orders for nagement of CHF, and | | | | |
| | The director of nurs review and/or revis procedures for mor ordered and monito appropriate treatme The DON or design appropriate staff or The DON or design | THOD OF CORRECTION: sing (DON) or designee could e the current policies and hitoring medical conditions as oring of symptoms to ensure ent. hee could educate the in the policies/procedures. hee could develop a monitoring ingoing compliance. |) | | | |
| | TIME PERIOD FOI (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 850 | MN Rule 4658.052 Proper Nursing Ca | 0 Subp. 2 D Adequate and re; Shaving | 2 850 | | | 1/3/20 |
| | proper care. The adequate and prop D. Assistance | or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean | | | | |
| | This MN Requirem | ent is not met as evidenced | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| 2 850 | Continued From pa | ge 15 | 2 850 | | | |
| | review, the facility | on, interview, and document ailed to ensure facial hair was dependent residents (R41) es of daily living (ADLs). | | Corrected | | |
| | Findings include: R41's Face Sheet printed 11/20/19, indicated R41's diagnoses included Parkinson's disease, anxiety, schizoaffective disorder, and bipolar. | | | | | |
| | | | | | | |
| | 10/14/19, indicated | num Data Set (MDS) dated R41 was cognitively intact, sive assistance for ADLs, oming. | | | | |
| | | sessment (CAA) Summary icated R41 required extensive oming. | | | | |
| | 11/17/19, indicated | tant care guide dated R41 required assistance with erred to have facial hair | | | | |
| | lying in her bed in a | 6 p.m. R41 was observed hospital gown. R41 had dark r on her upper lip and chin. | | | | |
| | the facial hair rema R41 stated she was twice a week, which stated she was una herself, and depend shaving. R41 furthe | 5 a.m. R41 was observed and ined on her upper lip and chin. s supposed to have a shower n did not always occur. R41 ble to remove the facial hair ded on staff to assist with er stated having facial hair she preferred to have her facial | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 00593 B. WING C 11/21/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C 11/21/2019 THE NORTH SHORE ESTATES LLC 7700 GRAND AVENUE DULUTH, MN 55807 V (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) COMP | Minnesc | ota Department of He | ealth | | | FORM | APPROVE |
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| Image: Control of the second state of the s | STATEMEN | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | |
| 00593 B. WING | | or contraction | IDENTIFICATION NOMBER. | A. BUILDING: | | | |
| WILLE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE T700 GRAND AVENUE DULUTH, MN S5807 DATE OF SPECTORE STEAD SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES FROUDERS FLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG PROVIDER'S FLAN OF CORRECTION EACH OF CORRECTIVE ACTION SHOULD BE CARD STREET STATES UNDER CARD STREET STATES STATES DEFICIENCY OR CARD STREET STATES STATES DEFICIENCY 2.850 Continued From page 16 2.850 0.111/19/19, at 1:10 p.m. R41's facial hair remained. R41 stated staff did not forfer to assistance with shaving during morning cares. Don 11/19/19, at 1:26 p.m. nursing assistant (NA)-A stated R41 was dependent on staff for all ADLs including shaving. NA-A Stated grooming assistance was provided for R41 during morning cares, but did not offer to assist R41 with shaving. NA-A further stated facial hair had been present for several days. NA-A verified R41's nursing care guide indicated R41 was dependent on staff for grooming, and preferred to have facial hair removed. 0.111/20/19, at 4:39 p.m. the director of nursing (DON) stated she would expect a resident that reguide did stated to be shaved if that was the resident's desire. DON stated if a resident's plan of care included a resident preferred to have facial hair removed, she would expect staff to follow the resident preferences. The DON tuber stated the lack of grooming for a resident that preferred to have facial hair removed was a dignity issue. The facility policy Shaving the Resident dated 2/18, indicated the purpose was to promote cleanifies and to provide skin cares to the resident's care plan to assess for any special needs of the resident, and to notify the supervisor if the resi | | | 00593 | B. WING | | | - |
| International Summary Statement of DEFICIENCES DULUTH, MN 55807 (2010) Summary Statement of DEFICIENCES ID PRETX PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MIST BE PRECEDD BY FULL REGULATORY ON LSC UDMITFYNG INFORMATION) ID PRETX PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY) ID DEFICIENCY) 2 850 Continued From page 16 2 850 2 850 On 11/19/19, at 1:10 p.m. R41's facial hair remained. R41 stated staff did not offer to assistance with shaving during morning cares. On 11/19/19, at 1:26 p.m. nursing assistant (NA) A stated R41 was dependent on staff for all ADLs including shaving. NA-A stated grooming assistance was provided for R41 during morning cares, but did not offer to assist R41 with shaving. NA-A further stated facial hair was noted that morning, and it appeared R41 facial hair regulee indicated R41 was dependent on staff for gooming, and preferred to have facial hair removed. On 11/20/19, at 4:39 p.m. the director of nursing (DON) stated she would expect a resident that regulee indicated R41 was dependent on staff for foll basist PON stated if a resident's blan of care included a resident preferred to have facial hair removed. Dn 11/20/19, at 4:39 p.m. the director of nursing (DON) stated she would expect a resident that reguleed assistance with shaving to be shaved if that was the resident deside hair removed was a dignity issue. The facility policy Shaving the Resident dated 2/18, indicated the purpose was to promote cleanliness and to provide skin cares to the resident. The policy directed staff to review the resident. The policy Grocted staff to review the resident. The policy Grocted staff to review the resident. The policy Grocted staff to review the resident. The policy Gr | NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | STATE, ZIP CODE | • | |
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| 2/18, indicated the purpose was to promote cleanliness and to provide skin cares to the resident. The policy directed staff to review the residents' care plan to assess for any special needs of the resident, and to notify the supervisor if the resident refuses the procedure. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure all residents that were dependent on staff | | (DON) stated she v required assistance that was the reside resident's plan of ca preferred to have fa expect staff to follo The DON futher sta resident that prefer | vould expect a resident that e with shaving to be shaved if nt's desire. DON stated if a are included a resident acial hair removed, she would w the resident preferences. ated the lack of grooming for a red to have facial hair | | | | |
| The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure all residents that were dependent on staff | | 2/18, indicated the cleanliness and to p resident. The polic residents' care plan needs of the reside | purpose was to promote provide skin cares to the y directed staff to review the n to assess for any special ent, and to notify the supervisor | | | | |
| | pagete D | The director of nurs review and /or revis ensure all residents | sing (DON) or designee could se policies and procedures to | | | | |
| UNITOTI | | | | ⁶⁸⁹⁹ J | M4C11 | If continuati | on sheet 17 c |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| 2 850 | Continued From pa | ge 17 | 2 850 | | | |
| | The DON or design appropriate staff on The DON or design systems to track co the Quality Assuran Improvement (QAP conduct audits to en | e with personal hygiene. we could educate all the policies and procedures. we could develop monitoring mpliance and report results to ice and Performance (1) committee. QAPI could insure ongoing compliance. R CORRECTION: Twenty-one | | | | |
| 2 900 | MN Rule 4658.052 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 1/3/20 |
| | comprehensive res of nursing services | sores. Based on the ident assessment, the director must coordinate the ursing care plan which | r | | | |
| | without pressure so pressure sores unle condition demonstr | o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and | | | | |
| | receives necessary | ho has pressure sores y treatment and services to event infection, and prevent veloping. | | | | |
| | by: Based on observati review, the facility f wound assessment | ent is not met as evidenced on, interview, and document ailed to ensure consistent to prevent worsening of d evaluate the effectiveness of | | Corrected | | |

| | ota Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | COM | E SURVEY PLETED |
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| 2 900 | Continued From pa | ge 18 | 2 900 | | | |
| | treatment for 2 of 4 residents (R5, R50) reviewed for pressure ulcers. | | | | | |
| | Findings include: | | | | | |
| | definitions for press Pressure Injury: Stage 1 Pressure Ir erythema of intact s area of non-blancha appear differently ir Presence of blanch sensation, tempera visual changes. Col purple or maroon di indicate deep tissue Stage 2 Pressure Ir loss with exposed of skin with exposed of viable, pink or red, n as an intact or ruptu Adipose (fat) is not not visible. Granula are not present. The from adverse micro over the pelvis and should not be used associated skin dar incontinence assoc intertriginous derma related skin injury (I (skin tears, burns, a | njury: Partial-thickness skin lermis Partial-thickness loss of lermis. The wound bed is moist, and may also present ured serum-filled blister. visible and deeper tissues are tion tissue, slough and eschar ese injuries commonly result climate and shear in the skin shear in the heel. This stage to describe moisture mage (MASD) including iated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds | | | | |

| STATEME | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | | E SURVEY PLETED |
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| 2 900 | Continued From pa | ige 19 | 2 900 | | | |
| | Fascia, muscle, ter and/or bone are no obscures the exten Unstageable Press Stage 4 Pressure In tissue loss Full-thic with exposed or dir- tendon, ligament, c Slough and/or esch (rolled edges), undo often occur. Depth If slough or eschar loss this is an Unsta Unstageable Press full-thickness skin a skin and tissue loss damage within the because it is obscu slough or eschar is 4 pressure injury wi (i.e. dry, adherent, if fluctuance) on the H not be softened or in R5's Admission Re- indicated R20's dia neuropathy, pressu non-pressure relate anemia, edema, an damage, disorder, of R5's annual Minimu 8/27/19, indicated F impairment, had no assessment period assistance of two s assistance of two s nonambulatory. | njury: Full-thickness skin and kness skin and tissue loss ectly palpable fascia, muscle, artilage or bone in the ulcer. har may be visible. Epibole ermining and/or tunneling varies by anatomical location. obscures the extent of tissue ageable Pressure Injury. ure Injury: Obscured and tissue loss Full-thickness is in which the extent of tissue ulcer cannot be confirmed ured by slough or eschar. If removed, a Stage 3 or Stage ill be revealed. Stable eschar intact without erythema or neel or ischemic limb should removed cord printed 11/20/19, gnoses included diabetes with ire ulcer of right heel, ed chronic ulcer of left foot, ind encephalopathy (brain | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| 2 900 | Continued From pa | ige 20 | 2 900 | | | |
| | pressure ulcers, and had an unstageable pressure ulcer with slough (dead yellow/creamy/greyish tissue in a wound bed) or eschar (dead thick, leathery, black tissue in a wound bed) present. | | | | | |
| | Ulcer/Injury dated 8 | sessment for Pressure 8/27/19, indicated weekly skin mpleted by a licensed nurse as | 5 | | | |
| | indicated R5 had a base of the right he the wound, and ten documentation indi | ointment dated 9/4/19, large pressure ulcer at the eel with dark tissue overlying der to touch. Physician cated R5's pressure ulcer did cutely infected at that time. | | | | |
| | a mobility impairme reposition every 2 h refused repositionin indicated R5 had a including pressure directed nursing to | ated 10/3/18, indicated R5 had ent, and directed staff to nours, and noted R5 frequently ng. R5's care plan further history of skin breakdown, ulcers to bilateral heels, and offer repositioning every 2 s dated 11/14/19, indicated R5 spital wound care. | 1 | | | |
| | indicated there wer | nspections dated 9/10/19, e no new areas of concern, o have an unstageable e right heel. | | | | |
| | dated 9/11/19, indic ulcer measured 3.8 and was unstageat | ure Ulcer Wound Evaluation cated R5's left heel pressure centimeters (cm) x 4.0 cm ble with 100% eschar. R5's documented as ongoing and | | | | |

| STATEMEN | <u>ta Department of He</u> NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| 2 900 | Continued From pa | age 21 | 2 900 | | | |
| | dated 9/17/19, indic ulcer measured 3.4 unstageable with 2 10% granulation (n and moderate sero mixed with the bloc pressure ulcer was improved. R5's Weekly Skin I | ure Ulcer Wound Evaluation cated R5's left heel pressure 4 cm x 5.0 cm and was 0% eschar, 70% slough and ew connective tissue) tissue, sanguineous (clear liquid od) drainage with odor. R5's documented as ongoing and | | | | |
| | and continued to ha | e no new areas of concern, ave an unstageable pressure el. R5 had not had a Weekly ce 9/11/19. | | | | |
| | indicated R5 had n | nspection dated 10/1/19, o new areas of concern, and able pressure area to right | | | | |
| | 10/3/19, indicated F measured 3.2 cm x with 25% granulation amount of serosan odor. R5's pressur ongoing and declin registered nurse as | ure Wound Evaluation dated R5's left heel pressure ulcer (4.5 cm, and was unstageable on, 75% slough, and moderate guineous drainage with an re area was documented as ed. R5 had not had a ssess the wound between 19, and the wound had hat time. | | | | |
| | 10/8/19, indicated F measured 4.0 cm x was 10% granulation moderate brownish R5's pressure ulcer and improved, thou | ure Wound Evaluation dated R5's right heel pressure ulcer 4.5 cm and was unstageable on and 90% slough, with a, green drainage and no odor. r was documented as ongoing ugh measurements and slough decreased granulation tissue. | | | | |

| | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | COM | E SURVEY PLETED |
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| 2 900 | Continued From pa | ge 22 | 2 900 | | | |
| | In addition, the right heel pressure ulcer had previously been documented on the Weekly Pressure Wound Evaluations as the left heel. | | | | | |
| | | R5's progress notes dated 10/14/19, indicated R5 went to wound clinic | | | | |
| | indicated R5 contin pressure area to th right great toe and | nspection dated 10/15/19, ued to have an unstageable e right heel, outer aspect of top of right second toe. R5 dy skin inspection since | | | | |
| | 10/17/19, indicated measured 3.5 cm x with 75% granulation moderate serosang odor. R5's pressur improved. In additi | ure Wound Evaluation dated R5's right heel pressure ulcer 3.0 cm and was unstageable on, and 25% slough, and guineous drainage with no e ulcer was documented as on, R5's wound evaluation tage one pressure area on his aled. | | | | |
| | physician called wit wound culture, and | s dated 10/22/19, indicated a h orders for an antibiotic, a follow up appointment for a er with possible infection. | | | | |
| | | s dated 10/23/19, indicated an red for a wound infection. | | | | |
| | culture result with a | s indicated R5 had a wound moderate amount of jinosa (bacteria organism). | | | | |
| | had a new order for a wound infection w | s dated 10/26/19, indicated R5 r a change in antibiotic to treat vith pseudomonas until ress notes, the same day | | | | |

| (EACH DEFICIENCY REGULATORY OR LE Continued From pa indicated R5 had go treatment orders ha | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 23 one to wound dare and ad changed to right heel and | A. BUILDING: _ B. WING DDRESS, CITY, ST AND AVENUE MN 55807 ID PREFIX TAG 2 900 | FATE, ZIP CODE PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | RECTION SHOULD BE | (X5) CMPLETED C 21/2019 |
|--|---|--|--|--|--|
| SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa indicated R5 had go treatment orders ha left medial fifth toe, | STREET AL 7700 GR/ DULUTH TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 23 one to wound dare and ad changed to right heel and | DRESS, CITY, ST AND AVENUE MN 55807 ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A | RECTION SHOULD BE | (X5) COMPLET |
| SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa indicated R5 had go treatment orders ha left medial fifth toe, | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 23 one to wound dare and ad changed to right heel and | AND AVENUE MN 55807 | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A | SHOULD BE | COMPLET |
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| (EACH DEFICIENCY REGULATORY OR L Continued From pa indicated R5 had go treatment orders ha left medial fifth toe, | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 23 one to wound dare and ad changed to right heel and | PREFIX TAG | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A | SHOULD BE | COMPLET |
| indicated R5 had go treatment orders ha left medial fifth toe, | one to wound dare and ad changed to right heel and | 2 900 | | | |
| treatment orders ha left medial fifth toe, | ad changed to right heel and | | | | |
| | including cleansing with soap legar solution. | | | | |
| indicated R5 contin pressure ulcer to th right great toe, and with a superficial ul | e right heel, outer aspect of top of right second toe, along cer between 4th and 5th toes. | | | | |
| determining risk for | skin breakdown), dated | | | | |
| refused to go to wo | und care appointment and | | | | |
| indicated R5 contin pressure ulcer, alor right great toe and t superficial ulcer bet | ued to have a right heel ng with the outer aspect of the tope of right second toe, and ween 4th and 5th toes. R5 | | | | |
| 11/14/19, indicated measured 3.3 cm x with 25% granulatic moderate amount c with no odor. R5's documented as imp had increased, the | R5's right heel pressure ulcer 5.2 cm and was unstageable on and 75% slough with a of serosanguineous drainage pressure ulcer was proved, though measurements granulation tissue had | | | | |
| i FrvFv Fork Fre Fi Frehv Fvrvohor | ndicated R5 contin pressure ulcer to th right great toe, and with a superficial ul- R5 had not had a w 10/15/19. R5's Braden Scale. determining risk for 11/7/19, indicated R preakdown. R5's progress notes refused to go to wo appointment was re R5's Weekly Skin In ndicated R5 contin pressure ulcer, alor right great toe and to superficial ulcer bet had not had a week 10/29/19. R5's Weekly Press 11/14/19, indicated measured 3.3 cm x with 25% granulatio moderate amount of with no odor. R5's documented as imp had increased, the decreased and slou | ndicated R5 continued to have unstageable pressure ulcer to the right heel, outer aspect of right great toe, and top of right second toe, along with a superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/15/19. R5's Braden Scale Assessment (a tool to assist in determining risk for skin breakdown), dated 11/7/19, indicated R5 was at risk for skin breakdown. R5's progress notes dated 11/8/19, indicated R5 refused to go to wound care appointment and appointment was rescheduled for 11/22/19. R5's Weekly Skin Inspection dated 11/12/19, ndicated R5 continued to have a right heel pressure ulcer, along with the outer aspect of the right great toe and tope of right second toe, and superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/29/19. R5's Weekly Pressure Wound Evaluation dated 11/14/19, indicated R5's right heel pressure ulcer measured 3.3 cm x 5.2 cm and was unstageable with 25% granulation and 75% slough with a moderate amount of serosanguineous drainage with no odor. R5's pressure ulcer was documented as improved, though measurements had increased, the granulation tissue had decreased and slough had increased. R5 had not had an RN assessment of the pressure ulcer | ndicated R5 continued to have unstageable pressure ulcer to the right heel, outer aspect of right great toe, and top of right second toe, along with a superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/15/19. R5's Braden Scale Assessment (a tool to assist in determining risk for skin breakdown), dated 11/7/19, indicated R5 was at risk for skin breakdown. R5's progress notes dated 11/8/19, indicated R5 refused to go to wound care appointment and appointment was rescheduled for 11/22/19. R5's Weekly Skin Inspection dated 11/12/19, ndicated R5 continued to have a right heel pressure ulcer, along with the outer aspect of the right great toe and tope of right second toe, and superficial ulcer between 4th and 5th toes. R5 had not had a weekly skin inspection since 10/29/19. 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R5 had not had an RN assessment of the pressure ulcer |

| TATEMEN | ta Department of He T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | OF CORRECTION | IDENTIFICATION NOWBER. | A. BUILDING: | | COM | PLETED |
| | | 00593 | B. WING | | | C 21/2019 |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | RTH SHORE ESTATE | 511C 7700 GR | AND AVENUE | | | |
| | | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLE DATE |
| 2 900 | Continued From pa | age 24 | 2 900 | | | |
| | at the facility since 10/17/19, though R5 had been treated for a worsening pressure ulcer with infection. | | | | | |
| | R5's Weekly Skin I not completed. | nspection dated 11/19/19, was | | | | |
| | R5's right heel ulce | es dated 11/20/19, indicated er measured 5 cm x 3.5 cm x mal amount of tan drainage. | | | | |
| | of nursing (ADON) pressure ulcer on t goes to wound car ADON stated R5's | 58 a.m. the assistant director stated R5 had an unstageable he right heel. ADON stated R5 e, but R5 was non-compliant. pressure ulcer was improving bod treatment for it. | | | | |
| | (LPN)-A looked at had showered. R5 | 4 a.m. licensed practical nurse R5's right heel wound after he b's right heel ulcer had regular and was unstageable. | • | | | |
| | wound looked bette | 15 a.m. LPN-A stated R5's er, with some slough and some stated R5 had previously had right heel ulcer. | • | | | |
| | nurse (RN)-F, soal pressure ulcers in LPN-A sanitized ha | 51 p.m. LPN-A with registered ked right heel and left 5th toe vinegar solution as ordered. ands, gloved, and measured sure ulcer at 5 cm x 3.5 cm x | | | | |
| | 0.3 cm. LPN-A use to remove some sl sanitized hands, gl | ed a cotton tip swab to attempt ough. LPN-A removed gloves, oved, and completed treatmen A stated R5's wound base had | | | | |
| | 50% slough. LPN-/ | A stated it had been debrided nce starting the vinegar | | | | |

| Minneso | ta Department of He | alth | | | | APPROVE |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | AND AVENUE | | | |
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| 2 900 | Continued From pa | ge 25 | 2 900 | | | |
| | (DON) verified wou done weekly, R5 ha | 4 p.m. director of nursing nd assessments were not ad a wound infection, and essments would be done | | | | |
| | The facility policy for Skin Assessment and Wound Management dated 12/18, directed a weekly skin inspection would be completed by licensed staff, document skin condition weekly on the Pressure Wound Evaluation, and review skin conditions with interdisciplinary team at least monthly. | | | | | |
| | indicated diagnoses non-pressure right | ecord printed 11/20/19, s that included chronic heel and mid foot ulcer, type 2 and chronic kidney disease. | | | | |
| | R50 had a severe of extensive assistant toileting, and was to | S dated 10/28/19, indicated cognitive impairment, required ce with bed mobility, transfers, otal dependent on person her indicated R50 had an ure ulcer. | | | | |
| | ulcer with soap and amount of lososorb wrap with kerlix and | lers directed to wash left heel water, dry, smear a small on Xeroform (yellow gauze), place surgilast, and change r heel boot while in bed, in chair. | | | | |
| | had a wound to righ included to offload l when R50 was in b physician orders. R50's medical reco | dated 3/29/19, indicated R50 nt heel and interventions heels by floatation off pillow ed, and treatment per rd lacked Weekly Pressure | | | | |
| nnesota Do ATE FORI | epartment of Health M | | 6899 I N | <i>I</i> /4C11 | lf continuati | on sheet 26 c |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | ECONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING: | A. BUILDING. | | С |
| | | 00593 | B. WING | B. WING | | 21/2019 |
| IAME OF F | PROVIDER OR SUPPLIER | | ET ADDRESS, CITY, S | | | |
| | TH SHORE ESTATES | SIIC | GRAND AVENUE JTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | ige 26 | 2 900 | | | |
| | | s from 5/23/19-6/12/19, 1 10/22/19-11/19/19. | | | | |
| | left heel pressure u The ADON verified wound assessment 11/19/19. The ADO dressing was chang did not coordinate v dressing was chang wound evaluation. important to completion | 0 p.m. the ADON stated R lcer was identified on 3/29/ she did not complete week ts for R50 from 10/22/19, to DN stated at that time, R50' ged every three days, and s with the nurses when the ged to complete the weekly The ADON stated it was ete weekly wound onitor the progress of the | 19. (ly o s she | | | |
| | | 9 p.m. the DON, stated she d assessments to be | 9 | | | |
| | The Director of Nur develop, review, an procedures to ensu- pressure ulcers are monitoring progress pressure ulcers. The Director of Nur educate all appropri procedures. The Director of Nur | THOD OF CORRECTION: rsing or designee could ad/or revise policies and are residents that have assessed weekly for s and to prevent worsening rsing or designee could riate staff on the policies an rsing or designee could systems to ensure ongoing | d | | | |
| | TIME PERIOD FOR (21) Days | R CORRECTION: Twenty | One | | | |
| 2 910 | MN Rule 4658.0523 Incontinence | 5 Subp. 5 A.B Rehab - | 2 910 | | | 1/3/20 |

| TATEMEN | ta Department of He IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SUR COMPLET | |
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| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | · | COMPLET | ±D |
| | | 00593 | B. WING | | C 11/21/2019 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, | | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE CO | (X5) OMPLET DATE |
| 2 910 | Continued From pa | age 27 | 2 910 | | | |
| | have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac | nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized t's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible. | | | | |
| | by: Based on observat review, the facility f to prevent incontine reviewed for incont failed to assess an to maintain contine | ent is not met as evidenced ion, interview, and document failed to ensure timely toileting ence for 1 of 2 residents (R29) inence. In addition, the facility d develop a toileting program ence of bowel and bladder for 1 8) reviewed for incontinence. | | Corrected | | |
| | Findings include: | | | | | |
| | indicated R29's dia embolism (blood cl arteries in the lungs | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive nxiety disorder. | | | | |
| | | num Data Set (MDS) dated R29 was cognitively intact with | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---|--|-----------------------------------|-------------------------|--|
| | | | | A. BUILDING. | | с | |
| | | 00593 | B. WING | | | 21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| HE NOF | TH SHORE ESTATES | SHC | AND AVENUE I, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 910 | Continued From pa | ge 28 | 2 910 | | | | |
| | no resistive behavior mood symptoms du R29's MDS further incontinent of bowe extensive assistance cares, and received R29's undated Care Urinary Incontinence completed for annu- date of 9/23/19, ind assistance with toile incontinent of bladd hospitalized with a to R29's CAA indicate every 2 hours and a transferred using a not always alert sta R29 received Lasix for urgency and free indicated R29 was R29's care plan rev was able to commu- by others, and could conversation. R29' frequently incontine directed staff to toile necessary. R29's care guide/po 11/17/19, indicated directed staff to pro awake. | brs, delirium, psychosis or uring the assessment period. indicated R29 was frequently and bladder, required the of two staff for toileting d a diuretic on a regular basis. The Area Assessment (CAA) for the and Indwelling Catheter, al MDS with the reference icated R29 required eting cares, was frequently ler, and had recently been urinary tract infection (UTI). d R29 was offered toileting as needed, and was stand-aide assist lift. R29 did ff to the need to use the toilet. , which could increase the risk quency. R29's CAA further able to communicate needs. rised 10/2/19, indicated R29 unicate needs, was understood d usually understand simple s care plan indicated R29 was ent of bowel and bladder, and et every 2 hours and as | | | | | |
| | as of 11/19/19, inclumedication) 40 milli | ary Report for Active Orders uded orders for Lasix (diuretic grams (mg) twice daily. | | | | | |
| | R29's progress note | es dated 10/21/19, through | | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| | PROVIDER OR SUPPLIER | | DDRESS, CITY, SI | | 11/2 | 21/2019 |
| | | 7700 GR | AND AVENUE | | | |
| THE NO | RTH SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 910 | Continued From pa | ge 29 | 2 910 | | | |
| | | 11/19/19, indicated R29 had not had incidents of refusing toileting cares. | | | | |
| | On 11/18/19, at 9:47 a.m. resident representative (RR)-F was interviewed and expressed concern that R29 did not get toileted frequently enough. | | | | | |
| | On 11/19/19, during observations from 7:25 a.m. through 8:58 a.m., R29 was in her room watching television, received her hearing aide, visited with RR-F, and ate breakfast. Staff had not entered her room since RR-F arrived at 8:05 a.m., and R29 was not offered toilet use since 7:25 a.mAt 8:51 a.m. RR-F talked to R29 about going to exercise group, turned on the call light, and told R29 she would be back 10 minutes prior to her appointment, later that morning. Before RR-F left the room, staff entered R29's room and RR-F informed staff R29 would like to go to exercise group and then she would come back before the appointment, and stated R29 would need to be toileted prior to the appointment. Staff did not offer toilet use prior to exercise groupAt 8:58 a.m. RR-F took R29 downstairs to exercise groupAt 9:46 a.m. R29 returned from exercise group and the nurse change R29's oxygenAt 9:48 a.m. staff brought R29 down to her room. | | t | | | |
| | been to the bathroo call light to ask to g | 1 a.m. R29 stated she had not om yet, and had just put on her o. Staff entered the room and had to go to the bathroom. | • | | | |
| | (NA)-F entered R29 lift and transferred I voided in the comm incontinent brief wa | 55 a.m. nursing assistant O's room with the stand-assist her to the commode. R29 node. NA-F verified R29's is a little damp. NA-F stated ted at least every 2 hours, but | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | or contraction | IDENTIFICATION NOMBER. | A. BUILDING: _ | | | |
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| 2 910 | Continued From pa | ge 30 | 2 910 | | | |
| | usually was toileted | l per her request. | | | | |
| | would usually call a go to the bathroom promptly. At that the guide directed toiled NA-H stated she wo | 26 a.m. NA-G stated R29 ind tell them when she had to , and they would answer me, NA-H verified the care t use every hour for R29. ould check on her and R29 fied staff should offer. | | | | |
| | of nursing (ADON) should provide care sheets. ADON state her toileted every h incontinent more fre plan directed every ADON verified the o | 04 a.m. the assistant director stated nursing assistants according to the care guide ed R29's family had wanted our for awhile when R29 was equently, and stated the care 2 hours and as needed. care guide sheets were not care plan was changed. | | | | |
| | Assistance per Car directed to provide residents based on plan. Incontinent re | or ADL (activities of daily living e Plan revised 5/20/19, ADL assistance to all the assessment and care esidents were to be checked ing to the care plan. |) | | | |
| | indicated R53's dia disease, morbid ob | ecord printed 11/20/19, gnoses included Parkinson's esity, and a gastrostomy tube ough the belly that brings the stomach). | | | | |
| | R53 was cognitively | S dated 11/5/19, indicated y intact, and required we with toileting, and was not am. | | | | |
| | R53's CAA dated 8 | /19/19, indicated R53 was | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | | CONSTRUCTION | | E SURVEY PLETED | | |
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| | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | | | | |
| | | 00593 | B. WING | | C 11/21/2019 | | | |
| NAME OF F | AME OF PROVIDER OR SUPPLIER STREET | | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | RTH SHORE ESTATES | SHC | AND AVENUE | | | | | |
| 0(1) 15 | | | , MN 55807 | PROVIDER'S PLAN OF | | ()(5) | | |
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| 2 910 | Continued From pa | ige 31 | 2 910 | | | | | |
| | indicated toileting n for R53 to continue | ent of urine. The CAA leeds would be care planned to offer toileting, check, and nours, and overall goal was to ontinence. | | | | | | |
| | R53's care plan dated 8/26/19, indicated R53 had alteration in elimination related to a history or urinary tract infections (UTI), urinary retention, impaired mobility, and was incontinent of bowel and bladder. R53's goal was to remain clean, dry, odor free, and to be free from signs and symptoms of UTI. R53 interventions included assistance of two and a Hoyer (mechanical lift) with toileting needs including peri care, pad, and clothing adjustments. | | | | | | | |
| | indicated R53 was bladder, did not info occasionally would had already voided R53 required two a Hoyer for transfers, management, and toileting, check, and | uation dated 9/20/19, incontinent of bowel and orm staff of need to void, and ask staff for a urinal but R53 and did not void in a urinal. ssists with toileting including a , clothing and pad peri care. Staff was to offer d change every two hours. ake needs known and | | | | | | |
| | 11/17/19, indicated | stant care guide sheet dated R53 was incontinent and and a Hoyer with toileting. | | | | | | |
| | in his pants becaus | 6 p.m. R53 stated he urinated e he was unable to use the Id be unable to use the urinal | | | | | | |
| | | on 11/19/19, at 10:07 a.m. I he had to "pee" during | | | | | | |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | , , | ECONSTRUCTION | | E SURVEY PLETED | |
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| | OF CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | | | |
| | | 00593 | B. WING | B. WING | | C 11/21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREE | ET ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| HE NOF | RTH SHORE ESTATES | SILC | GRAND AVENUE | | | | |
| | SUMMARY STA | | JTH, MN 55807 | PROVIDER'S PLAN OF | | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | COMPLET DATE | |
| 2 910 | Continued From pa | age 32 | 2 910 | | | | |
| | in his pants becaus incontinent brief. N urinal. NA-A stated told R53 that NA-A cleaned up when he On 11/19/19, 11:24 (LPN)-B confirmed and bladder, and st and maybe would b assistance. LPN-B assessed for a toile offered to use the u On 11/19/19, at 12: | a.m. licensed practical nur R53 was incontinent of boy tated R53 was getting stron be able to use a urinal with stated R53 should be eting program, and should b urinal or to be toileted. 50 p.m. R53 stated he wou | d a nd se vel ger be | | | | |
| | pants. R53 stated s to the bathroom or when staff would co | athroom and not "pee" in his staff did not offer to take hin offer a urinal. R53 stated ome into his room, R53 wou ' and the staff was used to | m uld | | | | |
| | and bladder assess admission, annually changes. The ADC signs that he/she m | 0 p.m. the ADON stated bo sments were completed upo y, and with any resident DN stated if a resident show hay be able to be continent he resident would be started am. | on ved of | | | | |
| | resident was able to the resident should program. A toileting | 9 p.m. the DON stated if a o verbalize they had to urina be on a bowel and bladder g log would be initiated to t's urinary patterns to promo octioning. | - | | | | |
| | The facility policy B | | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | IDENTIFICATION NONDER. | A. BUILDING: | | | | |
| | | 00593 | B. WING | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET # | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATE | SIIC | RAND AVENUE H, MN 55807 | | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF | CORRECTION | (X5) | |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLET DATE | |
| 2 910 | Continued From pa | age 33 | 2 910 | | | | |
| | plan to assess for a resident. Conduct resident and his or factors that may ha decline in urinary in and evaluate inform bladder habits, and Assess the residen | eview of the residents care any special needs of the a thorough assessment of the her environment to determine ave contributed to any recent nocontinence. Monitor, record, nation about the resident's d continence or incontinence. It for appropriateness of ns which promote urinary | | | | | |
| | The Director of Nur develop, review, ar procedures to ensu- toileting as determinindividualized asse The Director of Nur educate all appropri procedures. The Director of Nur | THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure residents are assisted with ined necessary by their ssment. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing | | | | | |
| | TIME PERIOD FOI (21) Days | R CORRECTION: Twenty On | e | | | | |
| 21025 | MN Rule 4658.061 | 5 Food Temperatures | 21025 | | | 1/3/20 | |
| | 40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co | bus food must be maintained a sheit (four degrees centigrade) egrees Fahrenheit (66 degrees ve. "Potentially hazardous bod subject to continuous time portrols in order to prevent the ive growth of infectious or anisms. | 5 | | | | |

| STATEMEN | It a Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| | PROVIDER OR SUPPLIER | • | DDRESS, CITY, | STATE, ZIP CODE | | |
| | | 7700 GR | AND AVENU | | | |
| THE NOP | RTH SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLET DATE |
| 21025 | Continued From pa | ige 34 | 21025 | | | |
| | by: Based on observat review, the facility f served at the appro food safety and pre had a potential to a | ent is not met as evidenced ion, interview, and document ailed to ensure food was opriate temperature to ensure event food borne illness. This ffect 63 of 65 residents who n the facility kitchen. | | Corrected | | |
| | On 11/17/19, at 5:3 food temperature k | 4 p.m. review of the facility og for November 2019, ares were not taken for the | | | | |
| | Breakfast food tem 11/9, 11/13, and 11 | peratures for 11/4, 11/5, 11/8, /14. | | | | |
| | Lunch food temper 11/9, 11/13, and 11 | atures for 11/4, 11/5, 11/8, /14. | | | | |
| | Supper food tempe and 11/15. | eratures for 11/2, 11/3, 11/9, | | | | |
| | (DM)-A was intervie reviewed November stated this was the dietary manager. D been notified if food taken so retraining DM-A stated food s was important to er | 57 p.m. dietary manager ewed, and stated she had not er food temperature logs. DM- <i>A</i> responsibility of the assistant M-A stated she soul have d temperatures were not being of staff could have occurred. eafety and temperature of food nsure bacterial growth does uld lead to food borne illness | | | | |
| | (DON) stated taking | 0 p.m. the director of nursing g food temperature before nportant not only for food | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| | | | A. BUILDING: | | С | | |
| | | 00593 | B. WING | B. WING | | 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SIIC | RAND AVENUE H, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21025 | Continued From pa | ge 35 | 21025 | | | | |
| | safety and preventing food borne illness, but also palpability of food. | |) | | | | |
| | 12/16, directed coo temperatures and r temperatures are n | culinary Department dated king foods at proper naintaining proper ecessary to prevent e producing bacteria). | | | | | |
| | undated, directed s hazardous food mu Fahrenheit or above hours, and held abo | ood Re-Heating and Handling taff that all potentially ist be reheated to 165 degree e for 15 seconds within two ove 150 degrees Fahrenheit ent bacteria from growth. | | | | | |
| | undated, directed k | material Food Preparation itchen staff to check and atures prior to service. | | | | | |
| | The dietary manage and/or revise the cu policies and proced and held to appropri food-borne illnesse The dietary manage the appropriate stat The dietary manage | THOD OF CORRECTION: er or designee could review urrent food temperature lures to ensure food is cooked riate temperatures to prevent s. er or designee could educate ff on the policies/procedures. er or designee could develop to ensure ongoing compliance | a | | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION: Twenty-one | 9 | | | | |
| 21385 | MN Rule 4658.0800 Staff assistance | 0 Subp. 3 Infection Control; | 21385 | | | 1/3/20 | |
| | | istance with infection control. assigned to assist with the | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION (X | 3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SILC | AND AVENU I, MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | |
| 21385 | Continued From pa | ge 36 | 21385 | | | |
| | the residents and n | ogram, based on the needs of ursing home, to implement ocedures of the infection | | | | |
| | by: Based on observati review, the facility fa hygiene and glove u toileting cares to pro- | ent is not met as evidenced on, interview and document ailed to ensure proper hand use during personal cares and event cross contamination for 29) reviewed for bowel and | | Corrected | | |
| | Findings include: | | | | | |
| | indicated R29's diag embolism (blood clo arteries in the lungs | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive nxiety disorder. | | | | |
| | completed 10/2/19, intact with no resist psychosis or mood assessment period R29 was frequently bladder, required ex | num Data Set (MDS) indicated R29 was cognitively ive behaviors, delirium, symptoms during the . R29's MDS further indicated incontinent of bowel and ktensive assistance of two res, and received a diuretic or | | | | |
| | Urinary Incontinence completed for annu date of 9/23/19, ind assistance with toile | e Area Assessment (CAA) for e and Indwelling Catheter, al MDS with the reference icated R29 required eting cares, was frequently ler, and had recently been | | | | |

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATE | SILC | AND AVENUE I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 21385 | Continued From pa | age 37 | 21385 | | | |
| hospitalized with a urinary tract infection R29's CAA indicated R29 was offered to every 2 hours and as needed, and was transferred using a stand-aide assist lift not always alert staff to the need to use R29 received Lasix (diuretic), which co increase the risk for urinary urgency ar frequency. R29's CAA further indicated able to communicate needs. | | ed R29 was offered toileting as needed, and was stand-aide assist lift. R29 did aff to the need to use the toilet. ((diuretic), which could or urinary urgency and CAA further indicated R29 was | | | | |
| | was able to commu by others, and coul conversation. R29 frequently incontine | vised 10/2/19, indicated R29 unicate needs, was understood ld usually understand simple 's care plan indicated R29 was ent of bowel and bladder, and let every 2 hours and as | | | | |
| | 11/17/19, indicated | ocket care plan dated R29 was incontinent, and ovide hourly toileting while | | | | |
| | (NA)-F entered R29 lift to assist R29 wir washed her hands, curtain and shades stand-assist lift up canvas and calf str gloves, sanitized he performing hand hy and removed R29's R29 to a standing p lowered R29's inco to the commode. N little damp with urin | 55 a.m. nursing assistant 9's room with the stand-assist th toileting cares. NA-F , donned gloves, closed the s, and positioned the to R29. NA-F hooked up the aps, and removed her soiled er hands and without ygiene donned clean gloves, s oxygen canula. NA-F raised position in the stand-assist lift, ontinent brief, and lowered R29 IA-F stated R29's brief was a ne. NA-F removed her soiled | | | | |
| mesota D | gloves and sanitize moderate amount of | ed her hands, as R29 voided a of yellow urine in the It performing hand hygiene, | 1 | | | |

| | NT OF DEFICIENCIES OF CORRECTION | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00593 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 11/21/2019 | |
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| NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST AND AVENUE | IATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SIIC | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLETI DATE |
| 21385 | Continued From pa | ige 38 | 21385 | | | |
| | stand-assist lift, wip personal cleansing her soiled gloves a put on clean gloves brief on R29, move way, put the wheelch into the wheelchair, pushed the wheelch her soiled gloves. N donned clean glove canula on R19's fac stand-assist lift out into the tub room. N had changed glove care, and said she On 11/19/19, at 11:: of nursing (ADON) soiled gloves, sanit | a gloves, raised R29 in the bed R29's peri area with a wipe. NA-F did not remove and perform hand hygiene, and s. NA-F put a clean incontinen d the commode out of the chair in place, lowered R29 , unbuckled the canvas, hair back, and then removed NA-F sanitized her hands and es. NA-F placed R29's oxygen ce. NA-F moved the of R29's room and brought it NA-F stated she thought she s and sanitized following peri should have. 04 a.m. the assistant director stated staff should remove ize or wash hands, and put ing from dirty to clean areas | | | | |
| | directed handwashi hands are visibly so visibly soiled, to use The policy further d be performed befor residents, before do after contact with be from contaminated during resident care | ashing policy dated 1/08, ing should be completed when biled, and when hands are not e an alcohol based hand rub. lirected hand hygiene should re and after contact with bing an invasive procedure, odily fluids, before moving body site to a clean body site es, after contact with hent, after removing gloves. | | | | |
| | The director of nurs | THOD OF CORRECTION: sing (DON) or designee could e the current hand hygiene dical equipment policies and | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | IDENTIFICATION NOMBER. | A. BUILDING: | | | |
| | | 00593 | B. WING | | C 11/21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATE | SILC | AND AVENUE , MN 55807 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLET DATE |
| 21385 | Continued From pa | ige 39 | 21385 | | | |
| | appropriate staff or The DON or design system to ensure o | | 1 | | | |
| 21426 | MN St. Statute 144 Prevention And Co | A.04 Subd. 3 Tuberculosis ntrol | 21426 | | | 1/3/20 |
| | maintain a comprehinfection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme | e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must be nursing home. | t | | | |
| | by: | ent is not met as evidenced | | Corrected | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SIIC | AND AVENUE | | | |
| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | COMPLET DATE |
| 21426 | Continued From pa | age 40 | 21426 | | | |
| | Tuberculin skin test check for tuberculo | ure resident's second step t (TST, a skin test used to sis infection) was completed (R2) reviewed for TST. | | | | |
| | Findings include: | | | | | |
| | R2's Face Sheet pr diagnoses included | rinted 11/20/19, indicated R2's I asthma. | | | | |
| | indicated R2 receiv 5/24/19, but lacked date, time, and inte screening form had second TST howev | erculin (TB) Screening form red his first step TST on information indicating the erpretation of the TST. R2's TI d provided space to record a ver, it was left blank. R2's ked documentation R2 step TST. | В | | | |
| | nursing (ADON) ve did not indicate res and also lacked ev required second ste documentation of th a positive or negative | 4 p.m. the assistant director o rified R2's TB Screening form ults from the first step TST, ridence that R2 received the ep TST. The ADON stated he TST results should include ve reading, along with the f induration, date, and time the | | | | |
| | (DON) verified R2 of second TST, and w TST to be complete | 7 p.m. the director of nursing did not receive the required yould expect the second step ed. The DON further stated if ST was not administered, she ST to be repeated. | | | | |
| | Screening of Resid qualified nurses inter | Resident Baseline Tuberculosis ent dated 11/10, directed erpret the TST 48 to 72 hours of the TST. All test results | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SIIC | MD AVENUE MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹ | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| 21426 | must be read in mil interpretation. Time greater than 72 hou The policy further in step TST is negativ TST one to three w administered. SUGGESTED MET The director of nurs review and/or revise ensure TB testing fe documented as req The DON or design staff on the process The DON or design monitoring or audit of TB screening and | limeter. Document the time of e of interpretation must not be ins after time of administration. indicated residents whose first e will receive a second step eeks after the initial TST was THOD OF CORRECTION: sing (DON) or designee could e the facility's process to pr resident is completed and uired. ee could re-educate nursing s and TB policy. ee could review current system to ensure compliance | 21426 | | | | |
| 21540 | Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medic medical director is n | 5 Subp. 2 Unnecessary Drug g. A nursing home must ent's drug regimen for usage, based on the nursing procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the al director for review if the not the attending physician. If determines that the attending | 21540 | | | 1/3/20 | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING | | с | |
| | | 00593 | B. WING | | 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SIIC | AND AVENU , MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLET DATE |
| 21540 | Continued From pa | ge 42 | 21540 | | | |
| | the order and if the change the order, the review to the Qualit (QAA) committee re the attending physic | have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter | | | | |
| | by: Based on interview facility failed to ensu pressures for monit related psychotropic for 3 of 6 residents unnecessary medic failed to ensure app medications for 1 of for unnecessary medic facility failed to ensu- ordered by a physic | ent is not met as evidenced and document review, the ure orthostatic blood toring of potential side effects c medications were completed (R29, R39, R3) reviewed for cations. In addition, the facility propriate diagnoses for use of f 6 residents (R39) reviewed edications. In addition, the ure monitoring of weights as cian regarding a medical residents (R29) reviewed for cations. | | Corrected | | |
| | indicated R29's diag embolism (blood clo arteries in the lungs respiratory failure, v | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive edema, bipolar disorder, and | | | | |
| | was at risk for falls including CHF, ede | iated 8/24/18, indicated R29 related to medical conditions, ma, bipolar disorder, and R29's care plan indicated | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---------------------------------|--|-------------------------------|--------------------------|--|
| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE | (X5) COMPLETI DATE | |
| 21540 | Continued From pa | ge 43 | 21540 | | | | |
| | R29 was taking psychotropic medications (mood and behavior altering medications), and directed nursing to obtain a monthly orthostatic blood pressure. | | | | | | |
| | as of 11/19/19, inclu- check vital signs d -Monthly psychotrop side effects, update the 24th, monthly. -Sertraline HCL (an bedtime. Order sta -Olanzapine (antips | aily. Order 9/17/19. pic side effect monitoring, if physician. Every day shift on tidepressant) 50 mg at | | | | | |
| | R29 refused an orth progress notes lack | es dated 9/24/19, indicated nostatic blood pressure. R29's ked documentation of any oach R29 for an orthostatic | 5 | | | | |
| | | dministration Record (TAR) nostatic blood pressure was | | | | | |
| | | Vitals Summary for 9/24/19, ion of an orthostatic blood | | | | | |
| | orthostatic blood pr psychotropic medic | ber 2019, indicated R29's essures for monitoring of ations were obtained on d documentation of orthostatic ults. | | | | | |
| | | es dated 10/24/19, lacked 29's orthostatic blood | | | | | |

| IAME OF PLAN (IAME OF PL THE NOR (X4) ID PREFIX TAG | T OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIER | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00593 | A. BUILDING: | | | E SURVEY PLETED |
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| THE NOR (X4) ID PREFIX TAG | | | B. WING | B. WING | | 21/2019 |
| (X4) ID PREFIX TAG | TH SHORE ESTATES | SIREELA | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | | SILC | AND AVENUE | | | |
| PRÉFIX TAG | | DULUTH | , MN 55807 | | | |
| 04540 | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| | Continued From page 44 R29's Weights and Vitals Summary for 10/24/19, lacked documentation of an orthostatic blood pressure. | | 21540 | | | |
| | | | | | | |
| | orthostatic blood pr taken, and was sch TAR indicated R29 | ember 2019, indicated R29's essure had not yet been eduled for 11/24/19. R29's was to be monitored monthly le effect monitoring monthly or | 1 | | | |
| | 10/3/19, through 11 | Vitals Summary dated /20/19, indicated no essures were obtained or | | | | |
| | (DON) verified ortho | 8 p.m. director of nursing ostatic BP's should be ring of psychotropic | | | | |
| | indicated R39's diag cognitive impairment | ecord printed 11/20/19, gnoses included CHF, mild nt, encephalopathy (brain or malfunction), major r, and insomnia. | | | | |
| | of 11/20/19, include -quetiapine (antipsy milligrams (mg) at b order dated 10/29/1 -Sertraline (antidep | chotic medication) 50 pedtime for primary insomnia, | 5 | | | |
| | medications withou medications: | rders included the following t diagnoses for use of the e (nerve pain medication) | | | | |
| ATE FORM | | | 6899 JN | <i>I</i> 4C11 | If continuati | on sheet 45 o |

| STATEMEN | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | СОМ | E SURVEY PLETED C |
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| | | 00593 | B. WING | | 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SIIC | AND AVENUE I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 21540 | Continued From pa | ge 45 | 21540 | | | |
| | -Metoprolol Tartrate pressure) -Melatonin (hormor -Lisinopril (for high failure) -Furosemide (diure -Atorvastatin Calciu -Diltiazem CD ER 2 and heart failure) -cholestyramine ligh -cholecalciferol (vita -Budesonide capsu Crohn's or ulcerativ - Aspirin | blood pressure and heart tic) Im (for high cholesterol) 24 hour (high blood pressure ht packet (for high cholesterol) amin D supplement) Ile DR (anti-inflammatory for | | | | |
| | monitoring of psych effects, and orthost | notropic medication side atic blood pressures for notropic medications. | | | | |
| | received psychotro risk for adverse sid directed nursing to | iated 8/29/19, indicated R39 pic medications and was at e effects. R29's care plan monitor for adverse drug n monthly orthostatic blood | | | | |
| | Review dated 7/19/ included monitoring orthostatic blood pr target behaviors. N | harmacist's Medication (19, recommendations of antipsychotics including ressures, side effects, and Jursing signed s completed on 8/12/19. | | | | |
| | for September 2019 quetiapine fumarate through 9/12/19, m | dministration Record (MAR) 9, indicated R39 received e for insomnia on 9/10/19 elatonin daily for insomnia, epression daily. R39's MAR | | | | |

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | | (X3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | B. WING | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | SUMMARY STATEMENT OF DEFICIENCIESID(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXREGULATORY OR LSC IDENTIFYING INFORMATION)TAG | | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE |
| 21540 | Continued From page 46 | | 21540 | | | |
| | | for antipsychotic side effect and was documented as 9. | | | | |
| | R39's Treatment Administration Record (TAR) for September 2019, directed nursing to obtain a lying and sitting (orthostatic) blood pressure due to antipsychotic medication monthly. R39's orthostatic blood pressure was documented as done, but without results. | | | | | |
| | documentation of o | es dated 9/619, lacked rthostatic blood pressure to reapproach for the essure. | | | | |
| | | Vitals Summary report for mentation of an orthostatic | | | | |
| | received quetiapine depression, and se melatonin for insom directives for antips | ober 2019, indicated R39 e fumarate for insomnia and rtraline for depression, and nnia. R39's MAR included sychotic side effect monitoring ocumented as completed on | | | | |
| | obtain an orthostati to antipsychotic me an orthostatic blood | ber 2019, directed nursing to c blood pressure monthly due dication. R39's TAR indicated pressure was obtained on documentation of results. | | | | |
| | indicated R39's orth completed, and ind | Vitals Summary for 10/6/19, nostatic blood pressure was icated no orthostatic n blood pressure) with change g to sitting. | | | | |

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| | | 00593 | B. WING | | | C 21/2019 |
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| | | | I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21540 | Continued From page 47 | | 21540 | | | |
| | received melatonin insomnia, and sertr | ember 2019, indicated R39 , quetiapine fumarate for aline for depression. R39's on to monitor for antipsychotic ects. | | | | |
| | | ember 2019, lacked direction c blood pressures monthly due dications. | • | | | |
| | | vitals Summary since 29/19, indicated no orthostatic d been obtained. | | | | |
| | 10/29/19, lacked do blood pressures, or | es since readmission on ocumentation of orthostatic clarification of diagnosis for r other medications. | | | | |
| | | Medication review dated completed and signed. | | | | |
| | R39's Target Behav 11/14/19. | vior Form was not completed | | | | |
| | had received quetia nursing reported no and R39 was unabl quetiapine was pres | dated 9/4/19, indicated R39 apine every night for agitation, agitation since admission, e to indicate when and why scribed. NP discontinued ted melatonin every evening. | | | | |
| | had not been sleep the physician had d | es dated 9/8/19, indicated R39 ing well and was concerned iscontinued the quetiapine · sleep good previously. | 9 | | | |
| | R39's primary care | es dated 9/9/19, indicated physician sated insomnia hac iapine was discontinued, so | | | | |

| | ta Department of He | | | CONSTRUCTION | | |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | | | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | 7700 GR | AND AVENUE | | | |
| | | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 21540 | Continued From page 48 | | 21540 | | | |
| | reordered quetiapir | ne at bedtime. | | | | |
| | insomnia was not a quetiapine. R39's Consultant P Review dated 9/12/ regarding quetiapin sleep was not an ap quetiapine and reco assessment of the R39, and if the diag use of quetiapine. changing R39's dia depression. R39's physician vis indicated R39 had s physician on 9/9/19 should restart queti been restarted. | es dated 9/12/19, indicated in approved diagnosis for harmacist's Medication '19, identified an irregularity e. The pharmacist indicated oproved indication for ommended a review and current use of quetiapine for gnosis is sleep, to discontinue R39's physician responded by gnosis for use of quetiapine to it notes dated 9/13/19, seen her primary care 9, and the physician felt she apine for insomnia, so it had es dated 9/13/19, indicated | | | | |
| | R39's diagnosis for depression. R39's Consultant P | quetiapine was changed to harmacist Medication Review tified an irregularity regarding | | | | |
| | use of quetiapine. 8/30/19, R39 was n and quetiapine was complained of not b | The pharmacist indicated on ot showing signs of agitation discontinued. Resident then being able to sleep and | | | | |
| | and then changed t The consultant pha | ted with a diagnosis of sleep to a diagnosis of depression. rmacist recommended e quetiapine and starting a | | | | |
| | medication that wor trazodone or mirtaz | uld target sleep, such as apine that would also help | | | | |
| | | 39's physician addressed the mendation by ordering | | | | |

| | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATE | SILC | AND AVENUE MN 55807 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
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| 21540 | Continued From pa | ige 49 | 21540 | | | |
| | trazodone in place | of quetiapine. | | | | |
| | R39 had been reac during 10/24/19 to exacerbation. R39 indicated medicatio diagnoses were no medications, and la or psychotic behav | tes dated 11/4/19, indicated Imitted from a hospital stay 10/29/19, for heart failure 's physician visit notes ons were reviewed, but t provided for use of acked diagnoses for psychosis iors. R39's physician visit ited R39 had not significant s. | | | | |
| | diagnoses for medi orders. R39's NP v mood was good, ar behavioral changes indicated R39 rece | s dated 11/11/19, lacked ications received by R39 per visit notes indicated R39's nd had no significant s. R39's NP visit notes further ived quetiapine for chronic blan was to continue the rred. | | | | |
| | 11/20/19, indicated had not been check | ioner (NP) visit notes dated orthostatic blood pressures ked between 11/19/19 and ed diagnoses for medications er orders. | | | | |
| | | 2 p.m. R39 stated she felt her nelpful and she had not de effects. | | | | |
| | (DON) stated she w pressures to be do any psychotropic m quetiapine is not an sleep and verified F | 9 p.m. director of nursing vould expect orthostatic blood ne when a resident is receiving nedication. DON verified n appropriate medication for R39's orthostatic blood t completed and antipsychotic | | | | |
| | | ng was not on the TAR | | | | |

| TATEMEN | Ita Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21540 | Continued From pa | ge 50 | 21540 | | | | |
| | been done. DON v had seen R39 since and nursing should diagnoses of medic verified R39's Psyc had not been comp | pital return and should have rerified the NP and physician e her return from the hospital have put in a request for cations at that time. DON hotropic Medication review leted as dated for 10/10/19, or Form was not completed for | | | | | |
| | revised 12/16, direct receive antipsychot necessary to treat s they are indicated a policy and procedur physician to identify symptoms that may antipsychotic medic specific condition for medications are ne based on a compres Antipsychotic media only symptoms wer | ntipsychotic Medication Use cted residents would "only ic medications when specific conditions for which and effective." The facility re further directed the γ , evaluate and document γ warrant the use of cations, and the diagnosis of a or which the antipsychotic cessary to treat would be shensive assessment. ations would not be used if the re one or more of symptoms ess, insomnia, nervousness, c | | | | | |
| | | cord dated 11/20/19, indicated luded major depressive y disorder. | | | | | |
| | had moderately imp also identified she antidepressant me | dication for seven days, during back period, and had two or | | | | | |
| | | ry Report dated 11/20/19, rdered orthostatic blood | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE | (X5) COMPLETE DATE |
| 21540 | Continued From pa | ge 51 | 21540 | | | |
| | medication usage of month. Further, R3 | ng due to psychotropic on the 10th day of every 3 was ordered fluoxetine 9 mg daily for depression on | | | | |
| | potential for psycho related to fluoxetine | d 3/14/19, indicated R3 had stropic adverse drug reactions e medication usage. led monitoring for adverse | | | | |
| | | 19 TAR lacked indication essures were taken. | | | | |
| | 12/2/19, lacked indi | ghts and vitals summary dated ication orthostatic blood orded from 8/1/19, to | t | | | |
| | conducted with regi confirmed she was blood pressures in stated staff were ex | 34 a.m. an interview was istered nurse (RN)-E. RN-E unable to locate orthostatic R3's medical record. RN-E spected to follow the order and ig a progress notes with ut into place. | 1 | | | |
| | conducted with the expected staff were | 7 p.m. an interview was DON. The DON stated she e to complete full sets of essures as indicated, and een a note. | | | | |
| | revised 12/16, direct document, and repo | ntipsychotic Medication Use cted nursing staff to observe, ort adverse consequences to cian such as "orthostatic | | | | |

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| | | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT | | (X5) COMPLET |
| TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | DATE |
| 21540 | Continued From pa | ge 52 | 21540 | | | |
| | The director of nurs review and/or revise psychotropic medic to ensure potential managed. The DON or design appropriate staff on The DON or design system to ensure o | THOD OF CORRECTION: sing (DON) or designee could e the current monitoring of ration policies and procedures side effects are identified and nee could educate the the policies/procedures. nee could develop a monitoring ngoing compliance. R CORRECTION: Twenty-one | 3 | | | |
| 21545 | A nursing home mu A. Its medication percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long- incorporated by refe- purposes of this pa (1) a discrepan prescribed and what administered to res (2) the administ medications. B. It is free of a error. A significant (1) an error we discomfort or jeopal safety; or (2) medication | D A.B.C Medication Errors ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident rdizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single | | | | 1/3/20 |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | | LE CONSTRUCTION | | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 21545 | Continued From pa | age 53 | 21545 | | | |
| | precipitate a reoccu toxicity. All medicat prescribed. An inc error report must b that occurs. Any si resident reactions r physician or the ph resident or the resid designated represe must be made in th C. All medicati prescribed. An incl report must be filed occurs. Any signifi resident reactions r physician or the ph resident or the resid designated represe | buld alter that level and urrence of symptoms or tions are administered as cident report or medication e filed for any medication error ignificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. ons are administered as ident report or medication error d for any medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. | | | | |
| | by: Based on observat review, the facility f dosage of a narcot | ent is not met as evidenced ion, interview, and document ailed to ensure a correct ic pain medication was of 8 residents (R52) reviewed inistration. | | Corrected | | |
| | Findings include: | | | | | |
| | indicated R52's dia | ecord dated 11/19/19, gnoses included humerus | | | | |
| | impairment. | f upper arm) and mild cognitive | | | | |

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| 21545 | Continued From pa | ige 54 | 21545 | | | |
| | needed pain medic | identified he received as ation, had occasional pain, I pain medication for seven | | | | |
| | indicated R52 was pain medication) 10 six hours as neede | hary Report dated 11/19/19, prescribed Norco (a narcotic 0-325 milligrams (mg) every d for pain rated six or greater n scale. The order was placed | | | | |
| | not wish to self-adn a mild cognitive imp further indicated R | ted 11/1/19, indicated R58 did ninister medications, and had pairment. The care plan 58 would be administered ysician orders and by a | | | | |
| | Record (MAR) print was prescribed hyd (Norco) 5-325 mg. every four hours as two tablets as need numeric pain scale. R58 was administe p.m. and 11/14/19, | D18 Medication Administration ted 11/19/19, indicated R58 procodone-acetaminophen R58 was to take one tablet a needed for pain rated 4-7, or led for pain rated 8-10 on the . The MAR further identified red Norco 11/12/19, at 4:39 at 1:06 a.m. The order was and discontinued on 11/15/19. | | | | |
| | indicated R58 was R58 was to take on needed, for pain rai needed, for pain rai scale. The MAR fu administered Norco and 11/17/19, at 8:4 | 018 MAR printed 11/19/19, prescribed Norco 5-325 mg. le tablet every six hours, as ted 4-7 or two tablets, as ted 8-10 on the numeric pain inther identified R58 was o on 11/16/19, at 6:31 a.m., 46 a.m. The order was started scontinued on 11/18/19. | | | | |

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| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
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| 21545 | Continued From pa | age 55 | 21545 | | | |
| | nurse (LPN)-C and administering medi LPN-C and LPN-E medication. LPN-C labeled Norco 10-3 a locked compartm LPN-C compared t electronic medicati (eMAR) and verbal card label did not n LPN-C did not adm requested LPN-E t located in R58's pa verified six doses of dispensed from the nurse (RN)-E walke informed LPN-C th | 17 p.m., licensed practical I LPN-E were observed ications. R58 approached and stated he needed pain C removed a medication card 825 mg, belonging to R58, from nent within the medication card the medication card label to the on administration record lized the dosage on medication natch the physicians order. hinister the Norco and o check the physicians order aper medical record. LPN-C of Norco 10-325 mg had been e medication card. Registered ed to the medication cart and e physician order indicated the s Norco 5-325, and stated she cation error form. | e n | | | |
| | conducted with RN medical record, an was updated in the verbalized the Nord from every four hou | 27 p.m., an interview was I-E. RN-E audited R58's d stated R58's Norco order e eMAR on 11/15/19. RN-E co frequency was changed urs to every six hours however 5 mg remained the same. | r, | | | |
| | RN-E stated the or according to the we error occurred as s medication label ag ensure accuracy. observed, and RN- incorrectly adminis | der transcription was accurate ritten physician order, and the staff had failed to verify the gainst the medication order to The medication card was agai E confirmed six doses were tered. The medication card as filled on 11/12/19. | | | | |
| pnesota D | 11/17/19, indicated | Reconciliation Form dated l, "Dose sent from pharmacy ed total of 6 times. Escript ser | nt | | | |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | | | (X3) DATE SURVEY COMPLETED | | |
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| | or connection | IDENTIFICATION NOMBER. | A. BUILDING: | | | | |
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| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) | |
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| 21545 | Continued From pa | ge 56 | 21545 | | | | |
| | 11/12/19." The Me Form further indica was administered a reached the patient harm." On 11/20/19, at 3:3 conducted with the The DON stated the medication labels a | t facility for updated dose on dication Error Reconciliation ted the wrong drug/dosage and "an error occurred that but did not cause patient 6 p.m. an interview was director of nursing (DON). e nurses were to check gainst the medication orders on. The DON further stated | | | | | |
| | of opioid pain medi and constipation. | nces of receiving double doses cation could include confusion | | | | | |
| | revised 4/19, direct administering the m THREE (3) times to medication, right do | dministering Medications ed, "The individual nedication checks the label o verify the right resident, right osage, right time and right dministration before giving the | | | | | |
| | The director of nurs review and/or revise administration and procedures to preve errors. | THOD OF CORRECTION: sing (DON) or designee could e the current medication medication error policies and ent significant medication nee could educate the | | | | | |
| | appropriate staff or The DON or design | n the policies/procedures. nee could develop a monitoring ngoing compliance. | 1 | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|--|---|---|----------------------------|---|--------------------------------|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | СОМ (°СОМ | IPLETED |
| | | 00593 | B. WING | B. WING | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | | 7700 GR | AND AVENUE | | | |
| THE NOP | RTH SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\ | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21880 | Continued From pa | ge 57 | 21880 | | | |
| 21880 | MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights | | 21880 | | | 1/3/20 |
| | their stay in a facility to understand and a patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fa nursing home ombut Americans Act, sec posted in a conspic | | | | | |
| | residential program 253C.01, every non facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies t limits for facility res or resident to have advocate; requires grievances; and pro an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs centers with section | inpatient facility, every in as defined in section hacute care facility, and every hore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written by ides for a timely decision by in maker if the grievance is not Compliance by hospitals, as as defined in section hospital-based primary s, and outpatient surgery 144.691 and compliance by e organizations with section | | | | |

| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | E SURVEY PLETED |
|----------------------------|---|--|------------------------------|--|-----------------------------------|-------------------------|
| | | | A. BUILDING | : | с | |
| | | 00593 | B. WING | | 11/21/2019 | |
| AME OF PRO | OVIDER OR SUPPLIER | STRE | ET ADDRESS, CITY, | STATE, ZIP CODE | | |
| HE NORTI | H SHORE ESTATES | | GRAND AVENU UTH, MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21880 C | ontinued From pa | age 58 | 21880 | | | |
| re | | to be compliance with the vritten internal grievance | | | | |
| by B fa gi | y: ased on interview acility failed to ens | ent is not met as evidence and document review, the ure a written response to a residents (R12) reviewed | | Corrected | | |
| | indings include: | | | | | |
| in in | dicated R12's dia | ecord printed 11/20/19, gnoses included unspecifie ies, and unspecified res). | ed | | | |
| 9/ de ui in sy | /10/19, indicated F eficit, was able to nderstood, and un idicated R12 displ | imum Data Set (MDS) data R12 had a moderate cognit speak clearly, was nderstood others. R12's M ayed no behaviors, no sign um or psychosis, and had r | tive DS ns or | | | |
| w of | as cognitively inta thers, was able to | iated 4/20/17, indicated R1 act, was able to understand be understood by others, a unicate needs effectively. | | | | |
| 1 [.] | | es dated 10/23/19 through ocumentation regarding | | | | |
| | | 7 p.m. R12 was interviewe I three to four pairs of miss | | | | |

| | NT OF DEFICIENCIES I OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|---|--------------------------|--|--------------------------------|--------------------------|
| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETI DATE |
| 21880 | purple shorts. R12 the shorts, and she facility was unable had reported it to th R12 denied getting to the missing cloth On 11/19/19, at 7:4 stated R12 had bee for 3 to 4 months. through everything LA-A stated R12's f On 11/20/19, at 2:4 (SS)-A stated she h missing clothing. S family gets updated grievance investiga written response. On 11/20/19, at 2:4 director (SS)-B state occurred some time administrator was s shorts, but the re w appropriate size. S not provide a writte resident representa keep the grievance for provided. The facility policy C Procedure dated 9/ to be completed, an as soon as reasona complaint had beer would provide a verte | stated the facility looked for e was told after she asked, the to find them. R12 stated she he lady who did the laundry. a written response in regards ning. 0 a.m. laundry aide (LA)-A en missing two purple shorts LA-A stated she has looked and was unable to find them. family knew about it. 0 p.m. social services director nad not heard about R12's SS-A stated the resident or d with the results of the tion, but they do not provide a 3 p.m. social services regional ted R12's missing shorts e ago. SS-B stated the supposed to purchase new ras a problem finding the SS-B confirmed the facility did n response to R12 or the ative. SS-B stated they would | r | | | |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|--------------------------|--|-----------------------------------|--------------------------|
| | | | A. BUILDING: | | | C |
| | | 00593 | B. WING | | 11/21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| | TH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 21880 | Continued From pa | ge 60 | 21880 | | | |
| | grievance. If the gr grievance form was Grievance Office, a grievance officer was grievance and notifi the proposed action resolved, it would b Directors and the B summary to the corn no later than 30 day grievance. All com | is days after the receipt of the ievance was not resolved, the is to be sent to the corporate nd within 7 days, the build attempt to resolve the y the complainant in writing of n. If the grievance was not e submitted to the Board of oard would issue a written nplainant of proposed action ys after receipt of the pleted grievance forms would t the facility for no less than 3 | | | | |
| | The administrator, a designee could revi grievances policies written response/re provided. The administrator, a designee could edu the policies/procedu The administrator, a designee could dev ensure ongoing cor | social services director, or elop a monitoring system to npliance. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 21925 | MN St. Statute 144 Residents of HC Fa | .651 Subd. 29 Patients & ac.Bill of Rights | 21925 | | | 1/3/20 |
| | shall not be arbitrar | ers and discharges. Residents ily transferred or discharged. notified, in writing, of the e or transfer and its | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|---|--|-----------------------|--|------------------------------------|-------------------------|--|
| | | 00593 | D. WING | | 11/2 | 21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SILC | AND AVENU MN 55807 | E | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE | |
| 21925 | Continued From pa | ige 61 | 21925 | | | | |
| | discharge from the transfer to another notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a) of this right, may ch notice period ends. shortened in situatic control, such as a co review, the accomm residents, a change treatment program, resident's welfare, of prohibited by the pu- paying for the resid the medical record. reasonable effort to without disrupting ro This MN Requireme by: Based on interview facility failed to ensi- reason for transfer 2 of 5 residents (R1 transfer/discharge. Findings include: R19's Admission Re- indicated R19's diag chronic kidney dise failure. | ent is not met as evidenced and document review, the ure a written notification of to a hospital was provided for 19, R50) reviewed for ecord printed 11/20/19, gnoses included anemia, ase, and congestive heart | | Corrected | | | |
| | 9/25/19, indicated F | harge paperwork dated R19 was admitted to the , for evaluation after a fall. | | | | | |

| STATEMEN | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|---|------------------------|--|----------------------------------|-------------------------|
| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENUE MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21925 | Continued From pa | ge 62 | 21925 | | | |
| | notice for transfer v | rd lacked evidence a written vas obtained and provided in or R19's representative. | | | | |
| | R19 had a fall and room for evaluation facility on 10/20/19. evidence a written | e dated 10/20/19, indicated was sent to the emergency and returned back to the R19's medical record lacked notice for transfer was to R19 and/or R19's | | | | |
| | indicated R50's dia | ecord printed 11/20/19, gnoses included chronic betes type 2, and had a mild nt. | | | | |
| | indicated R50 was 5/1/19, for Influenza lacked evidence a | e dated 5/1/19, at 2:31 p.m. admitted to the hospital on a. R50's medical record written notice of transfer was to R50 and/or R50's | | | | |
| | indicated R50 was swollen leg, fatigue medical record lack | Referral Form dated 8/16/19, hospitalized 8/12/16, for and poor appetite. R50's ded evidence a written notice by ided in writing to R50 and/or re. | | | | |
| | services stated whe hospital from the fa signed bed hold an transfer from the re able to sign for ther verbal from the res written Bed-Hold N | 8 p.m. director of social en a resident goes into the icility, the nurses will obtain a d a written notification of esident to sign if the resident is mselves, and if not will obtain a idents representative. A otice for Hospital Transfer and form given to the resident or | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/S | SUPPLIER/CLIA TION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | E SURVEY PLETED | |
|--------------------------|---|--|---|---------------------|--|-----------------------------------|-------------------------|--|
| | | 00593 | | B. WING | | | C | |
| | PROVIDER OR SUPPLIER | 00593 | | | STATE, ZIP CODE | | | |
| | | | | AND AVENUE | | | | |
| | RTH SHORE ESTATES | | DULUTH, | MN 55807 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENCY REGULATORY OR L | | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21925 | Continued From pa | ge 63 | | 21925 | | | | |
| | representative, and document in the res written was provide resident representa | sident's medica d to the reside | al record that a | | | | | |
| | On 11/20/19, at 2:00 (LPN)-A stated if a from the facility, the hold form including resident was unable would be obtained f representative over the resident's media completed form was and the director of r person or by email | resident goes resident woul reason for trai to sign, a ver from the reside the phone and cal record. LP s put into the r nursing (DON) | nto the hospital d sign a bed hsfer, and if the bal consent ent's d documented in N-A stated the esident's chart, was notified in | | | | | |
| | On 11/20/19, at 4:39 facility was not prov transfer to residents representatives only | viding a written s and/or reside y upon reques | notice of nt t. | | | | | |
| | The facility was una written notice of trai | | a policy on | | | | | |
| | SUGGESTED MET The Director of Nur develop, review, an procedures on disc ensure a written no is provided. The DON or design appropriate staff on The DON or design systems to ensure of | sing (DON) or d/or revise pol harges and/or tification of rea ee could educ the policies an ee could deve | designee could icies and transfers to ison for transfer ate all nd procedures. lop monitoring | | | | | |
| 21995 | MN St. Statute 626 Maltreatment of Vul | | | 21995 | | | 1/3/20 | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 11/21/2019 | |
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| | | 00593 | B. WING | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, | STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATE | SIIC | AND AVENU , MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE |
| 21995 | Continued From pa | age 64 | 21995 | | | |
| | Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltro facility has an intern mandated reporter requirements of thi internally. Howeve responsible for com reporting requirements by: Based on interview facility failed to report to the State Agency residents (R21) rev Findings include: R21's Admission R indicated R21's dia dementia with beha cerebral infarction R21's quarterly Min 9/19/19, indicated R impairment, display psychosis, no beha | I reporting of maltreatment. all establish and enforce an occedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting r, the facility remains nplying with the immediate ents of this section. ent is not met as evidenced r and document review, the ort bruises of unknown origin y within 2 hours for 1 of 3 viewed for abuse. ecord printed 11/20/19, gnoses included vascular avioral disturbance, and (stroke). himum Data Set (MDS) dated R21 had a severe cognitive yed no symptoms of delirium of aviors during the assessment d extensive assistance with all | r | Corrected | | |
| | was unable to remo due to physical and directed staff to ob- changes in vulnera staff to provide phy | tiated 4/24/17, indicated R21 ove self from harmful situations a cognitive deficits, and serve for and report any bility. R21's care plan directed sical assistance with all ADLs ted R21 could be resistive to | | | | |

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | COM | E SURVEY PLETED |
|--------------------------|--|--|---------------------------|--|----------------------------------|--------------------------|
| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATE | SILC | AND AVENUE I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE |
| 21995 | Continued From pa | age 65 | 21995 | | | |
| | re-approach as R2 further indicated R2 had a modified inde making and require situations, and had | es, and directed staff to 1 allowed. R21's care plan 21 was forgetful and confused, ependence with decision ed some assistance in new an impaired short term rately impaired long term | | | | |
| | staff to give space, demonstrating agita | stant care guide sheet directed and re-approach when ated behaviors, and Tubigrips nuckles to elbows as she | | | | |
| | as of 11/20/19, incl | nary Report with active orders uded a chewable 81 milligram R21's orders did not include coagulant or steroid | | | | |
| | a.m. indicated staff of R21's hands at t the right thumb bru (cm) by 1.0 cm, and cm x 4.0 cm. The being black and blu questions of how s | es dated 10/31/19, at 12:19 had reported bruises to both he base of the thumbs, with ise measuring 2.0 centimeters d the left thumb measuring 3.8 bruises were documented as ue. R21 did not respond to he got the bruises, or if she he oncoming licensed nurse e bruises. | | | | |
| | indicated the interd 10/31/19, to review 10/30/19. The IDT grab at staff and st refuse medications | es dated 11/1/19, at 9:55 a.m. isciplinary team (IDT) met on R21's bruises noted on noted R21 would frequently rike out with her hands, and and treatments. IDT decided o both arms from knuckles to on as R21 allowed. | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|--|-----------------------------------|-------------------------|
| | | | A. BUILDING: | | | С |
| | | 00593 | B. WING | | | 21/2019 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| HE NOF | RTH SHORE ESTATE | SIIC | AND AVENUE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21995 | Continued From pa | age 66 | 21995 | | | |
| | R21's progress notes lacked indication of a specific event that led to R21's bruises, and lacked indication that R21's bruises were reported to the State Agency. | | | | | |
| | R21 resisted exam increased behavior previous month. R | it note dated 11/4/19, indicated ination, and was seen for s and refusal behaviors the 21's physician note lacked on bilateral thumbs. | b | | | |
| | (DON) stated staff time of the incident bruising, and if no o happened, it should | 2 p.m. the director of nursing should have been asked at the for possible causes of one knew how it could have d have been reported to the 2 hours, as a potential abuse | | | | |
| | directed staff to imp who was then to at of the injury of unkn the administrator of and suspected abu | or Abuse ble Adult Plan dated 12/18, mediately notify the unit nurse, tempt to determine the cause nown origin, immediately notify f an injury of unknown origin, se would be reported to the er than 2 hours after forming | | | | |
| | The administrator, social services dire and/or revise the co abuse policies and reporting of potenti The administrator, | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---------------|--|--|---|--|-------------------------------|-----------------|--|
| | | IDENTIFICATION NOMBER. | A. BUILDING: | | | | |
| | | 00593 | B. WING | | | C 11/21/2019 | |
| AME OF F | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| | TH SHORE ESTATE | SILC | AND AVENUE MN 55807 | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | THE APPROPRIATE | COMPLET DATE | |
| 21995 | Continued From pa | age 67 | 21995 | | | | |
| - - | social services director or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | | | | | | |
| | | | | | | | |
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| Minnesc | ota Department of He | alth | | | | |
|--------------------------|---|--|-----------------------|---|-------------------|--------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | SURVEY LETED |
| | | 00593 | B. WING | | 0 11/2 | ; 1/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | ND AVENUE MN 55807 | : | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been | | | | |
| | that may result fron orders provided tha the Department wit | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet htttp://www.health.s obul.htm | participate in the electronic nsure orders consistent with | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | | (X6) DATE 12/19/19 |

STATE FORM

If continuation sheet 1 of 68

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------------|--|-----------------------------------|-------------------------|
| | | | A. BUILDING: _ | | | C |
| | | 00593 | B. WING | | | 21/2019 |
| IAME OF F | ROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| | TH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | |
| | being submitted to no plan of correction Statutes/Rules, plea in the box available indicate in the elect under the heading of orders will be corre | a Department of Health orders you electronically. Although n is necessary for State ase enter the word "corrected" for text. You must then ronic State licensure process, completion date, the date your cted prior to electronically innesota Department of | | | | |
| | Department's staff the following correct Please indicate in y correction that you and identify the date | gh 11/21/19, surveyors of this visited the above provider and ction orders are issued. rour electronic plan of have reviewed these orders, e when they will be completed. 3040C was investigated and | | | | |
| | the State Licensing federal software. Ta | nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for | | | | |
| | column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow | umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. | | | | |
| | PLEASE DISREGA FOURTH COLUMN epartment of Health | NRD THE HEADING OF THE | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | E SURVEY PLETED |
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| | OF CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING | : | | |
| | | 00593 | B. WING | | | C 21/2019 |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| | RTH SHORE ESTATE | SHC | AND AVENU , MN 55807 | E | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | IE APPROPRIATE | COMPLE DATE |
| 2 000 | Continued From pa | age 2 | 2 000 | | | |
| | APPLIES TO FEDI | AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. | | | | |
| | PLAN OF CORRE | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | | |
| | MN Rule 4658.010 Orientation and In- | 0 Subp. 1 Employee Service Education | 2 280 | | | 1/3/20 |
| | personnel must be of the law and the respective duties a documented. All p the policies of the r | ation and initial training. All instructed in the requirements rules pertaining to their nd the instruction must be ersonnel must be informed of nursing home, and procedure readily available to guide them a of their duties. | | | | |
| | by: Based on interview facility failed to ensi- training, and Alzhei provided to staff du working with reside assistants (NA-I) re addition, the facility reviews were comp 9 nursing assistant employed by the facility | ent is not met as evidenced and document review, the sure abuse, vulnerable adult imer's/dementia training was uring orientation and prior to ents for 1 of 5 nursing eviewed for staffing. In a failed to ensure performance oleted every 12 months for 1 of (NA-B) who had been ncility for over one year. This o affect all 65 residents residing | | Corrected | | |
| | Findings include: | | | | | |
| | | aining records indicated nursing is hired on 6/24/19, and had | 9 | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|---|--|-------------------------------|-------------------------|--|
| | | | A. BUILDING: | | | с | |
| | | 00593 | B. WING | | | 1/21/2019 | |
| IAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | ATE, ZIP CODE | | | |
| THE NO | RTH SHORE ESTATES | | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE | |
| 2 280 | Continued From pa | ge 3 | 2 280 | | | | |
| | not received abuse working with reside | or dementia training prior to nts. | | | | | |
| | | 8 p.m. director of nursing I had not received the required a training. | | | | | |
| | Adult Plan revised vulnerable adult, re | buse Prevention/Vulnerable 7/18, directed staff to receive sident's rights, and abuse loyee orientation and | | | | | |
| | revised 1/18, and w admission packet, i receive 8.25 hours hours worked, and thereafter. The fac training would inclu Alzheimer's, compr abuse prevention ir | ia Training Disclosure policy vas provided in the resident ndicated all staff would of training within their first 160 2 hours of training annually ility disclosure indicated de a comprehensive view of ehensive view of dementia, n persons with dementia, and ely impaired resident. | | | | | |
| | | vee Roster Report printed on onnel record review indicated | | | | | |
| | | as 6/6/18. No annual v had been completed. | | | | | |
| | consultant confirme | 9 p.m. the facility nurse ed NA-B did not have an e review completed. | | | | | |
| | | ersonal Records dated rformance evaluations were to ast annually. | | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 280 | The administrator, of designee could revisive staff training policies staff receive the ap training at orientation The DON or design appropriate staff on The DON or design system to ensure of | HOD OF CORRECTION: director of nursing (DON) or iew and/or revise the current and procedures to ensure al propriate abuse and dementia | | | | | |
| 2 302 | or related disorder | EASE OR RELATED | 2 302 | | | 1/3/20 | |
| | Alzheimer's disease or related or segregated or gene care staff | ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia | 1 | | | | |
| | (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic | of Alzheimer's disease and activities of daily living; with challenging behaviors; | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | E SURVEY PLETED | |
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| | | | A. BUILDING | : | с | | |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 302 | Continued From pa | ge 5 | 2 302 | | | | |
| | topics covered. | ncy of training, and the basic document compliance with | | | | | |
| | by: Based on interview facility failed to ensi- training containining components was pi- orientation, and prio 1 of 5 nursing assis | ent is not met as evidenced and document review, the ure Alzheimer's/dementia g all the appropriate rovided and received during or to working with residents fo stants (NA-I) reviewed for the potential to affect all | r | Corrected | | | |
| | Findings include: | | | | | | |
| | assistant (NA)-I wa | ining records indicated nursin s hired on 6/24/19, and had or dementia training prior to nts. | g | | | | |
| | (DON) verified NA- abuse and dementi immediately told sh | 8 p.m. director of nursing I had not received the require a training, and NA-I was e would not be able to work o ents that day, upon reviewing | | | | | |
| | | stated NA-I was removed fror ppropriate training was | n | | | | |
| | Prevention/Vulnera directed staff to rec | nd procedure for Abuse ble Adult Plan revised 7/18, eive vulnerable adult, id abuse training in new | | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | ^G 1 | | 1/21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | | ADDRESS, CITY, S | | | | |
| HE NOF | RTH SHORE ESTATES | SIIC | RAND AVENUE H, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 302 | Continued From pa | nge 6 | 2 302 | | | | |
| | employee orientation | on and annually. | | | | | |
| | 1/18, and was prov packet indicated all of training within the 2 hours of training a facility disclosure in a comprehensive view comprehensive view | w of dementia, abuse ons with dementia, and care c | n irs d | | | | |
| | The director of nurs review and/or revisit training policies and receive the appropriate The DON or design appropriate staff or The DON or design system to ensure of TIME PERIOD FOR | THOD OF CORRECTION: sing (DON) or designee could e the current Alzheimer's d procedures to ensure all sta riate Alzheimer's training. nee could educate the n the policies/procedures. nee could develop a monitorir ingoing compliance. R CORRECTION: Twenty-on | aff | | | | |
| | (21) days. | | | | | | |
| 2 680 | MN Rule 4658.046 and Death: Dis. Su | 5 Subp. 1 Transfer, Discharg ummay | e, 2 680 | | | 1/3/20 | |
| | a resident dies, the | rge summary at death. When nursing home must compile y that includes the date, time | а | | | | |
| | This MN Requirem | ent is not met as evidenced | | | | | |
| | Based on interview | | | Corrected | | | |

| STATEMEN | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | E CONSTRUCTION | | | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | PLETED | |
| | | 00593 | B. WING | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET / | ADDRESS, CITY, S | TATE, ZIP CODE | • | | |
| | RTH SHORE ESTATE | SHC | RAND AVENUE | | | | |
| | | DULUT | H, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 680 | Continued From page 7 | | 2 680 | | | | |
| | was completed for R62) reviewed for facility failed to doo | sure a recapitulation of stay 2 of 5 residents (R60, and , discharges. In addition, the cument and reconcile the ications for 1 of 5 residents discharge. | | | | | |
| | Findings include: | | | | | | |
| | indicated R60 was diagnoses included | Record printed 11/19/19, admitted on 5/9/17, and R60's d cancer of the prostate, heart al fibrillation, chronic kidney entia. | | | | | |
| | at the time of death | nary Report with active orders n, indicated R60's medications trolled medications. | | | | | |
| | R60's progress not R60 expired at 1:2 | tes dated 8/22/19, indicated 7 p.m. | | | | | |
| | summary with a re facility. R60's med | ord lacked a discharge capitulation of R60's stay at th lical record also lacked R60's medications dispensed owing R60's death. | e | | | | |
| | (DON) verified they summary or recapi find a disposition o DON stated R60's veteran's affairs (V | 58 p.m. director of nursing y could not find a discharge itulation of stay, and could not f medication form for R60. medications came from the ⁄A) and R60's spouse wanted ut the facility did not fill out a lave. | | | | | |
| | Summary Recapitu | and procedure for Discharge ulation and Plan revised | | | | | |
| nnesota D ATE FORI | epartment of Health | | 6899 | M4C11 | If continue | tion sheet | |

| | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED | | |
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| | | 00593 | B. WING | | C 11/21/2019 | | | |
| | PROVIDER OR SUPPLIER | | | SS, CITY, STATE, ZIP CODE | | | | |
| | | 7700 GR | | ATL, ZIF GODL | | | | |
| THE NOP | RTH SHORE ESTATES | S LLC DULUTH | I, MN 55807 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | | |
| 2 680 | Continued From page 8 | | 2 680 | | | | | |
| | 12/3/18, lacked dire stay following a dea | ectives for a recapitulation of a resident. | | | | | | |
| | Medications, revise reconciliation and d following a death of and procedure did i the medication disp signature of the per | nd procedure for Discharge ed 12/16, lacked direction for locumentation of medications f a resident. The facility policy include directions to complete position record, including the rson receiving the medications using the medications for a e. | | | | | | |
| | indicated R62's was 9/28/19, and include | cord printed 11/20/19, s admitted to the facility on ed the following diagnoses of ïbrillation, and had a | | | | | | |
| | | e dated 9/29/19, at 9:15 a.m. sent to the emergency room esing. | | | | | | |
| | indicated R62's so how long R62 was | ed dated 9/29/19, at 9:52 a.m. n declined bed hold due to going to be in the hospital was up R62's belongings that day. | | | | | | |
| | | nedical record lacked evidence stay was completed. | e | | | | | |
| | | 9 p.m. DON verified no ay was completed for R62 and completed. | | | | | | |
| | The Director of Nur develop, review, an | HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and dent discharges and or | | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
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| | | 00593 | B. WING | | | 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | | AND AVENU 1, MN 55807 | E | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLET DATE | |
| 2 680 | Continued From pa | ge 9 | 2 680 | | | | |
| | appropriate staff on The DON or design | ee could educate all the policies and procedures. ee could develop monitoring ongoing compliance. | | | | | |
| 2 830 | MN Rule 4658.0520 Proper Nursing Car |) Subp. 1 Adequate and e; General | 2 830 | | | 1/3/20 | |
| | receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be ou possible unless there is a he attending physician that the in in bed or the resident bed. | d t | | | | |
| | by: Based on observati review, the facility f weights as ordered medical condition for | ent is not met as evidenced on, interview, and document ailed to ensure monitoring of by a physician regarding a or 1 of 6 residents (R29) essary medications. | | Corrected | | | |
| | indicated R29's dia embolism (blood cl arteries in the lungs | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive | 3 | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00593 | B. WING | s. WING | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | 7700 GR | AND AVENUE | | | | |
| | RIN SHORE ESTATES | DULUTH | , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE | |
| 2 830 | Continued From pa | ge 10 | 2 830 | | | | |
| | was at risk for falls including CHF, ede R29's care plan ind psychotropic medic obtain a monthly or R29's care plan ide diagnoses and com bilateral leg edema Lasix (diuretic), but weights and notifica 3 pounds overnight R29's care guide la weights and weight of the physician. R29's Order Summ as of 11/19/19, inclu- check vital signs d -daily weights every | iated 8/24/18, indicated R29 related to medical conditions, ma, and vascular dementia. icated R29 was taking ations, and directed nursing to thostatic blood pressure. ntified R29's cardiovascular ditions, including CHF and with medications that included lacked direction for daily ation of provider of increase of or 5 pounds weekly. cked direction to obtain daily gain guidelines for notification ary Report with Active Orders uded orders for: aily. Order 9/17/19. / day shift, call Heart Center if unds overnight or 5 pounds in | 1 | | | | |
| | one week. Call he breath, orthopnea, 9/30/19. -Monthly orthostatic | ands overnight or 5 pounds in art center of shortness of edema or bloating. Order date blood pressure (lying, sitting, 24th of every month. Nursing | • | | | | |
| | order date 8/26/18. -Lasix (diuretic) 40 CHF. Order start d -Melatonin 3 mg at | milligrams (mg) twice daily for | | | | | |
| | extended release 2 | ite (for blood pressure) 4 hour; 25 mg in the a.m. tidepressant) 50 mg at | | | | | |
| | bedtime. Order sta -Olanzapine (antips | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE | ECONSTRUCTION | | E SURVEY PLETED | | |
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| | OF CORRECTION | IDENTIFIC | CATION NOWBER. | A. BUILDING: | | | | |
| | | 00593 | | B. WING | | | C 11/21/2019 | |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| | TH SHORE ESTATE | S LLC | | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENC) REGULATORY OR L | | FICIENCIES CEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 11 | | 2 830 | | | | |
| | R29's nurse practit 9/27/19, indicated I from 9/5/19, throug intestinal bleed, er damage, or malfun further indicated R2 hospital with orders and referral to the I | R29 had bee gh 9/17/19, w ncphalopathy nction). R29's 29 was disch s for Lasix ar | n hospitalized ith CHF, potential (brain disease, NP visit note arged from the | | | | | |
| | R29's Treatment A September 2019, in completed only on weekly weights. | ndicated R29 | had daily weights | | | | | |
| | R29's Physician Vision included signed NF to call the heart cer overnight or 5 pour symptoms of short edema or bloating. | P orders for c nter if weight nds in one we ness of brea | laily weights, and gain of 3 pounds eek, and if | | | | | |
| | R29's NP visit note R29 had been hos 9/17/19, with a GI b and CHF. R29 was daily weights, Lasix failure clinic. | pitalized 9/5/ bleed, acute s discharged | 19 through encephalopathy, with orders for | | | | | |
| | R29's TAR for 10/ indicated R29's dat daily starting 10/1/ were not obtained 10/17/19, and 10/2 2019 indicated R29 pounds. R29's TAI indicated R29's pre 9/25/19. | ily weight wa 19, and R29's 10/1/19, 10/2 2/19. R29's 9's weight on R for Septem | s to be obtained s daily weights 2/19, 10/10/19, TAR for October 10/3/19, was 180 uber 2019, | | | | | |
| | R29's TAR for 11/1 indicated R29's dai | | | | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING. | | | |
| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PRÉFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLET DATE |
| 2 830 | Continued From pa | ge 12 | 2 830 | | | |
| | had more than a 3 11/11/19, to 11/12/1 again on 11/13/19. 11/12/19, and 11/13 notification of the pl increase of greater documentation of m CHF, edema or res R29's Weights and through 11/20/19, ir weights from 10/1/1 10/17/19, 10/18/19, 11/14/19. -R29's weight recor gain of 8.5 pounds weights were record between 9/25/19, a notes dated 10/4/19 was reported to the evidence of monitor increased edema a -R29's weight recor gain of 4 pounds fro Progress notes lack notification of physi symptoms of CHF, increased edema, r - R29's weight recor gain of 4 pounds fro with no weight recor gain of 4 pounds fro | Vitals summary for 9/21/19, ndicated R29 had missed daily 19, through 10/3/19, 10/10/19, 10/22/19, 11/3/19, and rd indicated R29 had a weight from 9/25,/19 to 10/3/19. No ded in R29's medical record nd 10/3/19. R29's progress 0, indicated the weight gain physician, though lacked ring for symptoms of CHF, nd respiratory status. rd indicated R29 had a weight om 10/5/19, to 10/6/19. R29's ked documentation of cian, monitoring for signs and respiratory status, or related to R29's weight gain. rd indicated R29 had a weight om 10/9/19, through 10/11/19, rded on 10/10/19. Progress nentation of notification of ng for signs and symptoms of atus, or increased edema, | | | | |
| | gain of 3.7 pounds but had not obtaine | from 10/16/19, to 10/19/19, d a weight on 10/17/19, or notes lacked documentation | | | | |

| | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET / | ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | RAND AVENUE | | | |
| | | DULUT | H, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From page 13 | | 2 830 | | | |
| | and symptoms of C increased edema, r R29's progress not NP increased R29's visit. -R29's weight recor gain of 12.9 pounds R29's medical reco CHF clinic that day ordered. R29's me documentation of n CHF, increased ede -R29's weight recor gain of 3.2 pounds R29's medical reco notification of the pl weight gain and lac monitoring for symp edema and respirat -R29's weight recor gain of 7.5 pounds though had a weigh previous day. R29's nurse practiti 10/30/19, indicated increased a week p down 5 pounds, alc though the NP visit same day. | nonitoring for symptoms of ema and respiratory status. 'd indicated R29 had a weight from 11/11/19, to 11/12/19. rd lacked evidence of hysician or heart clinic of ked documentation of otoms of CHF, increased | | | | |
| | representative (RR R29's weight is not On 11/20/19, at 4:2 |)-F expressed concern that checked daily. 8 p.m. director of nursing | | | | |
| | notification to the pl | sing weights and lack of hysician. DON stated nursing symptoms of CHF with | 3 | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | | | | С | |
| | | 00593 | B. WING | | 11/ | 21/2019 | |
| AME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST AND AVENUE | TATE, ZIP CODE | | | |
| | TH SHORE ESTATES | SILC | I, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 14 | 2 830 | | | | |
| | have notified the he with the increased orthostatic BP's sho of psychotropic me documented. | DON verified nursing should eart center and monitored R29 weight. DON also verified ould be obtained for monitoring dications and should be leart Failure-Clinical Protocol | | | | | |
| | revised 11/18, lack symptoms of CHF, | ed direction for monitoring for following physician orders for nagement of CHF, and | | | | | |
| | The director of nurs review and/or revis procedures for mor ordered and monito appropriate treatme The DON or design appropriate staff or The DON or design | THOD OF CORRECTION: sing (DON) or designee could e the current policies and hitoring medical conditions as oring of symptoms to ensure ent. hee could educate the in the policies/procedures. hee could develop a monitoring ingoing compliance. |) | | | | |
| | TIME PERIOD FOI (21) days. | R CORRECTION: Twenty-one | | | | | |
| 2 850 | MN Rule 4658.052 Proper Nursing Ca | 0 Subp. 2 D Adequate and re; Shaving | 2 850 | | | 1/3/20 | |
| | proper care. The adequate and prop D. Assistance | or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean | | | | | |
| | This MN Requirem | ent is not met as evidenced | | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENU MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 2 850 | Continued From pa | ge 15 | 2 850 | | | |
| | review, the facility | on, interview, and document ailed to ensure facial hair was dependent residents (R41) es of daily living (ADLs). | | Corrected | | |
| | Findings include: | | | | | |
| | R41's diagnoses in | printed 11/20/19, indicated cluded Parkinson's disease, tive disorder, and bipolar. | | | | |
| | 10/14/19, indicated | num Data Set (MDS) dated R41 was cognitively intact, sive assistance for ADLs, oming. | | | | |
| | | sessment (CAA) Summary icated R41 required extensive oming. | | | | |
| | 11/17/19, indicated | tant care guide dated R41 required assistance with erred to have facial hair | | | | |
| | lying in her bed in a | 6 p.m. R41 was observed hospital gown. R41 had dark r on her upper lip and chin. | | | | |
| | the facial hair rema R41 stated she was twice a week, which stated she was una herself, and depend shaving. R41 furthe | 5 a.m. R41 was observed and ined on her upper lip and chin. s supposed to have a shower n did not always occur. R41 ble to remove the facial hair ded on staff to assist with er stated having facial hair she preferred to have her facial | | | | |

| TATEMENT (| Department of He | | | | | |
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| | STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER: | | | CONSTRUCTION | | E SURVEY PLETED |
| | CONTRECTION | BENTH IOANON NOMBER. | A. BUILDING: | | | |
| | | 00593 | B. WING | | C 11/21/2019 | |
| AME OF PRO | OVIDER OR SUPPLIER | | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | H SHORE ESTATES | 7700 GR | AND AVENUE | | | |
| | H SHOKE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| 2 850 C | Continued From pa | ge 16 | 2 850 | | | |
| re | emained. R41 state | 0 p.m. R41's facial hair ed staff did not offer to aving during morning cares. | | | | |
| (I A c N b F d | NA)-A stated R41 w ADLs including sha assistance was pro- cares, but did not or NA-A further stated norning, and it app been present for se R41's nursing care | 6 p.m. nursing assistant was dependent on staff for all ving. NA-A stated grooming vided for R41 during morning ffer to assist R41 with shaving facial hair was noted that eared R41 facial hair had everal days. NA-A verified guide indicated R41 was for grooming, and preferred to noved. | | | | |
| (I re th re P T T re | DON) stated she w equired assistance hat was the resider esident's plan of ca preferred to have fa expect staff to follow The DON futher sta | 9 p.m. the director of nursing yould expect a resident that with shaving to be shaved if nt's desire. DON stated if a are included a resident acial hair removed, she would w the resident preferences. ated the lack of grooming for a red to have facial hair nity issue. | | | | |
| 2 c re re | 2/18, indicated the p leanliness and to p esident. The polic esidents' care plan | having the Resident dated purpose was to promote provide skin cares to the y directed staff to review the to assess for any special nt, and to notify the supervisor es the procedure. | | | | |
| T re e | The director of nurs eview and /or revis ensure all residents | HODS OF CORRECTION: sing (DON) or designee could se policies and procedures to s that were dependent on staff | | | | |
| TE FORM | artment of Health | | ⁶⁸⁹⁹ JN | M4C11 | lf continuati | on sheet 17 c |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| | RTH SHORE ESTATES | 7700 GR | | E | | |
| | | DULUTH | I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLET DATE |
| 2 850 | Continued From pa | ge 17 | 2 850 | | | |
| | The DON or design appropriate staff on The DON or design systems to track co the Quality Assuran Improvement (QAP conduct audits to en | e with personal hygiene. we could educate all the policies and procedures. we could develop monitoring mpliance and report results to ice and Performance (1) committee. QAPI could insure ongoing compliance. R CORRECTION: Twenty-one | | | | |
| 2 900 | MN Rule 4658.052 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 1/3/20 |
| | comprehensive res of nursing services | sores. Based on the ident assessment, the director must coordinate the ursing care plan which | r | | | |
| | without pressure so pressure sores unle condition demonstr | o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and | | | | |
| | receives necessary | ho has pressure sores y treatment and services to event infection, and prevent veloping. | | | | |
| | by: Based on observati review, the facility f wound assessment | ent is not met as evidenced on, interview, and document ailed to ensure consistent to prevent worsening of d evaluate the effectiveness of | | Corrected | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | COM | E SURVEY PLETED |
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| | 00593 | | B. WING | | 11/2 | 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | 7700 GR | AND AVENUE | | | |
| | TH SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | ge 18 | 2 900 | | | |
| | treatment for 2 of 4 residents (R5, R50) reviewed for pressure ulcers. Findings include: | | | | | |
| | | | | | | |
| | definitions for press Pressure Injury: Stage 1 Pressure Ir erythema of intact s area of non-blancha appear differently ir Presence of blanch sensation, tempera visual changes. Col purple or maroon di indicate deep tissue Stage 2 Pressure Ir loss with exposed of skin with exposed of viable, pink or red, r as an intact or ruptu Adipose (fat) is not not visible. Granula are not present. The from adverse micro over the pelvis and should not be used associated skin dar incontinence assoc intertriginous derma related skin injury (I (skin tears, burns, a Stage 3 Pressure Ir Full-thickness loss of is visible in the ulce | njury: Partial-thickness skin lermis Partial-thickness loss of lermis. The wound bed is moist, and may also present ured serum-filled blister. visible and deeper tissues are tion tissue, slough and eschar ese injuries commonly result oclimate and shear in the skin shear in the heel. This stage to describe moisture mage (MASD) including iated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds abrasions). njury: Full-thickness skin loss of skin, in which adipose (fat) r and granulation tissue and nd edges) are often present. | F | | | |

| STATEME | ota Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED | |
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| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE | |
| 2 900 | Continued From pa | ge 19 | 2 900 | | | | |
| | Fascia, muscle, ten and/or bone are no obscures the exten Unstageable Press Stage 4 Pressure In tissue loss Full-thic with exposed or dire tendon, ligament, c Slough and/or eschar (rolled edges), unde often occur. Depth If slough or eschar loss this is an Unsta Unstageable Press full-thickness skin a skin and tissue loss damage within the because it is obscu slough or eschar is 4 pressure injury wi (i.e. dry, adherent, i fluctuance) on the f not be softened or n R5's Admission Ree indicated R20's dia neuropathy, pressu non-pressure relate anemia, edema, an damage, disorder, o R5's annual Minimu 8/27/19, indicated F impairment, had no assessment period assistance of two s assistance of two s nonambulatory. | njury: Full-thickness skin and kness skin and tissue loss ectly palpable fascia, muscle, artilage or bone in the ulcer. har may be visible. Epibole ermining and/or tunneling varies by anatomical location. obscures the extent of tissue ageable Pressure Injury. ure Injury: Obscured and tissue loss Full-thickness in which the extent of tissue ulcer cannot be confirmed red by slough or eschar. If removed, a Stage 3 or Stage ill be revealed. Stable eschar intact without erythema or neel or ischemic limb should removed cord printed 11/20/19, gnoses included diabetes with re ulcer of right heel, ed chronic ulcer of left foot, id encephalopathy (brain | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENUE I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | ge 20 | 2 900 | | | |
| | pressure ulcer with yellow/creamy/grey | ish tissue in a wound bed) or leathery, black tissue in a | | | | |
| | Ulcer/Injury dated 8 | sessment for Pressure 3/27/19, indicated weekly skin mpleted by a licensed nurse as | 5 | | | |
| | indicated R5 had a base of the right he the wound, and ten documentation indi | bintment dated 9/4/19, large pressure ulcer at the sel with dark tissue overlying der to touch. Physician cated R5's pressure ulcer did cutely infected at that time. | | | | |
| | a mobility impairme reposition every 2 h refused repositionin indicated R5 had a including pressure directed nursing to | ated 10/3/18, indicated R5 had ent, and directed staff to nours, and noted R5 frequently ng. R5's care plan further history of skin breakdown, ulcers to bilateral heels, and offer repositioning every 2 s dated 11/14/19, indicated R5 spital wound care. | 1 | | | |
| | indicated there wer | nspections dated 9/10/19, e no new areas of concern, o have an unstageable e right heel. | | | | |
| | dated 9/11/19, indic ulcer measured 3.8 and was unstageab | ure Ulcer Wound Evaluation cated R5's left heel pressure centimeters (cm) x 4.0 cm ble with 100% eschar. R5's documented as ongoing and | | | | |

| STATEMEN | <u>ta Department of He</u> NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BOILDING. | A. BUILDING: | | С |
| | | 00593 | B. WING | | 11/2 | 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATE | SIIC | AND AVENUE I, MN 55807 | | | |
| (X4) ID | _ | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLET DATE |
| 2 900 | Continued From pa | age 21 | 2 900 | | | |
| | dated 9/17/19, indic ulcer measured 3.4 unstageable with 2 10% granulation (n and moderate sero mixed with the bloc pressure ulcer was improved. R5's Weekly Skin I | ure Ulcer Wound Evaluation cated R5's left heel pressure 4 cm x 5.0 cm and was 0% eschar, 70% slough and ew connective tissue) tissue, sanguineous (clear liquid od) drainage with odor. R5's documented as ongoing and | | | | |
| | and continued to ha | e no new areas of concern, ave an unstageable pressure el. R5 had not had a Weekly ce 9/11/19. | | | | |
| | indicated R5 had n | nspection dated 10/1/19, o new areas of concern, and able pressure area to right | | | | |
| | 10/3/19, indicated F measured 3.2 cm x with 25% granulation amount of serosan odor. R5's pressur ongoing and declin registered nurse as | ure Wound Evaluation dated R5's left heel pressure ulcer (4.5 cm, and was unstageable on, 75% slough, and moderate guineous drainage with an re area was documented as ed. R5 had not had a ssess the wound between 19, and the wound had hat time. | | | | |
| | 10/8/19, indicated F measured 4.0 cm x was 10% granulation moderate brownish R5's pressure ulcer and improved, thou | ure Wound Evaluation dated R5's right heel pressure ulcer 4.5 cm and was unstageable on and 90% slough, with a, green drainage and no odor. r was documented as ongoing ugh measurements and slough decreased granulation tissue. | | | | |

| | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | СОМ | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| THE NO | RTH SHORE ESTATES | SIIC | AND AVENUE I, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| 2 900 | Continued From pa | age 22 | 2 900 | | | | |
| | previously been do | t heel pressure ulcer had cumented on the Weekly valuations as the left heel. | | | | | |
| | R5's progress notes dated 10/14/19, indicated R5 went to wound clinic | | | | | | |
| | indicated R5 contin pressure area to th right great toe and | nspection dated 10/15/19, ued to have an unstageable e right heel, outer aspect of top of right second toe. R5 kly skin inspection since | | | | | |
| | 10/17/19, indicated measured 3.5 cm x with 75% granulation moderate serosang odor. R5's pressur improved. In additi | ure Wound Evaluation dated R5's right heel pressure ulcer 3.0 cm and was unstageable on, and 25% slough, and guineous drainage with no e ulcer was documented as on, R5's wound evaluation stage one pressure area on his aled. | | | | | |
| | physician called wit wound culture, and | s dated 10/22/19, indicated a th orders for an antibiotic, a follow up appointment for a er with possible infection. | | | | | |
| | | s dated 10/23/19, indicated an red for a wound infection. | | | | | |
| | culture result with a | s indicated R5 had a wound a moderate amount of jinosa (bacteria organism). | | | | | |
| | had a new order for a wound infection w | s dated 10/26/19, indicated R5 r a change in antibiotic to treat vith pseudomonas until ress notes, the same day | | | | | |

| STATEMEN | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COM | PLETED | |
| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | 7700 GR | AND AVENUE | | | | |
| | | DULUTH | , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE | |
| 2 900 | Continued From pa | ige 23 | 2 900 | | | | |
| | treatment orders ha | one to wound dare and ad changed to right heel and including cleansing with soap negar solution. | | | | | |
| | indicated R5 contin pressure ulcer to th right great toe, and with a superficial ul | nspection dated 10/29/19, ued to have unstageable le right heel, outer aspect of top of right second toe, along cer between 4th and 5th toes. veekly skin inspection since | | | | | |
| | determining risk for | Assessment (a tool to assist ir skin breakdown), dated R5 was at risk for skin | 1 | | | | |
| | refused to go to wo | s dated 11/8/19, indicated R5 und care appointment and escheduled for 11/22/19. | | | | | |
| | indicated R5 contin pressure ulcer, alor right great toe and t superficial ulcer bet | nspection dated 11/12/19, ued to have a right heel ng with the outer aspect of the tope of right second toe, and tween 4th and 5th toes. R5 kly skin inspection since | | | | | |
| | 11/14/19, indicated measured 3.3 cm x with 25% granulatic moderate amount c with no odor. R5's documented as imp had increased, the | broved, though measurements granulation tissue had | | | | | |
| | | ugh had increased. R5 had essment of the pressure ulcer | | | | | |

| TATEMEN | ta Department of He T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | RTH SHORE ESTATE | 511C 7700 GR | AND AVENUE | | | |
| | | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLE ⁻ DATE |
| 2 900 | Continued From pa | age 24 | 2 900 | | | |
| | at the facility since 10/17/19, though R5 had been treated for a worsening pressure ulcer with infection. | | | | | |
| | R5's Weekly Skin I not completed. | nspection dated 11/19/19, was | | | | |
| | R5's right heel ulce | es dated 11/20/19, indicated er measured 5 cm x 3.5 cm x mal amount of tan drainage. | | | | |
| | of nursing (ADON) pressure ulcer on t goes to wound car ADON stated R5's | 58 a.m. the assistant director stated R5 had an unstageable he right heel. ADON stated R5 e, but R5 was non-compliant. pressure ulcer was improving bod treatment for it. | | | | |
| | (LPN)-A looked at had showered. R5 | 4 a.m. licensed practical nurse R5's right heel wound after he b's right heel ulcer had regular and was unstageable. | • | | | |
| | wound looked bette | 15 a.m. LPN-A stated R5's er, with some slough and some stated R5 had previously had right heel ulcer. | | | | |
| | nurse (RN)-F, soal pressure ulcers in LPN-A sanitized ha | 51 p.m. LPN-A with registered ked right heel and left 5th toe vinegar solution as ordered. ands, gloved, and measured sure ulcer at 5 cm x 3.5 cm x | | | | |
| | 0.3 cm. LPN-A use to remove some sl sanitized hands, gl | ed a cotton tip swab to attempt ough. LPN-A removed gloves, oved, and completed treatmen A stated R5's wound base had | | | | |
| | 50% slough. LPN-/ | A stated it had been debrided nce starting the vinegar | | | | |

| Minneso | ta Department of He | alth | | | | APPROVE |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | AND AVENUE | | | |
| | | DULUTH | I, MN 55807 | | | |
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| 2 900 | Continued From pa | ge 25 | 2 900 | | | |
| | (DON) verified wou done weekly, R5 ha | 4 p.m. director of nursing nd assessments were not ad a wound infection, and essments would be done | | | | |
| | The facility policy for Skin Assessment and Wound Management dated 12/18, directed a weekly skin inspection would be completed by licensed staff, document skin condition weekly on the Pressure Wound Evaluation, and review skin conditions with interdisciplinary team at least monthly. | | | | | |
| | indicated diagnoses non-pressure right | ecord printed 11/20/19, s that included chronic heel and mid foot ulcer, type 2 and chronic kidney disease. | | | | |
| | R50 had a severe of extensive assistant toileting, and was to | S dated 10/28/19, indicated cognitive impairment, required ce with bed mobility, transfers, otal dependent on person her indicated R50 had an ure ulcer. | | | | |
| | ulcer with soap and amount of lososorb wrap with kerlix and | lers directed to wash left heel water, dry, smear a small on Xeroform (yellow gauze), place surgilast, and change r heel boot while in bed, in chair. | | | | |
| | had a wound to righ included to offload l when R50 was in b physician orders. R50's medical reco | dated 3/29/19, indicated R50 nt heel and interventions heels by floatation off pillow ed, and treatment per rd lacked Weekly Pressure | | | | |
| nnesota Do ATE FORI | epartment of Health M | | 6899 I N | <i>I</i> /4C11 | lf continuati | on sheet 26 c |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | ECONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING: | | | С |
| | | 00593 | B. WING | B. WING | | 21/2019 |
| IAME OF F | PROVIDER OR SUPPLIER | | ET ADDRESS, CITY, S | | | |
| | TH SHORE ESTATES | SIIC | GRAND AVENUE JTH, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | ige 26 | 2 900 | | | |
| | | s from 5/23/19-6/12/19, I 10/22/19-11/19/19. | | | | |
| | left heel pressure u The ADON verified wound assessment 11/19/19. The ADO dressing was chang did not coordinate v dressing was chang wound evaluation. important to completion | 0 p.m. the ADON stated R lcer was identified on 3/29/ she did not complete week ts for R50 from 10/22/19, to DN stated at that time, R50' ged every three days, and s with the nurses when the ged to complete the weekly The ADON stated it was ete weekly wound onitor the progress of the | 19. (ly o s she | | | |
| | | 9 p.m. the DON, stated she d assessments to be | 9 | | | |
| | The Director of Nur develop, review, an procedures to ensu- pressure ulcers are monitoring progress pressure ulcers. The Director of Nur educate all appropri procedures. The Director of Nur | THOD OF CORRECTION: rsing or designee could ad/or revise policies and are residents that have assessed weekly for s and to prevent worsening rsing or designee could riate staff on the policies an rsing or designee could systems to ensure ongoing | ıd | | | |
| | TIME PERIOD FOR (21) Days | R CORRECTION: Twenty | One | | | |
| 2 910 | MN Rule 4658.052 Incontinence | 5 Subp. 5 A.B Rehab - | 2 910 | | | 1/3/20 |

| TATEMEN | ta Department of He IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SUR COMPLET | |
|--------------------------|--|---|---------------------|--|--------------------------|------------------------|
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | · | COMPLET | ±D |
| | | 00593 | B. WING | | C 11/21/2019 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, | | | |
| | TH SHORE ESTATE | SIIC | AND AVENU | Ξ | | |
| | | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE CO | (X5) OMPLET DATE |
| 2 910 | Continued From pa | age 27 | 2 910 | | | |
| | have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac | nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized t's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible. | | | | |
| | by: Based on observat review, the facility f to prevent incontine reviewed for incont failed to assess an to maintain contine | ent is not met as evidenced ion, interview, and document failed to ensure timely toileting ence for 1 of 2 residents (R29) inence. In addition, the facility d develop a toileting program ence of bowel and bladder for 1 8) reviewed for incontinence. | | Corrected | | |
| | Findings include: | | | | | |
| | indicated R29's dia embolism (blood cl arteries in the lungs | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive nxiety disorder. | | | | |
| | | num Data Set (MDS) dated R29 was cognitively intact with | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | A. BOILDING. | A. BUILDING: | | с | |
| | | 00593 | B. WING | | | 21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| HE NOF | TH SHORE ESTATES | SHC | AND AVENUE I, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 910 | Continued From page 28 | | 2 910 | | | | |
| | no resistive behavior mood symptoms du R29's MDS further incontinent of bowe extensive assistance cares, and received R29's undated Care Urinary Incontinence completed for annu- date of 9/23/19, ind assistance with toile incontinent of bladd hospitalized with a to R29's CAA indicate every 2 hours and a transferred using a not always alert sta R29 received Lasix for urgency and free indicated R29 was R29's care plan rev was able to commu- by others, and could conversation. R29' frequently incontine directed staff to toile necessary. R29's care guide/po 11/17/19, indicated directed staff to pro awake. | brs, delirium, psychosis or uring the assessment period. indicated R29 was frequently and bladder, required the of two staff for toileting d a diuretic on a regular basis. The Area Assessment (CAA) for the and Indwelling Catheter, al MDS with the reference icated R29 required eting cares, was frequently ler, and had recently been urinary tract infection (UTI). d R29 was offered toileting as needed, and was stand-aide assist lift. R29 did ff to the need to use the toilet. , which could increase the risk quency. R29's CAA further able to communicate needs. rised 10/2/19, indicated R29 unicate needs, was understood d usually understand simple s care plan indicated R29 was ent of bowel and bladder, and et every 2 hours and as | | | | | |
| | as of 11/19/19, inclumedication) 40 milli | ary Report for Active Orders uded orders for Lasix (diuretic grams (mg) twice daily. | | | | | |
| | R29's progress note | es dated 10/21/19, through | | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|---|-------------------------------|--|---------------------------------|-------------------------|
| | | 00593 | B. WING | | C 11/21/2019 | |
| | PROVIDER OR SUPPLIER | | DDRESS, CITY, SI | | 11/2 | 21/2019 |
| | | 7700 GR | AND AVENUE | | | |
| THE NO | RTH SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y STATEMENT OF DEFICIENCIES ID IENCY MUST BE PRECEDED BY FULL PREFIX OR LSC IDENTIFYING INFORMATION) TAG | | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 910 | Continued From pa | ge 29 | 2 910 | | | |
| | | 11/19/19, indicated R29 had not had incidents of refusing toileting cares. | | | | |
| | On 11/18/19, at 9:47 a.m. resident representative (RR)-F was interviewed and expressed concern that R29 did not get toileted frequently enough. | | | | | |
| | On 11/19/19, during observations from 7:25 a.m. through 8:58 a.m., R29 was in her room watching television, received her hearing aide, visited with RR-F, and ate breakfast. Staff had not entered her room since RR-F arrived at 8:05 a.m., and R29 was not offered toilet use since 7:25 a.mAt 8:51 a.m. RR-F talked to R29 about going to exercise group, turned on the call light, and told R29 she would be back 10 minutes prior to her appointment, later that morning. Before RR-F left the room, staff entered R29's room and RR-F informed staff R29 would like to go to exercise group and then she would come back before the appointment, and stated R29 would need to be toileted prior to the appointment. Staff did not offer toilet use prior to exercise groupAt 8:58 a.m. RR-F took R29 downstairs to exercise groupAt 9:46 a.m. R29 returned from exercise group and the nurse change R29's oxygenAt 9:48 a.m. staff brought R29 down to her room. | | t | | | |
| | been to the bathroo call light to ask to g | 1 a.m. R29 stated she had not om yet, and had just put on her o. Staff entered the room and had to go to the bathroom. | • | | | |
| | (NA)-F entered R29 lift and transferred I voided in the comm incontinent brief wa | 55 a.m. nursing assistant O's room with the stand-assist her to the commode. R29 node. NA-F verified R29's is a little damp. NA-F stated ted at least every 2 hours, but | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| | or contraction | IDENTIFICATION NOMBER. | A. BUILDING: _ | | | | |
| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| THE NOP | RTH SHORE ESTATES | SIIC | AND AVENUE | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 910 | Continued From pa | ge 30 | 2 910 | | | | |
| | usually was toileted | l per her request. | | | | | |
| | would usually call a go to the bathroom promptly. At that the guide directed toiled NA-H stated she wo | 26 a.m. NA-G stated R29 ind tell them when she had to , and they would answer me, NA-H verified the care t use every hour for R29. ould check on her and R29 fied staff should offer. | | | | | |
| | of nursing (ADON) should provide care sheets. ADON state her toileted every h incontinent more fre plan directed every ADON verified the o | 04 a.m. the assistant director stated nursing assistants according to the care guide ed R29's family had wanted our for awhile when R29 was equently, and stated the care 2 hours and as needed. care guide sheets were not care plan was changed. | | | | | |
| | Assistance per Car directed to provide residents based on plan. Incontinent re | or ADL (activities of daily living e Plan revised 5/20/19, ADL assistance to all the assessment and care esidents were to be checked ing to the care plan. |) | | | | |
| | indicated R53's dia disease, morbid ob | ecord printed 11/20/19, gnoses included Parkinson's esity, and a gastrostomy tube ough the belly that brings the stomach). | | | | | |
| | R53 was cognitively | S dated 11/5/19, indicated y intact, and required we with toileting, and was not am. | | | | | |
| | R53's CAA dated 8 | /19/19, indicated R53 was | | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | | CONSTRUCTION | | E SURVEY PLETED | |
|--------------------------|---|--|--------------------------------|--|-----------------------------------|-------------------------|--|
| | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | | | |
| | | 00593 | B. WING | | C 11/21/2019 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | RTH SHORE ESTATES | SHC | AND AVENUE | | | | |
| 0(1) 15 | | | , MN 55807 | PROVIDER'S PLAN OF | | ()(5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 910 | Continued From pa | ige 31 | 2 910 | | | | |
| | frequently incontinent of urine. The CAA indicated toileting needs would be care planned for R53 to continue to offer toileting, check, and change every two hours, and overall goal was to improve urinary incontinence. R53's care plan dated 8/26/19, indicated R53 had alteration in elimination related to a history or urinary tract infections (UTI), urinary retention, impaired mobility, and was incontinent of bowel and bladder. R53's goal was to remain clean, dry, odor free, and to be free from signs and symptoms of UTI. R53 interventions included assistance of two and a Hoyer (mechanical lift) with toileting needs including peri care, pad, and clothing adjustments. | | | | | | |
| | | | | | | | |
| | indicated R53 was bladder, did not info occasionally would had already voided R53 required two a Hoyer for transfers, management, and toileting, check, and | uation dated 9/20/19, incontinent of bowel and orm staff of need to void, and ask staff for a urinal but R53 and did not void in a urinal. ssists with toileting including a , clothing and pad peri care. Staff was to offer d change every two hours. ake needs known and | | | | | |
| | 11/17/19, indicated | stant care guide sheet dated R53 was incontinent and and a Hoyer with toileting. | | | | | |
| | in his pants becaus | 6 p.m. R53 stated he urinated e he was unable to use the Id be unable to use the urinal | | | | | |
| | | on 11/19/19, at 10:07 a.m. I he had to "pee" during | | | | | |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | , , | ECONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|-------------------------------------|---|-----------------------------------|-----------------|--|
| | OF CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | | | |
| | | 00593 | B. WING | B. WING | | C 11/21/2019 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREE | ET ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| HE NOF | RTH SHORE ESTATES | SILC | GRAND AVENUE | | | | |
| | SUMMARY STA | | JTH, MN 55807 | PROVIDER'S PLAN OF | | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | COMPLET DATE | |
| 2 910 | Continued From pa | age 32 | 2 910 | | | | |
| | in his pants becaus incontinent brief. N urinal. NA-A stated told R53 that NA-A cleaned up when he On 11/19/19, 11:24 (LPN)-B confirmed and bladder, and st and maybe would b assistance. LPN-B assessed for a toile offered to use the u On 11/19/19, at 12: | a.m. licensed practical nur R53 was incontinent of boy tated R53 was getting stron be able to use a urinal with stated R53 should be eting program, and should b urinal or to be toileted. 50 p.m. R53 stated he wou | d a nd se vel ger be | | | | |
| | pants. R53 stated s to the bathroom or when staff would co | athroom and not "pee" in his staff did not offer to take hin offer a urinal. R53 stated ome into his room, R53 wou ' and the staff was used to | m uld | | | | |
| | and bladder assess admission, annually changes. The ADC signs that he/she m | 0 p.m. the ADON stated bo sments were completed upo y, and with any resident DN stated if a resident show hay be able to be continent he resident would be started am. | on ved of | | | | |
| | resident was able to the resident should program. A toileting | 9 p.m. the DON stated if a o verbalize they had to urina be on a bowel and bladder g log would be initiated to t's urinary patterns to promo octioning. | - | | | | |
| | The facility policy B | | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | IDENTIFICATION NONDER. | A. BUILDING: | | C | | |
| | | 00593 | B. WING | B. WING | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET # | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATE | SIIC | RAND AVENUE H, MN 55807 | | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF | CORRECTION | (X5) | |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLET DATE | |
| 2 910 | Continued From pa | age 33 | 2 910 | | | | |
| | plan to assess for a resident. Conduct resident and his or factors that may ha decline in urinary in and evaluate inform bladder habits, and Assess the residen | eview of the residents care any special needs of the a thorough assessment of the her environment to determine ave contributed to any recent nocontinence. Monitor, record, nation about the resident's d continence or incontinence. It for appropriateness of ns which promote urinary | | | | | |
| | The Director of Nur develop, review, ar procedures to ensu- toileting as determinindividualized asse The Director of Nur educate all appropri procedures. The Director of Nur | THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure residents are assisted with ined necessary by their ssment. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing | | | | | |
| | TIME PERIOD FOI (21) Days | R CORRECTION: Twenty On | e | | | | |
| 21025 | MN Rule 4658.061 | 5 Food Temperatures | 21025 | | | 1/3/20 | |
| | 40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co | bus food must be maintained a sheit (four degrees centigrade) egrees Fahrenheit (66 degrees ve. "Potentially hazardous bod subject to continuous time portrols in order to prevent the ive growth of infectious or anisms. | 5 | | | | |

| STATEMEN | It a Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | C 11/21/2019 | | |
| | PROVIDER OR SUPPLIER | • | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | | 7700 GR | AND AVENU | | | | |
| THE NOP | RTH SHORE ESTATES | DULUTH | , MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLET DATE | |
| 21025 | Continued From pa | ige 34 | 21025 | | | | |
| | by: Based on observat review, the facility f served at the appro food safety and pre had a potential to a | ent is not met as evidenced ion, interview, and document ailed to ensure food was opriate temperature to ensure event food borne illness. This ffect 63 of 65 residents who n the facility kitchen. | | Corrected | | | |
| | On 11/17/19, at 5:3 food temperature k | 4 p.m. review of the facility og for November 2019, ares were not taken for the | | | | | |
| | Breakfast food tem 11/9, 11/13, and 11 | peratures for 11/4, 11/5, 11/8, /14. | | | | | |
| | Lunch food temper 11/9, 11/13, and 11 | atures for 11/4, 11/5, 11/8, /14. | | | | | |
| | Supper food tempe and 11/15. | eratures for 11/2, 11/3, 11/9, | | | | | |
| | (DM)-A was intervie reviewed November stated this was the dietary manager. D been notified if food taken so retraining DM-A stated food s was important to er | 57 p.m. dietary manager ewed, and stated she had not er food temperature logs. DM- <i>A</i> responsibility of the assistant M-A stated she soul have d temperatures were not being of staff could have occurred. eafety and temperature of food nsure bacterial growth does uld lead to food borne illness | | | | | |
| | (DON) stated taking | 0 p.m. the director of nursing g food temperature before nportant not only for food | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
|--------------------------|--|--|----------------------------|--|-----------------------------------|-------------------------|--|
| | | | A. BUILDING: | | | | |
| | | 00593 | B. WING | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SIIC | RAND AVENUE H, MN 55807 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21025 | Continued From pa | ge 35 | 21025 | | | | |
| | safety and preventing food borne illness, but also palpability of food. | |) | | | | |
| | 12/16, directed coo temperatures and r temperatures are n | culinary Department dated king foods at proper naintaining proper ecessary to prevent e producing bacteria). | | | | | |
| | undated, directed s hazardous food mu Fahrenheit or above hours, and held abo | ood Re-Heating and Handling taff that all potentially ist be reheated to 165 degree e for 15 seconds within two ove 150 degrees Fahrenheit ent bacteria from growth. | | | | | |
| | undated, directed k | material Food Preparation itchen staff to check and atures prior to service. | | | | | |
| | The dietary manage and/or revise the cu policies and proced and held to appropri food-borne illnesse The dietary manage the appropriate stat The dietary manage | THOD OF CORRECTION: er or designee could review urrent food temperature lures to ensure food is cooked riate temperatures to prevent s. er or designee could educate ff on the policies/procedures. er or designee could develop to ensure ongoing compliance | a | | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION: Twenty-one | 9 | | | | |
| 21385 | MN Rule 4658.0800 Staff assistance | 0 Subp. 3 Infection Control; | 21385 | | | 1/3/20 | |
| | | istance with infection control. assigned to assist with the | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION (X | 3) DATE SURVEY COMPLETED | |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SILC | AND AVENU I, MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | |
| 21385 | Continued From pa | ge 36 | 21385 | | | |
| | the residents and n | ogram, based on the needs of ursing home, to implement ocedures of the infection | | | | |
| | by: Based on observati review, the facility fa hygiene and glove u toileting cares to pro- | ent is not met as evidenced on, interview and document ailed to ensure proper hand use during personal cares and event cross contamination for 29) reviewed for bowel and | | Corrected | | |
| | Findings include: | | | | | |
| | indicated R29's diag embolism (blood clo arteries in the lungs | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive nxiety disorder. | | | | |
| | completed 10/2/19, intact with no resist psychosis or mood assessment period R29 was frequently bladder, required ex | num Data Set (MDS) indicated R29 was cognitively ive behaviors, delirium, symptoms during the . R29's MDS further indicated incontinent of bowel and ktensive assistance of two res, and received a diuretic or | | | | |
| | Urinary Incontinence completed for annu date of 9/23/19, ind assistance with toile | e Area Assessment (CAA) for e and Indwelling Catheter, al MDS with the reference icated R29 required eting cares, was frequently ler, and had recently been | | | | |

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | | | |
|---|--|--|---------------------|--|-----------------|-------------------------|--|--|--|
| | | 00593 | B. WING | | C 11/21/2019 | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | | | |
| THE NORTH SHORE ESTATES LLC 7700 GRAND AVENUE DULUTH, MN 55807 | | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE | | | |
| 21385 | Continued From pa | age 37 | 21385 | | | | | | |
| | hospitalized with a urinary tract infection (UTI). R29's CAA indicated R29 was offered toileting every 2 hours and as needed, and was transferred using a stand-aide assist lift. R29 did not always alert staff to the need to use the toilet. R29 received Lasix (diuretic), which could increase the risk for urinary urgency and frequency. R29's CAA further indicated R29 was able to communicate needs. | | | | | | | | |
| | was able to commu by others, and coul conversation. R29 frequently incontine | vised 10/2/19, indicated R29 unicate needs, was understood ld usually understand simple 's care plan indicated R29 was ent of bowel and bladder, and let every 2 hours and as | | | | | | | |
| | 11/17/19, indicated | ocket care plan dated R29 was incontinent, and ovide hourly toileting while | | | | | | | |
| | (NA)-F entered R29 lift to assist R29 wir washed her hands, curtain and shades stand-assist lift up canvas and calf str gloves, sanitized he performing hand hy and removed R29's R29 to a standing p lowered R29's inco to the commode. N little damp with urin | 55 a.m. nursing assistant 9's room with the stand-assist th toileting cares. NA-F , donned gloves, closed the s, and positioned the to R29. NA-F hooked up the aps, and removed her soiled er hands and without ygiene donned clean gloves, s oxygen canula. NA-F raised position in the stand-assist lift, ontinent brief, and lowered R29 IA-F stated R29's brief was a ne. NA-F removed her soiled | | | | | | | |
| mesota D | gloves and sanitize moderate amount of | ed her hands, as R29 voided a of yellow urine in the It performing hand hygiene, | 1 | | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00593 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 11/21/2019 | |
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| 21385 | Continued From pa | ige 38 | 21385 | | | |
| | stand-assist lift, wip personal cleansing her soiled gloves a put on clean gloves brief on R29, move way, put the wheelch into the wheelchair, pushed the wheelch her soiled gloves. N donned clean glove canula on R19's fac stand-assist lift out into the tub room. N had changed glove care, and said she On 11/19/19, at 11:: of nursing (ADON) soiled gloves, sanit | a gloves, raised R29 in the bed R29's peri area with a wipe. NA-F did not remove and perform hand hygiene, and s. NA-F put a clean incontinen d the commode out of the chair in place, lowered R29 , unbuckled the canvas, hair back, and then removed NA-F sanitized her hands and es. NA-F placed R29's oxygen ce. NA-F moved the of R29's room and brought it NA-F stated she thought she s and sanitized following peri should have. 04 a.m. the assistant director stated staff should remove ize or wash hands, and put ing from dirty to clean areas | | | | |
| | directed handwashi hands are visibly so visibly soiled, to use The policy further d be performed befor residents, before do after contact with be from contaminated during resident care | ashing policy dated 1/08, ing should be completed when biled, and when hands are not e an alcohol based hand rub. lirected hand hygiene should re and after contact with bing an invasive procedure, odily fluids, before moving body site to a clean body site es, after contact with hent, after removing gloves. | | | | |
| | The director of nurs | THOD OF CORRECTION: sing (DON) or designee could e the current hand hygiene dical equipment policies and | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| 21385 | Continued From pa | ige 39 | 21385 | | | |
| | appropriate staff or The DON or design system to ensure o | | 1 | | | |
| 21426 | MN St. Statute 144 Prevention And Co | A.04 Subd. 3 Tuberculosis ntrol | 21426 | | | 1/3/20 |
| | maintain a comprehinfection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme | e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must be nursing home. | t | | | |
| | by: | ent is not met as evidenced | | Corrected | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF | CORRECTION | (X5) |
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| 21426 | Continued From pa | age 40 | 21426 | | | |
| | facility failed to ensure resident's second step Tuberculin skin test (TST, a skin test used to check for tuberculosis infection) was completed for 1 of 5 residents (R2) reviewed for TST. | | | | | |
| | Findings include: | | | | | |
| | R2's Face Sheet pr diagnoses included | rinted 11/20/19, indicated R2's I asthma. | | | | |
| | indicated R2 receiv 5/24/19, but lacked date, time, and inte screening form had second TST howev | erculin (TB) Screening form red his first step TST on information indicating the erpretation of the TST. R2's TI d provided space to record a ver, it was left blank. R2's ked documentation R2 step TST. | В | | | |
| | nursing (ADON) ve did not indicate res and also lacked ev required second ste documentation of th a positive or negative | 4 p.m. the assistant director o rified R2's TB Screening form ults from the first step TST, ridence that R2 received the ep TST. The ADON stated he TST results should include ve reading, along with the f induration, date, and time the | | | | |
| | (DON) verified R2 of second TST, and w TST to be complete | 7 p.m. the director of nursing did not receive the required yould expect the second step ed. The DON further stated if ST was not administered, she ST to be repeated. | | | | |
| | Screening of Resid qualified nurses inter | Resident Baseline Tuberculosis ent dated 11/10, directed erpret the TST 48 to 72 hours of the TST. All test results | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED | |
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| 21426 | must be read in mil interpretation. Time greater than 72 hou The policy further in step TST is negativ TST one to three w administered. SUGGESTED MET The director of nurs review and/or revise ensure TB testing fe documented as req The DON or design staff on the process The DON or design monitoring or audit of TB screening and | limeter. Document the time of e of interpretation must not be ins after time of administration. indicated residents whose first e will receive a second step eeks after the initial TST was THOD OF CORRECTION: sing (DON) or designee could e the facility's process to pr resident is completed and uired. ee could re-educate nursing s and TB policy. ee could review current system to ensure compliance | 21426 | | | | |
| 21540 | Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medic medical director is n | 5 Subp. 2 Unnecessary Drug g. A nursing home must ent's drug regimen for usage, based on the nursing procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the al director for review if the not the attending physician. If determines that the attending | 21540 | | | 1/3/20 | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLET DATE |
| 21540 | Continued From pa | ge 42 | 21540 | | | |
| | the order and if the change the order, the review to the Qualit (QAA) committee re the attending physic | have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter | | | | |
| | by: Based on interview facility failed to ensu pressures for monit related psychotropic for 3 of 6 residents unnecessary medic failed to ensure app medications for 1 of for unnecessary medic facility failed to ensu- ordered by a physic | ent is not met as evidenced and document review, the ure orthostatic blood toring of potential side effects c medications were completed (R29, R39, R3) reviewed for cations. In addition, the facility propriate diagnoses for use of f 6 residents (R39) reviewed edications. In addition, the ure monitoring of weights as cian regarding a medical residents (R29) reviewed for cations. | | Corrected | | |
| | indicated R29's diag embolism (blood clo arteries in the lungs respiratory failure, v | ecord printed 11/19/19, gnoses included pulmonary ot in one of the pulmonary s), acute and chronic vascular dementia, congestive edema, bipolar disorder, and | | | | |
| | was at risk for falls including CHF, ede | iated 8/24/18, indicated R29 related to medical conditions, ma, bipolar disorder, and R29's care plan indicated | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | | (X3) DATE SURVEY COMPLETED | |
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| 21540 | Continued From pa | ge 43 | 21540 | | | |
| | and behavior altering | chotropic medications (mood ng medications), and directed monthly orthostatic blood | | | | |
| | R29's Order Summary Report with Active Orders as of 11/19/19, included orders for: -check vital signs daily. Order 9/17/19. -Monthly psychotropic side effect monitoring, if side effects, update physician. Every day shift on the 24th, monthly. -Sertraline HCL (antidepressant) 50 mg at bedtime. Order start date 9/17/19. -Olanzapine (antipsychotic) 5 mg every evening for bipolar disorder. Order start dated 9/17/19. | | | | | |
| | R29 refused an orth progress notes lack | es dated 9/24/19, indicated nostatic blood pressure. R29's ked documentation of any oach R29 for an orthostatic | 5 | | | |
| | | dministration Record (TAR) nostatic blood pressure was | | | | |
| | | Vitals Summary for 9/24/19, ion of an orthostatic blood | | | | |
| | orthostatic blood pr psychotropic medic | ber 2019, indicated R29's essures for monitoring of ations were obtained on d documentation of orthostatic ults. | | | | |
| | | es dated 10/24/19, lacked 29's orthostatic blood | | | | |

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| 04540 | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| | Continued From page 44 | | 21540 | | | |
| | | Vitals Summary for 10/24/19, ion of an orthostatic blood | | | | |
| f t f c c c c c c c c c c c c c c c c c | orthostatic blood pr taken, and was sch TAR indicated R29 | ember 2019, indicated R29's essure had not yet been eduled for 11/24/19. R29's was to be monitored monthly le effect monitoring monthly or | 1 | | | |
| | 10/3/19, through 11 | Vitals Summary dated /20/19, indicated no essures were obtained or | | | | |
| | (DON) verified ortho | 8 p.m. director of nursing ostatic BP's should be ring of psychotropic | | | | |
| | indicated R39's diag cognitive impairment | ecord printed 11/20/19, gnoses included CHF, mild nt, encephalopathy (brain or malfunction), major r, and insomnia. | | | | |
| | of 11/20/19, include -quetiapine (antipsy milligrams (mg) at b order dated 10/29/1 -Sertraline (antidep | chotic medication) 50 pedtime for primary insomnia, | 5 | | | |
| | medications withou medications: | rders included the following t diagnoses for use of the e (nerve pain medication) | | | | |
| ATE FORM | | | 6899 JN | <i>I</i> 4C11 | If continuati | on sheet 45 o |

| STATEMEN | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
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| 21540 | Continued From pa | ge 45 | 21540 | | | |
| | -Metoprolol Tartrate pressure) -Melatonin (hormor -Lisinopril (for high failure) -Furosemide (diure -Atorvastatin Calciu -Diltiazem CD ER 2 and heart failure) -cholestyramine ligh -cholecalciferol (vita -Budesonide capsu Crohn's or ulcerativ - Aspirin | blood pressure and heart tic) Im (for high cholesterol) 24 hour (high blood pressure ht packet (for high cholesterol) amin D supplement) Ile DR (anti-inflammatory for | | | | |
| | monitoring of psych effects, and orthost | notropic medication side atic blood pressures for notropic medications. | | | | |
| | received psychotro risk for adverse sid directed nursing to | iated 8/29/19, indicated R39 pic medications and was at e effects. R29's care plan monitor for adverse drug n monthly orthostatic blood | | | | |
| | Review dated 7/19/ included monitoring orthostatic blood pr target behaviors. N | harmacist's Medication (19, recommendations of antipsychotics including ressures, side effects, and Jursing signed s completed on 8/12/19. | | | | |
| | for September 2019 quetiapine fumarate through 9/12/19, m | dministration Record (MAR) 9, indicated R39 received e for insomnia on 9/10/19 elatonin daily for insomnia, epression daily. R39's MAR | | | | |

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | | (X3) DATE SURVEY COMPLETED | |
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| 21540 | Continued From page 46 | | 21540 | | | |
| | | for antipsychotic side effect and was documented as 9. | | | | |
| | R39's Treatment Administration Record (TAR) for September 2019, directed nursing to obtain a lying and sitting (orthostatic) blood pressure due to antipsychotic medication monthly. R39's orthostatic blood pressure was documented as done, but without results. | | | | | |
| | documentation of o | es dated 9/619, lacked rthostatic blood pressure to reapproach for the essure. | | | | |
| | | Vitals Summary report for mentation of an orthostatic | | | | |
| | received quetiapine depression, and se melatonin for insom directives for antips | ober 2019, indicated R39 e fumarate for insomnia and rtraline for depression, and nnia. R39's MAR included sychotic side effect monitoring ocumented as completed on | | | | |
| | obtain an orthostati to antipsychotic me an orthostatic blood | ber 2019, directed nursing to c blood pressure monthly due dication. R39's TAR indicated pressure was obtained on documentation of results. | | | | |
| | indicated R39's orth completed, and ind | Vitals Summary for 10/6/19, nostatic blood pressure was icated no orthostatic n blood pressure) with change g to sitting. | | | | |

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| 21540 | Continued From page 47 | | 21540 | | | |
| | received melatonin insomnia, and sertr | ember 2019, indicated R39 , quetiapine fumarate for aline for depression. R39's on to monitor for antipsychotic ects. | | | | |
| | | ember 2019, lacked direction c blood pressures monthly due dications. | • | | | |
| | | vitals Summary since 29/19, indicated no orthostatic d been obtained. | | | | |
| | 10/29/19, lacked do blood pressures, or | es since readmission on ocumentation of orthostatic clarification of diagnosis for r other medications. | | | | |
| | | Medication review dated completed and signed. | | | | |
| | R39's Target Behav 11/14/19. | vior Form was not completed | | | | |
| | had received quetia nursing reported no and R39 was unabl quetiapine was pres | dated 9/4/19, indicated R39 apine every night for agitation, agitation since admission, e to indicate when and why scribed. NP discontinued ted melatonin every evening. | | | | |
| | had not been sleep the physician had d | es dated 9/8/19, indicated R39 ing well and was concerned iscontinued the quetiapine · sleep good previously. | 9 | | | |
| | R39's primary care | es dated 9/9/19, indicated physician sated insomnia hac iapine was discontinued, so | | | | |

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| 21540 | Continued From pa | ge 48 | 21540 | | | |
| | reordered quetiapir | ne at bedtime. | | | | |
| | insomnia was not a quetiapine. R39's Consultant P Review dated 9/12/ regarding quetiapin sleep was not an ap quetiapine and reco assessment of the R39, and if the diag use of quetiapine. changing R39's dia depression. R39's physician vis indicated R39 had s physician on 9/9/19 should restart queti been restarted. | es dated 9/12/19, indicated in approved diagnosis for harmacist's Medication '19, identified an irregularity e. The pharmacist indicated oproved indication for ommended a review and current use of quetiapine for gnosis is sleep, to discontinue R39's physician responded by gnosis for use of quetiapine to it notes dated 9/13/19, seen her primary care 9, and the physician felt she apine for insomnia, so it had es dated 9/13/19, indicated | | | | |
| | R39's diagnosis for depression. R39's Consultant P | quetiapine was changed to harmacist Medication Review tified an irregularity regarding | | | | |
| | use of quetiapine. 8/30/19, R39 was n and quetiapine was complained of not b | The pharmacist indicated on ot showing signs of agitation discontinued. Resident then being able to sleep and | | | | |
| | and then changed t The consultant pha | ted with a diagnosis of sleep to a diagnosis of depression. rmacist recommended e quetiapine and starting a | | | | |
| | medication that wor trazodone or mirtaz | uld target sleep, such as apine that would also help | | | | |
| | | 39's physician addressed the mendation by ordering | | | | |

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| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
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| 21540 | Continued From pa | ige 49 | 21540 | | | |
| | trazodone in place | of quetiapine. | | | | |
| | R39 had been reac during 10/24/19 to exacerbation. R39 indicated medicatio diagnoses were no medications, and la or psychotic behav | tes dated 11/4/19, indicated Imitted from a hospital stay 10/29/19, for heart failure 's physician visit notes ons were reviewed, but t provided for use of acked diagnoses for psychosis iors. R39's physician visit ited R39 had not significant s. | | | | |
| | diagnoses for medi orders. R39's NP v mood was good, ar behavioral changes indicated R39 rece | s dated 11/11/19, lacked ications received by R39 per visit notes indicated R39's nd had no significant s. R39's NP visit notes further ived quetiapine for chronic blan was to continue the rred. | | | | |
| | 11/20/19, indicated had not been check | ioner (NP) visit notes dated orthostatic blood pressures ked between 11/19/19 and ed diagnoses for medications er orders. | | | | |
| | | 2 p.m. R39 stated she felt her nelpful and she had not de effects. | | | | |
| | (DON) stated she w pressures to be do any psychotropic m quetiapine is not an sleep and verified F | 9 p.m. director of nursing vould expect orthostatic blood ne when a resident is receiving nedication. DON verified n appropriate medication for R39's orthostatic blood t completed and antipsychotic | | | | |
| | | ng was not on the TAR | | | | |

| TATEMEN | Ita Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | | | |
| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | | |
| | RTH SHORE ESTATES | SIIC | AND AVENUE | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21540 | Continued From pa | ge 50 | 21540 | | | | |
| | been done. DON v had seen R39 since and nursing should diagnoses of medic verified R39's Psyc had not been comp | pital return and should have rerified the NP and physician e her return from the hospital have put in a request for cations at that time. DON hotropic Medication review leted as dated for 10/10/19, or Form was not completed for | | | | | |
| | revised 12/16, direct receive antipsychot necessary to treat s they are indicated a policy and procedur physician to identify symptoms that may antipsychotic medic specific condition for medications are ne based on a compres Antipsychotic media only symptoms wer | ntipsychotic Medication Use cted residents would "only ic medications when specific conditions for which and effective." The facility re further directed the γ , evaluate and document γ warrant the use of cations, and the diagnosis of a or which the antipsychotic cessary to treat would be shensive assessment. ations would not be used if the re one or more of symptoms ess, insomnia, nervousness, c | | | | | |
| | | cord dated 11/20/19, indicated luded major depressive y disorder. | | | | | |
| | had moderately imp also identified she antidepressant me | dication for seven days, during back period, and had two or | | | | | |
| | | ry Report dated 11/20/19, rdered orthostatic blood | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COM | |
|--------------------------|--|--|---------------------------|--|------------------|--------------------------|
| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SHC | AND AVENUE I, MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE | (X5) COMPLETE DATE |
| 21540 | Continued From pa | ge 51 | 21540 | | | |
| | medication usage of month. Further, R3 | ng due to psychotropic on the 10th day of every 3 was ordered fluoxetine 9 mg daily for depression on | | | | |
| | potential for psycho related to fluoxetine | d 3/14/19, indicated R3 had stropic adverse drug reactions e medication usage. led monitoring for adverse | | | | |
| | | 19 TAR lacked indication essures were taken. | | | | |
| | 12/2/19, lacked indi | ghts and vitals summary dated ication orthostatic blood orded from 8/1/19, to | t | | | |
| | conducted with regi confirmed she was blood pressures in stated staff were ex | 34 a.m. an interview was istered nurse (RN)-E. RN-E unable to locate orthostatic R3's medical record. RN-E spected to follow the order and ig a progress notes with ut into place. | 1 | | | |
| | conducted with the expected staff were | 7 p.m. an interview was DON. The DON stated she e to complete full sets of essures as indicated, and een a note. | | | | |
| | revised 12/16, direct document, and repo | ntipsychotic Medication Use cted nursing staff to observe, ort adverse consequences to cian such as "orthostatic | | | | |

| STATEME | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | ······ | | |
| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | 7700 GR | AND AVENUE | | | |
| | | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT | | (X5) COMPLET |
| TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | DATE |
| 21540 | Continued From pa | ge 52 | 21540 | | | |
| | The director of nurs review and/or revise psychotropic medic to ensure potential managed. The DON or design appropriate staff on The DON or design system to ensure o | THOD OF CORRECTION: sing (DON) or designee could e the current monitoring of ration policies and procedures side effects are identified and nee could educate the the policies/procedures. nee could develop a monitoring ngoing compliance. R CORRECTION: Twenty-one | 3 | | | |
| 21545 | A nursing home mu A. Its medication percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long- incorporated by refe- purposes of this pa (1) a discrepan prescribed and what administered to res (2) the administ medications. B. It is free of a error. A significant (1) an error we discomfort or jeopal safety; or (2) medication | D A.B.C Medication Errors ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident rdizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single | | | | 1/3/20 |

| | a Department of He T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | E SURVEY PLETED |
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| | OF CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING | : | | |
| | | 00593 | B. WING | | C 11/21/2019 | |
| IAME OF P | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, | STATE, ZIP CODE | | |
| | TH SHORE ESTATE | SILC | AND AVENU MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 21545 | Continued From pa | age 53 | 21545 | | | |
| | precipitate a reoccu toxicity. All medicat prescribed. An inc error report must b that occurs. Any si resident reactions r physician or the ph resident or the resid designated represe must be made in th C. All medicati prescribed. An incl report must be filed occurs. Any signifi resident reactions r physician or the ph resident or the resid designated represe | buld alter that level and urrence of symptoms or tions are administered as cident report or medication e filed for any medication error ignificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. ons are administered as ident report or medication error d for any medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. | | | | |
| | by: Based on observat review, the facility f dosage of a narcot | ent is not met as evidenced ion, interview, and document ailed to ensure a correct ic pain medication was of 8 residents (R52) reviewed inistration. | | Corrected | | |
| | Findings include: | | | | | |
| | indicated R52's dia | ecord dated 11/19/19, gnoses included humerus | | | | |
| | impairment. | f upper arm) and mild cognitive | | | | |

| STATEMEN | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | COM | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NOP | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED | | | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21545 | Continued From pa | ige 54 | 21545 | | | |
| | needed pain medic | identified he received as ation, had occasional pain, I pain medication for seven | | | | |
| | indicated R52 was pain medication) 10 six hours as neede | hary Report dated 11/19/19, prescribed Norco (a narcotic 0-325 milligrams (mg) every d for pain rated six or greater n scale. The order was placed | | | | |
| | not wish to self-adn a mild cognitive imp further indicated R | ted 11/1/19, indicated R58 did ninister medications, and had pairment. The care plan 58 would be administered ysician orders and by a | | | | |
| | Record (MAR) print was prescribed hyd (Norco) 5-325 mg. every four hours as two tablets as need numeric pain scale. R58 was administe p.m. and 11/14/19, | D18 Medication Administration ted 11/19/19, indicated R58 procodone-acetaminophen R58 was to take one tablet a needed for pain rated 4-7, or led for pain rated 8-10 on the . The MAR further identified red Norco 11/12/19, at 4:39 at 1:06 a.m. The order was and discontinued on 11/15/19. | | | | |
| | indicated R58 was R58 was to take on needed, for pain rai needed, for pain rai scale. The MAR fu administered Norco and 11/17/19, at 8:4 | 018 MAR printed 11/19/19, prescribed Norco 5-325 mg. le tablet every six hours, as ted 4-7 or two tablets, as ted 8-10 on the numeric pain inther identified R58 was o on 11/16/19, at 6:31 a.m., 46 a.m. The order was started scontinued on 11/18/19. | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| | | 00593 | B. WING | | | C 11/21/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| | RTH SHORE ESTATE | SILC | RAND AVENUE H, MN 55807 | | | | |
| (X4) ID | SUMMARY ST | | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | THE APPROPRIATE | COMPLET DATE | |
| 21545 | Continued From pa | age 55 | 21545 | | | | |
| | nurse (LPN)-C and administering medi LPN-C and LPN-E medication. LPN-C labeled Norco 10-3 a locked compartm LPN-C compared t electronic medicati (eMAR) and verbal card label did not n LPN-C did not adm requested LPN-E t located in R58's pa verified six doses of dispensed from the nurse (RN)-E walke informed LPN-C th | 17 p.m., licensed practical I LPN-E were observed ications. R58 approached and stated he needed pain C removed a medication card 825 mg, belonging to R58, from nent within the medication card the medication card label to the on administration record lized the dosage on medication natch the physicians order. hinister the Norco and o check the physicians order aper medical record. LPN-C of Norco 10-325 mg had been e medication card. Registered ed to the medication cart and e physician order indicated the s Norco 5-325, and stated she cation error form. | e n | | | | |
| | conducted with RN medical record, an was updated in the verbalized the Nord from every four hou | 27 p.m., an interview was I-E. RN-E audited R58's d stated R58's Norco order e eMAR on 11/15/19. RN-E co frequency was changed urs to every six hours however 5 mg remained the same. | r, | | | | |
| | RN-E stated the or according to the we error occurred as s medication label ag ensure accuracy. observed, and RN- incorrectly adminis | der transcription was accurate ritten physician order, and the staff had failed to verify the gainst the medication order to The medication card was agai E confirmed six doses were tered. The medication card as filled on 11/12/19. | | | | | |
| pnesota D | 11/17/19, indicated | Reconciliation Form dated l, "Dose sent from pharmacy ed total of 6 times. Escript ser | nt | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
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| | or connection | IDENTIFICATION NOMBER. | A. BUILDING: | | | |
| | | 00593 | B. WING | | | C 21/2019 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLET DATE |
| 21545 | Continued From pa | ge 56 | 21545 | | | |
| | 11/12/19." The Me Form further indica was administered a reached the patient harm." On 11/20/19, at 3:3 conducted with the The DON stated the medication labels a | t facility for updated dose on dication Error Reconciliation ted the wrong drug/dosage and "an error occurred that but did not cause patient 6 p.m. an interview was director of nursing (DON). e nurses were to check gainst the medication orders on. The DON further stated | | | | |
| | of opioid pain medi and constipation. | nces of receiving double doses cation could include confusion | | | | |
| | revised 4/19, direct administering the m THREE (3) times to medication, right do | dministering Medications ed, "The individual nedication checks the label o verify the right resident, right osage, right time and right dministration before giving the | | | | |
| | The director of nurs review and/or revise administration and procedures to preve errors. | THOD OF CORRECTION: sing (DON) or designee could e the current medication medication error policies and ent significant medication nee could educate the | | | | |
| | appropriate staff or The DON or design | n the policies/procedures. nee could develop a monitoring ngoing compliance. | 1 | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |

| STATEMEN | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DAT | E SURVEY |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | СОМ (°СОМ | IPLETED |
| | | 00593 | B. WING | B. WING | | C 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | | 7700 GR | AND AVENUE | | | |
| THE NOP | RTH SHORE ESTATES | DULUTH | , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\ | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21880 | Continued From pa | ge 57 | 21880 | | | |
| 21880 | | | 21880 | | | 1/3/20 |
| | their stay in a facility to understand and a patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fa nursing home ombut Americans Act, sec posted in a conspic | | | | | |
| | residential program 253C.01, every non facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies t limits for facility res or resident to have advocate; requires grievances; and pro an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs centers with section | inpatient facility, every in as defined in section hacute care facility, and every hore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written by ides for a timely decision by in maker if the grievance is not Compliance by hospitals, as as defined in section hospital-based primary s, and outpatient surgery 144.691 and compliance by e organizations with section | | | | |

| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING | : | | С |
| | | 00593 | B. WING | | 11/21/2019 | |
| AME OF PRO | OVIDER OR SUPPLIER | STRE | ET ADDRESS, CITY, | STATE, ZIP CODE | | |
| HE NORTI | H SHORE ESTATES | | GRAND AVENU UTH, MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21880 C | ontinued From pa | age 58 | 21880 | | | |
| re | | to be compliance with the vritten internal grievance | | | | |
| by B fa gi | y: ased on interview acility failed to ens | ent is not met as evidence and document review, the ure a written response to a residents (R12) reviewed | | Corrected | | |
| 0 | indings include: | | | | | |
| in in | dicated R12's dia | ecord printed 11/20/19, gnoses included unspecifie ies, and unspecified res). | ed | | | |
| 9/ de ui in sy | /10/19, indicated F eficit, was able to nderstood, and un idicated R12 displ | imum Data Set (MDS) data R12 had a moderate cognit speak clearly, was nderstood others. R12's M ayed no behaviors, no sign um or psychosis, and had r | tive DS ns or | | | |
| w of | as cognitively inta thers, was able to | iated 4/20/17, indicated R1 act, was able to understand be understood by others, a unicate needs effectively. | | | | |
| 1 [.] | | es dated 10/23/19 through ocumentation regarding | | | | |
| | | 7 p.m. R12 was interviewe I three to four pairs of miss | | | | |

| | NT OF DEFICIENCIES I OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | C 11/21/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETI DATE |
| 21880 | purple shorts. R12 the shorts, and she facility was unable had reported it to th R12 denied getting to the missing cloth On 11/19/19, at 7:4 stated R12 had bee for 3 to 4 months. through everything LA-A stated R12's f On 11/20/19, at 2:4 (SS)-A stated she h missing clothing. S family gets updated grievance investiga written response. On 11/20/19, at 2:4 director (SS)-B state occurred some time administrator was s shorts, but the re w appropriate size. S not provide a writte resident representa keep the grievance for provided. The facility policy C Procedure dated 9/ to be completed, an as soon as reasona complaint had beer would provide a verte | stated the facility looked for e was told after she asked, the to find them. R12 stated she he lady who did the laundry. a written response in regards ning. 0 a.m. laundry aide (LA)-A en missing two purple shorts LA-A stated she has looked and was unable to find them. family knew about it. 0 p.m. social services director nad not heard about R12's SS-A stated the resident or d with the results of the tion, but they do not provide a 3 p.m. social services regional ted R12's missing shorts e ago. SS-B stated the supposed to purchase new ras a problem finding the SS-B confirmed the facility did n response to R12 or the ative. SS-B stated they would | r | | | |

| ND PLAN | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|--|-----------------------------------|--------------------------|
| | | | A. BUILDING: | | | C |
| | | 00593 | B. WING | | | 21/2019 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| | TH SHORE ESTATES | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 21880 | Continued From pa | ge 60 | 21880 | | | |
| | grievance. If the gr grievance form was Grievance Office, a grievance officer was grievance and notifi the proposed action resolved, it would b Directors and the B summary to the corn no later than 30 day grievance. All com | is days after the receipt of the ievance was not resolved, the is to be sent to the corporate nd within 7 days, the build attempt to resolve the y the complainant in writing of n. If the grievance was not e submitted to the Board of oard would issue a written nplainant of proposed action ys after receipt of the pleted grievance forms would t the facility for no less than 3 | | | | |
| | The administrator, a designee could revi grievances policies written response/re provided. The administrator, a designee could edu the policies/procedu The administrator, a designee could dev ensure ongoing cor | social services director, or elop a monitoring system to npliance. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 21925 | MN St. Statute 144 Residents of HC Fa | .651 Subd. 29 Patients & ac.Bill of Rights | 21925 | | | 1/3/20 |
| | shall not be arbitrar | ers and discharges. Residents ily transferred or discharged. notified, in writing, of the e or transfer and its | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | | |
|--------------------------|---|--|-----------------------|--|------------------------------------|-------------------------|--|--|
| | | 00593 | D. WING | | - 11/21/201 | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | | |
| | RTH SHORE ESTATES | SILC | AND AVENU MN 55807 | E | | | | |
| (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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE | | |
| 21925 | Continued From pa | ige 61 | 21925 | | | | | |
| | discharge from the transfer to another notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a) of this right, may ch notice period ends. shortened in situation control, such as a ch review, the accomment residents, a change treatment program, resident's welfare, of prohibited by the pu- paying for the resid the medical record. reasonable effort to without disrupting re This MN Requirement by: Based on interview facility failed to ensi- reason for transfer 2 of 5 residents (R1 transfer/discharge. Findings include: R19's Admission Re- indicated R19's diag chronic kidney dise failure. | ent is not met as evidenced and document review, the ure a written notification of to a hospital was provided for 19, R50) reviewed for ecord printed 11/20/19, gnoses included anemia, ase, and congestive heart | | Corrected | | | | |
| | 9/25/19, indicated F | harge paperwork dated R19 was admitted to the , for evaluation after a fall. | | | | | | |

| STATEMEN | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00593 | B. WING | | | C 21/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATES | SILC | AND AVENUE MN 55807 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21925 | Continued From pa | ge 62 | 21925 | | | |
| | notice for transfer v | rd lacked evidence a written vas obtained and provided in or R19's representative. | | | | |
| | R19 had a fall and room for evaluation facility on 10/20/19. evidence a written | e dated 10/20/19, indicated was sent to the emergency and returned back to the R19's medical record lacked notice for transfer was to R19 and/or R19's | | | | |
| | indicated R50's dia | ecord printed 11/20/19, gnoses included chronic betes type 2, and had a mild nt. | | | | |
| | indicated R50 was 5/1/19, for Influenza lacked evidence a | e dated 5/1/19, at 2:31 p.m. admitted to the hospital on a. R50's medical record written notice of transfer was to R50 and/or R50's | | | | |
| | indicated R50 was swollen leg, fatigue medical record lack | Referral Form dated 8/16/19, hospitalized 8/12/16, for and poor appetite. R50's ded evidence a written notice by ided in writing to R50 and/or re. | | | | |
| | services stated whe hospital from the fa signed bed hold an transfer from the re able to sign for ther verbal from the res written Bed-Hold N | 8 p.m. director of social en a resident goes into the icility, the nurses will obtain a d a written notification of esident to sign if the resident is mselves, and if not will obtain a idents representative. A otice for Hospital Transfer and form given to the resident or | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/S | SUPPLIER/CLIA TION NUMBER: | | | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|---|--|---|---------------------|--|-----------------------------------|-------------------------|--|--|
| | | 00593 | | B. WING | | | C 11/21/2019 | | |
| | PROVIDER OR SUPPLIER | 00593 | | | STATE, ZIP CODE | · | | | |
| | | | | AND AVENUE | | | | | |
| | RTH SHORE ESTATES | | DULUTH, | MN 55807 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENCY REGULATORY OR L | | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | | |
| 21925 | Continued From pa | ge 63 | | 21925 | | | | | |
| | representative, and document in the res written was provide resident representa | sident's medica d to the reside | al record that a | | | | | | |
| | On 11/20/19, at 2:00 (LPN)-A stated if a from the facility, the hold form including resident was unable would be obtained f representative over the resident's media completed form was and the director of r person or by email | resident goes resident woul reason for trai to sign, a ver from the reside the phone and cal record. LP s put into the r nursing (DON) | nto the hospital d sign a bed hsfer, and if the bal consent ent's d documented in N-A stated the esident's chart, was notified in | | | | | | |
| | On 11/20/19, at 4:39 facility was not prov transfer to residents representatives only | viding a written s and/or reside y upon reques | notice of nt t. | | | | | | |
| | The facility was una written notice of trai | | a policy on | | | | | | |
| | SUGGESTED MET The Director of Nur develop, review, an procedures on disc ensure a written no is provided. The DON or design appropriate staff on The DON or design systems to ensure of | sing (DON) or d/or revise pol harges and/or tification of rea ee could educ the policies an ee could deve | designee could icies and transfers to ison for transfer ate all nd procedures. lop monitoring | | | | | | |
| 21995 | MN St. Statute 626 Maltreatment of Vul | | | 21995 | | | 1/3/20 | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 11/21/2019 | |
|--------------------------|--|---|-------------------------|--|--|-------------------------|
| | | 00593 | B. WING | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, | STATE, ZIP CODE | | |
| THE NO | RTH SHORE ESTATE | SIIC | AND AVENU , MN 55807 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE |
| 21995 | Continued From pa | age 64 | 21995 | | | |
| | Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltro facility has an intern mandated reporter requirements of thi internally. Howeve responsible for com reporting requirements by: Based on interview facility failed to report to the State Agency residents (R21) rev Findings include: R21's Admission R indicated R21's dia dementia with beha cerebral infarction R21's quarterly Min 9/19/19, indicated R impairment, display psychosis, no beha | I reporting of maltreatment. all establish and enforce an occedure in compliance with grules to ensure that all cases eatment are reported. If a may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section. ent is not met as evidenced r and document review, the ort bruises of unknown origin y within 2 hours for 1 of 3 viewed for abuse. ecord printed 11/20/19, gnoses included vascular avioral disturbance, and (stroke). himum Data Set (MDS) dated R21 had a severe cognitive yed no symptoms of delirium of aviors during the assessment d extensive assistance with all | r | Corrected | | |
| | was unable to remo due to physical and directed staff to ob- changes in vulnera staff to provide phy | tiated 4/24/17, indicated R21 ove self from harmful situations a cognitive deficits, and serve for and report any bility. R21's care plan directed sical assistance with all ADLs ted R21 could be resistive to | | | | |

| AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | (X3) DATE SURVEY COMPLETED C 11/21/2019 | | |
|---|--|--|---|--|--|--|--|
| | | 00593 | | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| THE NORTH SHORE ESTATES LLC 7700 GRAND AVENUE DULUTH, MN 55807 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE COMPL THE APPROPRIATE DAT | | |
| 21995 | Continued From pa | age 65 | 21995 | | | | |
| | assistance with cares, and directed staff to re-approach as R21 allowed. R21's care plan further indicated R21 was forgetful and confused, had a modified independence with decision making and required some assistance in new situations, and had an impaired short term memory and moderately impaired long term memory. | | , | | | | |
| | staff to give space, demonstrating agita | stant care guide sheet directed and re-approach when ated behaviors, and Tubigrips knuckles to elbows as she | 1 | | | | |
| | as of 11/20/19, incl (mg) aspirin daily. | nary Report with active orders uded a chewable 81 milligram R21's orders did not include coagulant or steroid | | | | | |
| | a.m. indicated staff of R21's hands at t the right thumb bru (cm) by 1.0 cm, and cm x 4.0 cm. The being black and blu questions of how s | es dated 10/31/19, at 12:19 had reported bruises to both he base of the thumbs, with ise measuring 2.0 centimeters d the left thumb measuring 3.8 bruises were documented as ue. R21 did not respond to he got the bruises, or if she he oncoming licensed nurse e bruises. | | | | | |
| | indicated the interd 10/31/19, to review 10/30/19. The IDT grab at staff and st refuse medications | es dated 11/1/19, at 9:55 a.m. isciplinary team (IDT) met on 2 R21's bruises noted on noted R21 would frequently rike out with her hands, and and treatments. IDT decided to both arms from knuckles to on as R21 allowed. | | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|-----------------------|--|-------------------------------|-----------------|
| | | | A. BUILDING. | | с | |
| | | 00593 | B. WING | | | 21/2019 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | RTH SHORE ESTATE | SIIC | AND AVENUE | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF | | (-) | |
| PREFIX TAG | (EACH DEFICIENC) REGULATORY OR L | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLET DATE |
| 21995 | Continued From pa | age 66 | 21995 | | | |
| | R21's progress notes lacked indication of a specific event that led to R21's bruises, and lacked indication that R21's bruises were reported to the State Agency. | | | | | |
| | R21's physician visit note dated 11/4/19, indicated R21 resisted examination, and was seen for increased behaviors and refusal behaviors the previous month. R21's physician note lacked notation of bruises on bilateral thumbs. | | d | | | |
| | (DON) stated staff time of the incident bruising, and if no o happened, it should | 2 p.m. the director of nursing should have been asked at the for possible causes of one knew how it could have d have been reported to the 2 hours, as a potential abuse | | | | |
| | directed staff to immu who was then to at of the injury of unkn the administrator of and suspected abu | or Abuse ble Adult Plan dated 12/18, mediately notify the unit nurse tempt to determine the cause nown origin, immediately notify f an injury of unknown origin, se would be reported to the er than 2 hours after forming | | | | |
| | The administrator, social services dire and/or revise the co abuse policies and reporting of potenti The administrator, | | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--------------------------|--|-----------------|-----------------|
| AND PLAN OF CONNECTION | | IDENTIFICATION NOWIDER. | A. BUILDING: | | C | |
| | | 00593 | B. WING | | | 21/2019 |
| AME OF F | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| | TH SHORE ESTATE | SIIC | AND AVENUE , MN 55807 | | | |
| (X4) ID | SUMMARY ST | | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | THE APPROPRIATE | COMPLET DATE |
| 21995 | Continued From page 67 | | 21995 | | | |
| | social services director or designee could develop a monitoring system to ensure ongoing compliance. | | | | | |
| | TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | | | | | |
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