DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MEE	DICARE & MEDIO	CAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: 0830
	PART I -	TO BE COMP	LETED BY T	THE STAT	FE SURVEY AGENCY		Facility ID: 00080
1. MEDICARE/MEDICAID PROVID (L1) 245384 2.STATE VENDOR OR MEDICAID (L2) 365745100		 NAME AND AI (L3) NORTH SH (L4) 515 - 5TH A (L5) GRAND MA 	ORE HEALTH VENUE WEST	ł	(L6) 55604	 TYPE OF ACTION Initial Termination Validation 	 DN: <u>7</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other er Complaint
6. DATE OF SURVEY 07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	27/2021 (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 0 15 ASC 16 HOSPICE	FISCAL YEAR END 12/31	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO From (a) : To (b) :	DN			AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	e 1	ervices Limit
12.Total Facility Beds 13.Total Certified Beds	37 (L18)37 (L17)	B. Not in Cor	cceptable POC npliance with Prog and/or Applied V	-	4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	(L12) F) 8. Patient Room 9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKD	OWN	1			15. FACILITY MEETS		
18 SNF 18/19 SNF 37	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE Teresa Ament, Unit Su)7/27/2021 BY HCFA RE	(L19) E GIONAI	18. STATE SURVEY AGENCY Joanne Simon, Enforce OFFICE OR SINGLE S	ment Specialist	Date: 07/27/2021 (L20)
 DETERMINATION OF ELIGIBIT <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	I CIVIL	 Statement of Finar Ownership/Control Both of the Above 	l Interest Disclosure Stm	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 01/01/1987	BEGINNING	B DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to	<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	
(L27)	-	1 of Admissions: 1spension Date:	(L44)		04-Other Reason for withdrawar	07-Provid 00-Active	ler Status Change
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		06201					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	N OF APPROVAL	DATE			
	(L32)	07/14/2021		(L33)	DETERMINATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 27, 2021

CMS Certification Number (CCN): 245384

Administrator North Shore Health 515 - 5th Avenue West Grand Marais, MN 55604

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 July 20, 2021 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 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,

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered July 27, 2021

Administrator North Shore Health 515 - 5th Avenue West Grand Marais, MN 55604

RE: CCN: 245384 Cycle Start Date: May 28, 2021

Dear Administrator:

On July 23, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR ME	DICARE & MEDICA	ID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION	AND TRANSMITTAL	ID:	0830
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Fac	cility ID: 00080
1. MEDICARE/MEDICAID PROVID (L1) 245384	ER NO.	3. NAME AND AE (L3) NORTH SH				4. TYPE OF ACTION:	<u>2 (</u>L8)
2.STATE VENDOR OR MEDICAID	NO.	(L4) 515 - 5TH A				1. Initial	2. Recertification
(L2) 365745100		(L5) GRAND MA	RAIS, MN		(L6) 55604	 Termination Validation 	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit	9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After C	omplaint
6. DATE OF SURVEY 05/2	8/2021 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING	GDATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III			DATE: (LSS)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirement	s:
To (b):		Program Re Compliance	equirements Based On:		2. Technical Personne	_ •	
		· · · ·			3. 24 Hour RN	7. Medical Direc	
12.Total Facility Beds	37 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI 5. Life Safety Code	NF) 8. Patient Room 9. Beds/Room	Size
13.Total Certified Beds	37 (L17)	X B. Not in Com		-	-		
		Requirements	and/or Applied V	Waivers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDO		105			15. FACILITY MEETS	(115)	
18 SNF 18/19 SNF 37	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
(E37) (E38)	(133)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Colleen Johnson HFE	- NE II	0	7/06/2021	(L19)	Joanne Simon. Enforce	ment Specialist	07/12/2021 (L20)
PA	RT II - TO BE	COMPLETED H	BY HCFA RH	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBII	JTY		IPLIANCE WITH	H CIVIL		ancial Solvency (HCFA-2572)	
X 1. Facility is Eligible to I	Participate	RIGH	ITS ACT:		 Ownership/Contr Both of the Abov 	rol Interest Disclosure Stmt (H ve :	CFA-1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	I ENT	26. TERMINATION ACTION	I: (L3	30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 0	0 INVOLUNT.	ARY
01/01/1987					01-Merger, Closure		eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur	00 1 411 10 111	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	OTHER	
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-110014013	Status Change
(L27)	B Rescind S	uspension Date:	(L44)			00-Active	
	D. Resenia S	aspension Dute.	(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/			30. REMARKS		
		06201					
	(L28)	-		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 22, 2021

Administrator North Shore Health 515 - 5th Avenue West Grand Marais, MN 55604

RE: CCN: 245384 Cycle Start Date: May 28, 2021

Dear Administrator:

On May 28, 2021, 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.

North Shore Health June 22, 2021 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:

Terri Ament, Unit Supervisor Duluth District Office 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 Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

North Shore Health June 22, 2021 Page 3

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 28, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 28, 2021 (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>

Please note that the failure to complete the informal dispute resolution process will not delay the dates

North Shore Health June 22, 2021 Page 4 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:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145 Cell: (507) 361-6204 Email: william.abderhalden@state.mn.us Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

		AND HUMAN SERVICES			FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1	C	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	Сом	E SURVEY PLETED
		245384	B. WING_			C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	SHORE HEALTH			515 - 5TH AVENUE WEST		
NORTH				GRAND MARAIS, MN 55604		
(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 SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	compliance with Ap Preparedness Required conducted during a survey. The facility The facility is enroll signature is not req page of the CMS-22 correction is required acknowledge receip INITIAL COMMENT On 5/24/21, throug recertification surve facility. A complaint conducted. Your fac compliance with the Subpart B, Require Facilities.	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. TS h 5/28/21, a standard ey was conducted at your investigation was also cility was found to be NOT in e requirements of 42 CFR 483, ments for Long Term Care	F 0(00		
	The following comp UNSUBSTANTIATE H5384025C (MN67 H5384026C (MN72 H5384027C (MN68 H5384029C (MN72	784) 739) 330)				
	UNSUBSTANTIATE deficiencies were ci	laints were found to be ED, however related ited. 774), with a deficiency cited at				
	as your allegation o Departments accep	f correction (POC) will serve f compliance upon the otance. Because you are				
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

06/30/2021

PRINTED: 07/01/2021

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 & MEDICAID SERVICES			FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG	(X3) DAT COM	E SURVEY IPLETED
		245384	B. WING _			C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of you validate that substa regulations has bee Notify of Changes (CFR(s): 483.10(g)(14) Not (i) A facility must im consult with the res consistent with his of representative(s) w (A) An accident inver results in injury and physician interventi (B) A significant cha mental, or psychoso deterioration in hea status in either life- clinical complication (C) A need to alter the a need to discontinue treatment due to acc commence a new fi (D) A decision to tra- resident from the fa §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informa- is available and pro physician.	our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained. Injury/Decline/Room, etc.) 14)(i)-(iv)(15) ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of lverse consequences, or to orm of treatment); or ansfer or discharge the icility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the	F 00			7/7/21
F 580	enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of you validate that substa regulations has bee Notify of Changes (CFR(s): 483.10(g)(14) Not (i) A facility must im consult with the res consistent with his of representative(s) w (A) An accident inver results in injury and physician interventi (B) A significant cha mental, or psychoso deterioration in hea status in either life- clinical complication (C) A need to alter the a need to discontinue treatment due to acc commence a new fi (D) A decision to tra- resident from the fa §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informa- is available and pro physician.	our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained. Injury/Decline/Room, etc.) 14)(i)-(iv)(15) ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of lverse consequences, or to orm of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2)				7/7/2

Facility ID: 00080

If continuation sheet Page 2 of 33

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		245384	B. WING		C 05/28/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 580	Continued From pa	ige 2	F 58	0		
	resident and the resident there is- (A) A change in roo as specified in §483 (B) A change in resident State law or regulat (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a com- that is a composite §483.5) must disclo- its physical configura- locations that comp- part, and must spec- room changes betwo under §483.15(c)(9) This REQUIREMEN	sident representative, if any, om or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. st record and periodically (mailing and email) and he resident hose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to veen its different locations				
	facility failed to follo notify the physician reviewed for unnec addition, the facility representative was 4 residents (R16) re Findings include: R22's quarterly Min 4/7/21, indicated R2 diagnoses included	v and document review, the bw up on low blood sugars and for 1 of 5 residents (R22) essary medications. In failed to ensure a resident notified following a fall for 1 of eviewed for accidents.		F580 Notification of Changes Preparation, submission, and implementation of this Plan of C does not constitute and admiss agreement with, the facts and c set forth in the statement of def This Plan of Correction is prepa executed as a means to continu improve the quality of care, to c applicable state and federal reg requirements and constitutes th facility□s allegation of complian	ion of, or conclusions iciencies. ared and/or uously comply with julatory ie ice.	

Facility ID: 00080

If continuation sheet Page 3 of 33

		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` ́сом	E SURVEY PLETED	
		245384	B. WING			C 28/2021	
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 000		
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	i i		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 580	monitored for diabe appropriate self-ad care plan lacked pa R22's physician of R22's physician or -insulin glargine (La units subcutaneous -insulin human lisp insulin) 5 units sub with meals R22's physician pro- indicated R22's dia R22's blood sugars increasing hemoglo measures your ave- the past 3 months) add insulin at meal R22's physician pro- indicated R22 had related to increase ordered the previou had been decrease blood sugars and h blood glucose at th on 5/5/21. R22's p noted that R22 was intake and was hap R22's Blood Glucos and 5/5/21, after R meals, indicated R2 before breakfast ra (mg)/deciliter (dl) to	etes and was monitored for ministration of insulin. R22's arameters for notification of out lying blood glucose. ders printed 5/27/21, included: antus-long acting insulin) 23 sly twice daily ro (Humalog-short acting cutaneously three times daily ogress notes dated 4/5/21, gnoses included diabetes, and s were elevated with an obin A1C (a blood test that erage blood sugar levels over . R22's physician planned to time. ogress notes dated 5/5/21, some low blood glucose d insulin at meal time as us month, so insulin dosing ed in response to R22's low had not had any further low e time of the physician's visit hysician progress notes further s working on decreasing her opy with some weight loss. se Record between 4/6/21, 22's increase in insulin at 22's morning blood glucose inged from 62 milligrams o 167 mg/dl, with 5 od glucose values in the 60's,	F 58	 of the low blood sugars. New or received May 28, 2021. On May the Director of Nursing notified t of R16 about the fall. On June 14, 2021, the Resident Manager reviewed all charts of r who have diabetes with insulin t need to notify provider of low blo sugars. Documentation from the days was reviewed for five of fiv charts. This did not include R22 had already been reviewed. Two residents had an isolated low blo reading with effective intervention Charge Nurse and no notificatio provider. None of the resident of the criteria of the Hypoglycemia need to notify provider. Nurses we educated to inform provider of low sugars when there are low sugar sin a seven day period. The parameters came from R22 s p provider and were reviewed and by the Medical Director. The Hypoglycemia policy has been u reflect these parameters, and w reviewed with Care Center nursion next monthly meeting on July 7, On June 14, 2021, the Resident Manager reviewed the fall invest reports for the past 30 days. The nineteen falls had no documentation for the family includin involving R 16. In the other two s falls occurred in the evening or provider in the evening or prov	27, 2021, he family Care esidents herapy for ood a last 30 e resident as she o of five ood sugar on by the n of the harts met policy for were ow blood rese orimary approved updated to ill be es at their 2021. Care tigation ree of ation of g the fall situations,		

Facility ID: 00080

		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	Сом	E SURVEY IPLETED	
		245384	B. WING			C 28/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 580	Continued From pa	ge 4	F 5	580			
	R22's progress not	es dated 4/28/21, at 10:00 was shaking, sweating, and		later.			
	had numbness in h and had severe itch was 57 mg/dl, and	er left leg and foot, was crying niness. R22's blood glucose she was given a snack. No cose was documented.		Our current fall investigat document prompts nurse at the time of the fall and to record that it was done meet multiple times a we	es to notify family provides a place e. IDT members		
	R22's progress notes dated 5/3/21, indicated R22 received 23 units of Lantus insulin (long acting insulin) twice daily, and R22's Humalog or Novalog insulin (rapid acting insulin) had been reduced to from 10 units to 5 units three times daily on 4/29/21, due to some low blood glucose results.		aspects of the investigati including whether family notified. If documentation whether the family notifie the fall, IDT members wi done at the next time IDT	on reports, members were n is unclear about ed at the time of Il assure it is			
	R22's Blood Glucos 5/27/21, following a indicated R22's blo response to blood g -5/6/21, at 7:35 a.m "powders" with pills blood glucose was -5/14/21, at 6:32 a. 180 milliliters (ml) o recorded	m.: 64 mg/dl; R22 received orange juice, no follow up was m. 59 mg/dl; no action taken,		By July 2, 2021, electron Center family email conta available to Care Center Education about this acc provided to nurses at the meeting on July 7, 2021. email family members ar or night to notify them of injury, or with only minor overnight nurses to take notification and not rely of notification duties on to the	acts will be Nurses. ess will be ir monthly The ability to ny time of the day a fall with no injury, will allow care of the on passing the		
	-5/16/21, at 6:34 a. no follow up record -5/18/21, at 7:45 a. no follow up record -5/19/21, at 8:00 a. no follow up record -5/20/21, at 7:35 a. no follow up record -5/21/21, no blood g -5/23/21, at 5:51 a.	 m.: 55 mg/dl: no action taken, ed m.; 66 mg/dl; no action taken, ed m.; 79 mg/dl: no action taken, ed m.; 77 mg/dl; no action taken, ed 		The Director of Nursing of monitor the electronic ch resident with diabetes an for episodes of low blood in a row or two times in a period with notification of monitor starts on June 28 for one month. If 100% of achieved we will transition monthly for three months compliance is achieved,	arts of each id insulin therapy I sugar two days iny seven day provider. This 3, 2021, weekly ompliance is n to monitoring 5. If 100%		

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If continuation sheet Page 5 of 33

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		IPLETED C	
		245384	B. WING _			28/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 580	 -5/24/21, at 5:58 a. orange juice; follow 7:12 a.m. was 92 n -5/25/21, at 5:48 a. orange juice; follow 6:58 a.m. was 116 R22's progress not R22's blood glucos of orange juice and the night before. R was 92 mg/dl, and R22's progress not R22's blood glucos 240 ml orange juice said she did not ea before. R22 had a mg/dl. R22's progress not R22's blood glucos 240 ml orange juice, and 240 ml of milk. could not remember supper the previous R22's progress not physician had been pattern of low blood 0n 5/27/21, at 9:44 stated R22's param physician for a blood mg/dl, but lacked p for low blood glucos as low blood glucos as 	 m.; 52 mg/dl; drank 240 ml y up blood glucose recorded at ng/dl m.; 68 mg/dl; drank 240 ml of y up blood glucose recorded at mg/dl. es dated 5/24/21, indicated e was 52 mg/dl, drank 240 ml I stated she did not eat dinner tated she did not eat dinner tated she did not eat dinner tated she glucose R22 was sleeping. e dated 5/25/21, indicated e was 68 mg/dl, R22 drank e and was asymptomatic, and t much for dinner the night follow up blood glucose of 116 es dated 5/26/21, indicated e was 59 mg/dl and drank 240 ate a piece of toast with butter, R22 was asymptomatic and er what she had eaten for s night. 	F 58	monitor will be reported to Qua Improvement/Peer Review qua the length of the monitor. The Director of Nursing or des monitor all fall investigation re evidence of family being notific monitor began June 1, 2021 at continue for three months. If 1 compliance is achieved, monit discontinued. Reports of this r will reported to Quality Improv Review quarterly for the length monitor.	arterly for ignee will oorts for ed. The nd will 00% or will be nonitored ement/Peer		

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		AND HUMAN SERVICES			FORM	: 07/01/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATI COM	E SURVEY IPLETED
		245384	B. WING			C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	to eat or drink with RN-B verified R22's documentation of ir blood glucose for m glucose. RN-B furt would be unable to regarding diabetes physician is not not glucose. On 5/27/21, at 11:0 expectation was to intervention for low R22 had several low follow-up blood gluc expect a follow-up to of the low blood gluc R22 would be at ris glucose. RN-A verif notify the physician diabetes and insulir notify R22's physici The facility policyHy directed follow up b minutes if a blood g twice and had symp a blood glucose is a provide a snack of a facility policy lacked between 60 and 85	ted they give R22 something low blood glucose results. Is medical record lacked interventions and follow-up nost occurrences of low blood her verified the physician make appropriate decisions and insulin management if the ified of R22's low or high blood 9 a.m. RN-A stated the do a follow-up and blood glucose. RN-A verified w blood glucose without cose. RN-A stated she would blood glucose within an hour icose result. RN-A verified k for a continued drop in blood fied it would be beneficial to for better management of n, and stated it was time to an. ypoglycemia reviewed 5/22, blood glucose within 15 glucose is below 60 mg/dl btoms of hypoglycemia, and if above 85 mg/dl, staff was to a complex carbohydrate. The d guidance for blood glucose mg/dl. The facility further nen to notify a physician of	F 580			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		DENTIFICATION NONDER.	A. BUILDII	NG			C
		245384	B. WING			05/2	28/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH				15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 580	Continued From pa	ge 7	F 58	80			
		clude dementia, macular blindness, and osteoarthritis.					
	3/17/21, indicated F impairment, was inc	imum data Set (MDS) dated R16 had severe cognitive dependent in bed mobility, and n with transfers, and					
	had impaired mobil	iated 4/18/16, indicated R16 ity, was at risk for falls, alker, and required hourly hile in her room.					
	5/16/21, indicated F her room and had r	ivestigation (FSI) dated R16 was found on the floor in no apparent injury. R16's FSI 16's representative was not I.					
	was yelling from he						
	heard yelling from h floor sitting in front complained of right broken, it hurts insid bed, a head-to-toe and no reddened of R16's progress note	e dated 5/16/21, R16 was her room and was found on the of her a recliner chair. R16 leg pain and stated, "it is not de". R16 was assisted into assessment was completed r opened areas were found. es lacked evidence R16's notified at time of fall.					

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		AND HUMAN SERVICES				FORM	07/01/2021 APPROVED
	CALCERT CONTRACT	& MEDICAID SERVICES	(X2) MUI	TIP	LE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	· ·		;	`́сом	PLETED
		245384	B. WING	i			C 28/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH \$	SHORE HEALTH				515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 580	Continued From pa	ige 8	F٤	580			
		a.m. family member (FM)-A been notified of R16's falling in					
	resident's family an notified of any resid R16's Fall Event, F	ector or nursing (DON) stated d/or representatives should be lent falls. The DON verified SI, and progress notes lacked S's representative was notified 6/21.					
F 656 SS=D	12/19/18, directed s family and physicial Develop/Implement	icy and Procedure revised staff to notify a resident's n when a resident falls. t Comprehensive Care Plan 1)	F€	656			7/20/21
	§483.21(b)(1) The f implement a compr care plan for each r resident rights set fo §483.10(c)(3), that objectives and time medical, nursing, an needs that are iden assessment. The co describe the followi (i) The services that or maintain the resi physical, mental, ar required under §483. (ii) Any services that under §483.24, §48 provided due to the	t are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse					

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		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED	
		245384	B. WING			C	
	PROVIDER OR SUPPLIER	240304		STREET ADDRESS, CITY, STATE, ZIP CODE	05/2	28/2021	
NAIVIE OF F	ROVIDER OR SUPPLIER			, , ,			
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	1		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 656	Continued From pa	0.000	F 65	e			
1 000		-	F 00	6			
	rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation v resident's represen (A) The resident's g desired outcomes. (B) The resident's g future discharge. F whether the resider community was as local contact agend entities, for this pur (C) Discharge plan plan, as appropriate requirements set for section.	If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate					
	Based on interview facility failed to dev comprehensive per include risk factors	v and document review, the elop and implement a rson-centered care plan to and interventions following a esident (R21) reviewed for a origin.		F656 Develop/Implement Comp Care Plan Preparation, submission, and implementation of this Plan of Co does not constitute and admissio	rrection n of, or		
	Findings include:			agreement with, the facts and co set forth in the statement of defic This Plan of Correction is prepare	iencies.		
		nic obstructive pulmonary eft femur fracture, heart failure,		executed as a means to continue improve the quality of care, to co- applicable state and federal regu requirements and constitutes the facility s allegation of compliance	usly mply with latory		
	4/6/21, indicated R	imum Data Set (MDS) dated 21 was dependent on staff with extensive assist with bed		The Care Card and Plan of Care were updated with identified risk	for R21		

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	13 FOR MEDICARE	& MEDICAID SERVICES				0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	Сом	E SURVEY PLETED		
		245384	B. WING _			C 05/28/2021		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 656	Continued From pa	ge 10	F 65	56				
	mobility, dressing, t had lower extremity	oileting, personal hygiene, and / impairment.			and interventions to prevent future fractures on June 6, 2021.			
	had impaired mobil cerebrovascular ac muscle tone and co a new right knee fra flexed at 90 degree R21's care plan ind assistance with beo and reposition ever and required a Hoy to help with transfer indicated R21 had a fracture, and right k knee brace for supprisk factors which p interventions to pre R21's progress not winced and cried of repositioning.			 The Resident Care Manage and update the Plans of C residents that have experient injury in the past three modetermine if all risk factors for and appropriate interver place to reduce the risk of July 2, 2021. A facility Care Planning Pordeveloped outlining the prodeveloping a comprehensing person-centered care plant the parameters of when care to be updated by July 20, 2000 The Nurse and Nursing Asprovided education on implicate routing the parameter of and Plan of Care during the Meeting on July 7, 2021 and Assistant Meetings on July July 8, 2021. 	ager will review Care of all rienced a major onths to rs are accounted ventions are in of further injury by Policy will be rocedure for sive, in and identifying care plans need , 2021. Assistants will be oplementing the on the Care Card the Nurse and the Nursing			
	continued to compli- bilateral legs/knees positioning. R21's Consulting R knee dated 5/10/21 comminuted fractur two pieces) of the c (above the right knee	e dated 5/9/21, indicated R21 ain of excessive pain in with movement and adiologist report of the right , indicated findings included a re (broken bone in more than distal femoral meta diaphysis be). te dated 5/12/21, indicated R		The Director of Nursing or audit two Care Cards and per week for one month; o Household and will then au Card and Plan of Care for The audit will evaluate the accuracy of the Care Card Care for the care and serv and received by the reside appropriate implementatio The Director of Nursing or also monitor quarterly the	Plans of Cares one per each udit one Care another month. pertinence and l and Plan of rices needed ents and n. designee will			

Facility ID: 00080

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI	0938-039 E SURVEY PLETED			
	ST CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		C			
		245384	B. WING		05/28/2021				
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE			
F 656	- 15		F 65	6					
	previously had a left had no falls and wa from low impact tra repositioning and c osteoporosis, was f current life expecta months. The physic based on R21's ove fracture as with her based approach, in and consult physica knee brace. R21's Live Event da had been expressin repositioning espect 5/7/21. An X-ray w the results were rec physician ordered a	ve a right knee fracture and ft knee fracture last year. R21 as presumed the fracture was numa, perhaps during ares. R1 had profound frail, and believed R21's incy was to be less than 6 ician note further indicated erall health, would treat the last two fractures with comfort acrease scheduled narcotics, al therapy (PT) for a protective ated 5/12/21, indicated R21 ng severe pain during cially in knees starting on ras ordered on 5/10/21, and ceived 5/12/21. R21's an increase in pain PT to assess for a brace to		(POC) of residents with a signific with each MDS assessment/Care Conference window to assure the had been updated per Care Plan Policy at the time(s) of significant event(s). The monitoring will take for six months, and if 100% comp achieved, we will discontinue mo Monitoring will be reported quarte Quality Improvement/Peer Revie duration of the monitor.	e pir POC ning b place place is nitoring. erly to				
	(NA)-A stated durin R21 began to holle heard before. NA-/ bed bath the previo complain of any pa report on 5/10/21, t complained of in he been a result of not placement and R21 bedrails. NA-A state wool around her be protection, and the back on when R21 verified R21's care	t knee. 5 a.m. nursing assistant ig morning cares on 5/10/21, r out in pain like she had never A stated she had given R21 a bus day and R21 did not in. NA-A stated during morning he previous shift reported R21 er leg and thought it may have t having her pillows in proper 1's knees bumping against the ted R21 was to have lambs edrails for padding and lambs wool was never put got her new bed. NA-A sheet did not indicate R21 ures or interventions to prevent							

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		AND HUMAN SERVICES					FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245384	B. WING	i				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP COD	E		
NORTH	SHORE HEALTH				315 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 12	F	656				
	possible further fraction repositioning.	ctures during cares and						
	assessed and treat a right knee fracture were contracted, ha had a history of frac event. PT-A further there was no indica was a result from a On 05/27/21, at 3:2	3 p.m. RN-A stated R21 had						
	history of fractures R21 had been com x-ray and results re above the right kne physician note indic have occurred durin to her osteoporosis were not educated or interventions to p fractures from occur care plan and care for fractures during	s were fragile, and had a from low impact. RN-A stated plaining of knee pain, had an evealed R21 had a fracture e. RN-A stated R21's primary cated R21's fracture could ng repositioning and cares due and fragility. R21 stated staff on R21's risk for fractures and prevent further possible urring. RN-A verified R21's guide did not include R1's risk cares or interventions to tures while caring for R21.						
	(DON) stated R21 h history of fractures event. The DON st guide should includ direct staff to have during cares due to	p.m. the director of nursing had fragile bones and had a without signs of a traumatic tated R21's care plan and care le R21's risk for fractures, and more of a gentle approach R21's condition.						

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/01/2021 M APPROVED D. 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) D	ATE SURVEY DMPLETED		
		245384	B. WING		0	C 5/28/2021		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
NORTH	SHORE HEALTH		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 684	Continued From pa	ge 13	F 6	84				
	Quality of Care CFR(s): 483.25		F 6	84		7/20/21		
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro practice, the compresent care plan, and the re This REQUIREMEN by: Based on observat review, the facility fa positioning support reviewed for position Finding include: R6's diagnoses incl depression, and de R6's quarterly Minin 3/9/21, indicated R6 cognition, required mobility, transfers, a impairment. R6's care plan print impaired mobility re monitoring, assista psychosis, and had and "leaning". R6's R6 would not coope (PT) or nursing reha- indicated R6 had so	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 reassess the need for for 1 of 1 resident (R6) ning.			F684 Quality of Care Preparation, submission, and implementation of this Plan of Correction does not constitute and admission of, or agreement with, the facts and conclusior set forth in the statement of deficiencies. This Plan of Correction is prepared and/o executed as a means to continuously improve the quality of care, to comply wit applicable state and federal regulatory requirements and constitutes the facility s allegation of compliance. On June 28, 2021, the Resident Care Manager updated the Care Card and Pla of Care (POC) for resident R6 to address support and positioning needs. On June 28, 2021, the Resident Care Manager attended the monthly Charge Nurse Meeting and provided training to nurses on the procedure for making the Care Plan Review calendar and communicating the scheduled review to	s or h		

Facility ID: 00080

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			0	FORM MB NO.	0938-039	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED	
		245384	B. WING			C		
	PROVIDER OR SUPPLIER	245364	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	05/28/2021		
	PROVIDER OR SUPPLIER				15 - 5TH AVENUE WEST			
NORTH	SHORE HEALTH				GRAND MARAIS, MN 55604			
(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) COMPLETIO DATE	
F 684	Continued From pa	age 14	F 6	84				
	(ADLs), mobility, or	-	1.0	-0	the Nursing Assistants. Each resid	lent is		
					reviewed once in every two week t			
		nted 5/25/21, lacked			period. An official facility correspor	ndence		
		R6's positioning needs of			was sent out to all nursing assistar			
		r the use of a pillow for /as observed leaning.			nurses on June 28, 2021 asking fo on any recent changes in functiona			
	support when ito w	as observed learning.			in residents that have not yet been			
	PT note dated 3/9/2	21, indicated PT-A saw R6 for			assessed, and to email Resident			
		I was observed leaning into the			Assessment Coordinator with infor			
		. PT-A recommended a pillow			by July 2, 2021. Any resident iden			
	lean.	vhen sitting to support her			will have a Rehab Assessment per and Physical Therapy referrals will	tormed		
	ican.				made accordingly.	be		
		5/17, indicated R6 continued to						
		nd PT-A reminded staff to			A policy will be created to outline the			
	position a pillow un	der R6's right arm.			procedure for obtaining a Physical Therapy evaluation for a resident v			
	On 5/24/21 at 3:07	p.m. R6 was observed sitting			change of function by July 20, 202			
		r in her room leaning			change of fanotion by daily 20, 202	••		
	significantly to the I	left.			The Nursing Assistants will be prov			
					education on North Shore Health			
		p.m. R6 was observed sitting			positioning policy during the Nursir Assistant Meetings on July 7, 2021			
		ing room leaning to the left e decorative pillow propped			July 8, 2021.	anu		
	underneath R6's le							
					The Director of Nursing or designe	e will		
		9 p.m. R6 was continued to			audit two residents per week for			
	iean to the left while	e attempting to eat supper.			positioning in compliance with their of Care for one month and will the			
	On 5/26/21. at 9:14	a.m. R6 was observed sitting			one resident per week for another			
	in a stationary chai	r in her room in front of the			The Director of Nursing or designe			
		to the left, with no support			also monitor the Plans of Care of			
	cushion in place.				residents with a functional change			
	On 5/26/21 at 10.2	27 a.m. R6 was observed			quarterly with each MDS assessment/Care Conference wind	dow to		
		ry chair in her room leaning to			assure their POC had been update			
	the left. A cushion	was observed on the left arm			Care Planning Policy for a change	in		
		triangle wedge cushion was			function and positioning needs. Th			
	observed on R6's le	ett side.			monitoring will take place for six m	onths,		

Facility ID: 00080

DEPARTMENT OF HEALTH					FORM	07/01/2021 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
	245384	B. WING				C 28/2021
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH SHORE HEALTH				15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 Continued From pag	ge 15	F€	684			
On 5/27/21, at 10:17 (NA)-A stated R6 ha of her armchair for s to help keep her sit care guide did not a or direct staff to place support when R6 wa where the support d On 5/27/21, at 12:05 (PT)-A stated R6 ha was seen on 3/9/17, assessed for a walk compliant with thera use the walker. PT- notes, and stated PT 3/15/17, identified R recommended a pill side when sitting to she did not order a w positioning, and furth R6 was leaning to th verified R6 had not b 6/16/17, and there w R6 for positioning. On 5/27/21, at 12:42 nurse (LPN)-A state R6 was tired. LPN-/ down or place a pillo with her positioning. aware R6 had a wed positioning. LPN-A to observed a wedge of LPN-A stated the we new.	7 a.m. nursing assistant ad a cushion on the right side support, and a wedge cushion straight up. NA-A stated R6's ddress R6's positioning needs be a wedge cushion for as leaning. NA-A was unsure			and if 100% compliance is achieve monitoring will be discontinued. Monitoring will be reported quarter QI/Peer Review.		

	B NO. 0938-0391 X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	COMPLETED
245384 B. WING	05/28/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTH SHORE HEALTH 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION)	
F 684 Continued From page 16 F 684 was unsure when RN-A was assessed last for positioning. RN-A stated R6 had scolosis and R6's had been leaning for a long time. RN-A was unaware where R6 wedge cushion or cushion on the arm of her chair. RN-A stated she would expect staff to report any resident changes to the charge nurse, and further stated if a resident had a change in function, RN-A would expect therapy to be notified to complete an evaluation. On 5/27/21, at 4:54 p.m. the director of nursing (DON) stated he would expect staff to report any changes in a resident's functional status to the charge nurse. The DON further stated he would expect the range or motion dues and make any therapy referrals. The facility policy Positioning and Body Alignment revised 9/1/14, indicated cushions, wedges, and other corrective devices for seating are properly applied after assessment and implementation by the nursing department. Effectiveness, or lack of it, in maintaining a desired position is reviewed and updated as necessary but at least quarterly. F 688 F 688 Increase/Prevent Decrease in ROM/Mobility S483.25(c)(1).16 facility must ensure that a resident who enters the facility without limited range of motion unless the resident via clinical condition demonstrates that a reduction in range of motion unavoidable; and F 688	7/20/21

Facility ID: 00080

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245384	B. WING				28/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 000	
NORTH	SHORE HEALTH				15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 688	 §483.25(c)(2) A res motion receives app services to increase prevent further deci- §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN by: Based on interview facility failed to ensu- implemented, rease resident needs to m motion (ROM) and residents (R17) rev programs. Findings include: R17's annual Minim assessment dated a moderate cognitive of care behaviors d required extensive a and ambulation in h the hallway. R17's indicated R17 had a lower extremities or not participate in a n for ROM or ambula period. R17's Care Area As of Daily Living (ADL Potential indicated I 	ge 17 ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and ain or improve mobility with icable independence unless a v is demonstrably unavoidable. NT is not met as evidenced and document review, the use a restorative program was bessed, and revised to meet naintain or improve range of functional mobility for 1 of 4 iewed for restorative mum Data Set (MDS) 3/17/21, indicated R17 had a impairment, had no rejection uring the assessment period, assist of one staff for transfers per room, and did not walk in comprehensive assessment a ROM deficit of upper and none side of the body, and did restorative program such as tion during the assessment a ROM deficit of upper and none side of the body, and did restorative program such as tion during the assessment a ROM deficit of upper and none side of the body, and did restorative program such as tion during the assessment stion during the assessment	Fθ	\$88	F688 Increase/Prevent Decrease ROM/Mobility Preparation, submission, and implementation of this Plan of Corr does not constitute and admission agreement with, the facts and cond set forth in the statement of deficie This Plan of Correction is prepared executed as a means to continuou improve the quality of care, to com applicable state and federal regula requirements and constitutes the facility s allegation of compliance. On June 28, 2021, R17 was reased by the Resident Care Manger for rehabilitative needs and a request Physical Therapy referral was mad Primary Physician. The Director of Nursing or designe review all 37 residents Plans of C and charting to assess that their cu nursing rehab programs are approp for their status by July 20, 2021.	ection of, or clusions ncies. I and/or sly ply with tory essed for a e to her e will care urrent	

Facility ID: 00080

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLI	E CONSTRUCTION	MB NO. (X3) DATE	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
							2	
		245384	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	05/2	28/2021	
NAME OF	PROVIDER OR SUPPLIER							
NORTH	SHORE HEALTH				15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(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) COMPLETIO DATE	
F 688	Continued From pa	ige 18	F 68	88				
	and Parkinson's, ar mobility. R17's CA restorative program NuStep Arms, level with front-wheeled dining room with co the wheelchair to fo tolerated. R17's care plan init had impaired mobil complete the NuSte helps strengthen m bone strength, incre- stiffness) arms prog walking rehab prog dining room with co 40-80 feet, distance R17's physical ther 6/1/18, indicated R one contact guard a 200 feet. R17's Care Guide s R17 had a nursing directed staff to hav from her room to th guard assist of one 40-80 feet, distance NuStep program. R17's physician pro- indicated R17 was Parkinson's and sig R17's History and F	nd required assistance with A indicated R17 had a in that included using the 3 for 10 to 20 minutes, walk walker (FWW) in her room to ontact guard assist of one with ollow, for 40-80 feet, as iated 4/26/18, indicated R17 ity and directed staff for R17 to ep (exercise machine that uscles around joints, build ease ROM, reduce pain and gram for 10 to 20 minutes, a ram with her FWW to the ontact guard assist of one for			The Director of Nursing or designe create a document outlining the pro- for obtaining a Physical Therapy evaluation for a resident with a cha function by July 20, 2021. The Nursing Assistants will be prov- education on the implementation of Nursing Rehab Programs and mar work flow during the Nursing Assis Meetings on July 7, 2021 and July 2021. The Director of Nursing or designed audit resident participation and pro- suitability of four residents per weet their Nursing Rehab Programs for month and will then audit two resid per week for another month. The D of Nursing, or designee, will also m quarterly the Plans of Care of resident with a functional change with each assessment/Care Conference wind assure their Plan of Care had beer updated per Care Planning Policy for change in function and rehab prog needs. The monitor will take place months, and if 100% compliance is achieved, the monitoring will be discontinued. The results of the mo will be reported quarterly to QI/Peer Review.	bcedure inge of vided f the haging tant 8, e will gram k in one ents Director honitor lents MDS dow to hor for a ram for six sonitor		

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		AND HUMAN SERVICES				FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245384	B. WING				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH				515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 688	which can put press (curvature of the sp disease of the cervi and osteoporosis (li and fragile bones). was at her baseline knees and lower ex decline in ambulation disease, with an inter- of Sinemet (medical syndrome). R17's li ambulatory due to F osteoarthritis. R17's physical ther indicated R17 had b previous week due R17 walked approx that time. R17's pro- physician had been for R17, and PT do nothing further PT of R17's restorative wa 1/2020 through 12/2 1/2020: R17 ambu days out of 31 poss 3/2020: R17 ambu days out of 31 poss 3/2020: R17 ambu days out of 31 poss 5/2020: R17 walke day out of 31 poten 6/2020: R17 walke of 30 potential oppor	g of the spaces in the spine, sure on the nerves), scoliosis bine), degenerative joint ical spine (neck) and knees, oss of bone, leading to weak R17's H&P indicated R17 with continued pain in her stremities, and a gradual on related to Parkinson's olerance to increased dosage ation for Parkinson's disease or H&P indicated R17 was very Parkinson's and significant rapy note dated 3/20/19, been refusing to walk for the to severe leg and knee pain. timately 30 feet with therapy at ogress note indicated the working on pain management cumented that there was could offer. alking documentation dated 2020, indicated the following: lated 5 days and refused 3 sible opportunities. lated 6 days, and refused 8 sible opportunities. lated 7 days and refused 6 sible opportunities. d 10 days and refused none out	Fθ	\$88			

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		AND HUMAN SERVICES				FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245384	B. WING				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH				515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	out of 31 potential of 9/2020: R17 walke out of 30 potential of 10/2020: R17 walk out of 31 potential of 11/2020: R17 walk out of 30 potential of 12/2020: R17 walk days out of 31 potential of 12/2020: R17 walk days out of 31 potential days out of 31 potential 2/2020: R17 did the days out of 31 potential 3/2020: R17 did the days out of 31 potential 3/2020: R17 did the days out of 31 potential 6/2020: R17 did the days out of 31 potential 6/2020: R17 did the days out of 31 potential 6/2020: R17 did the day out of 31 potential 8/2020: R17 did the day out of 31 potential 6/2020: R17 did the day out of 31 potential 8/2020: R17 did the day out of 31 potential 8/2020: R17 did the day out of 31 potential 9/2020: R17 did the day out of 31 potential 8/2020: R17 did the day out of 31 potential 9/2020: R17 had the day out of 31 potential day out o	ortunities. d 2 days and refused 3 days opportunities. d 2 days and refused 2 days opportunities. ed 3 days and refused 1 day opportunities. ed no days and refused 1 day opportunities. ed no days and refused none opportunities. ed no days and refused 2 ntial opportunities. ocumentation for her NuStep the following: e NuStep 5 days and refused 3 ntial opportunities. e NuStep 1 day and refused 6 ntial opportunities. e NuStep 1 day and refused 6 ntial opportunities. e NuStep 3 days and refused tential opportunities. e NuStep 4 days and refused ential opportunities. e NuStep 1 day and refused tential opportunities. e NuStep 1 day and refused ential opportunities. e NuStep 2 days and refused 1 tial opportunities. e NuStep 1 day and refused 1	F	588			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/01/2021 APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED				
		245384	B. WING				C 28/2021				
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE						
NORTH	SHORE HEALTH		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604								
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 688	opportunities. R17's documentation reason for non-part R17's medical recondocumentation for 2 R17's Rounds Revinursing rehabilitation R17 had been amb the stand-assist lift bathroom. R17's Rounds Revinursing rehabilitation R17's Rounds Revinursing rehabilitation R17's care conferent dated 4/7/21, indicat R17's care conferent dated 4/7/21, indicat R17's progress note regarding R17's lact in status regarding planned. R17's Rounds Revinursing rehabilitation R17 was rarely amb stand-assist lift for the resident preferences R17's Rounds Revinursing rehabilitation R17's Rounds Revinursing rehabilitation	d refusals out of 31 potential on had several "no's" without a icipation. rd lacked restorative 1/2021 through 5/2021. ew progress notes regarding on dated 2/15/21, indicated ulating less, and was using more frequently for trips to the ew progress notes regarding on dated 3/23/21, indicated oulating, and was using the trips to the bathroom per s. nce review progress note ted R17 was not walking. e lacked documentation k of participation and change restorative programs as care ew progress notes regarding on dated 4/19/21, indicated oulating, and was using the trips to the bathroom per s.	F	588							

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		AND HUMAN SERVICES				FORM	07/01/2021 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` '			(X3) DATE SURVEY COMPLETED			
	245384		B. WING_			C 05/28/2021			
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE				
NORTH SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 688	A review of R17's m of restorative progra and evaluation of R a lack of revision of and care plan. On 5/25/21, at 9:32 difficulty moving he falling in the past. If exercises and said side-by-side. R17 s On 5/27/21, at 10:0 (RN)-A stated R17 to her knees being Parkinson's. RN-A used the stand-ass maybe go back to t dressed by staff an shoulder hurting he have a restorative a assistants have to o ROM. On 5/27/21, at 10:1 (NA)-B stated R17 was using the stand if a resident was on was unable to partic the charge nurse. On 5/27/21, at 10:2 easy chair in her ro walk alone; only wh R17 stated her arm unable to reach her On 5/27/21, at 11:2	nge 22 nedical record revealed a lack am participation, assessment (17's lack of participation, and f R17's restorative programs a.m. R17 stated she had r left arm, and said it was from R17 stated she did not get any staff walked with her said she should walk more. 0 a.m. registered nurse did not do her programs due so bad, and tremors from stated R17 tried to walk, but ist lift, and thought she could herapy. RN-A stated R17 is d did not complain about her er. RN-A stated they do not aide at this time, so the nursing do the restorative programs or 6 a.m. nursing assistant had not walked for awhile, and d-assist lift more. NA-B stated a restorative program and cipate, she would report it to 0 a.m. R17 was sitting in her om and stated she could not hen staff were there with her. s were stiff and she was phone half the time. 8 a.m. registered nurse used to walk, but has had a	F 6	88					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/01/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
245384		B. WING			05/28/2021		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH			-	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	SHORE HEALTH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 gradual change, and her walking program was no longer appropriate. RN-A stated they should reassess a resident's ability to participate in their restorative programs during the quarterly assessments. RN-A verified R17's participation had declined and her restorative programs and her ability to participate had not been assessed and re-evaluated for over a year. RN-A stated if the program is not appropriate, they should assess and have therapy re-evaluate. RN-A stated she believed R17's ability to walk declined related to her Parkinson's disease and not likely because she did not get restorative, and stated R17 was at her highest therapeutic level of Sinemet. RN-A stated R17 wanted to use the stand-assist lift and refused to walk now. The facility policy and procedure for Nursing Rehabilitation Program revised 9/1/14, indicated the purpose of the nursing rehabilitation program was to "maximize each resident's functional independence." The facility policy directed nursing to reassess and evaluate possible changes in a resident's mobility needs at least quarterly and based on the assessment, the resident's plan of care would be revised to reflect the resident's current needs. The facility policy and procedure directed the nursing rehabilitation program to be monitored on the nursing rehabilitation work sheet and weekly progress was to be documented weekly in the progress notes. If a resident refused to participate, the charge nurse would be informed of the resident's refusal and reason for refusal. Physical therapy was to be asked to consult if a resident		F	588			
	The facility policy and Rehabilitation Progra the purpose of the re- was to "maximize e- independence." The nursing to reassess changes in a resider quarterly and based resident's plan of cas the resident's currer and procedure direct program to be mon- rehabilitation work se was to be document notes. If a resident charge nurse would refusal and reason document the resid was to be asked to	nd procedure for Nursing ram revised 9/1/14, indicated nursing rehabilitation program ach resident's functional e facility policy directed and evaluate possible nt's mobility needs at least d on the assessment, the are would be revised to reflect nt needs. The facility policy cted the nursing rehabilitation fored on the nursing sheet and weekly progress refused to participate, the l be informed of the resident's for refusal, who would then ent's refusal. Physical therapy consult if a resident					

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		TE SURVEY		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING) ´co	MPLETED				
		245384	B. WING		C 05/28/2021			
NAME OF F	PROVIDER OR SUPPLIER		 [:	STREET ADDRESS, CITY, STATE, ZIP CODE		/20/2021		
NORTH SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
F 690	Continued From pa	ge 24	F 690)				
	Bowel/Bladder Inco CFR(s): 483.25(e)(ntinence, Catheter, UTI 1)-(3)	F 690)		7/8/21		
	resident who is con admission receives maintain continenc condition is or becc not possible to mai	facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical omes such that continence is ntain. resident with urinary						
	comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical co catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that	essment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that						
	receives appropriat	is incontinent of bladder te treatment and services to t infections and to restore xtent possible.						
	incontinence, base comprehensive ass ensure that a reside receives appropriat restore as much no possible.	a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel the treatment and services to ormal bowel function as						

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		& MEDICAID SERVICES	1				0938-039		
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
245384		B. WING		C 05/28/2021					
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE				
NORTH SHORE HEALTH				515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE		
F 690	Continued From pa	age 25	F 6	90					
	Based on interview and document review, the facility failed to ensure bladder continence was maintained for 1 of 2 residents (R4) reviewed for bowel and bladder continence. Findings include: R4's Face Sheet printed 5/27/21, indicated R4's diagnoses included heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), diabetes mellitus, non-Alzheimer's dementia, and				F690 Bowel/Bladder Incontinence, Catheter, UTI				
					Preparation, submission, and implementation of this Plan of Correction does not constitute and admission of, or agreement with, the facts and conclusions				
					set forth in the statement of deficien This Plan of Correction is prepared executed as a means to continuous improve the quality of care, to comp applicable state and federal regulat	ncies. and/or sly oly with			
	hemiplegia/hemipa	resis (muscle weakness or one side of the body).			requirements and constitutes the facility s allegation of compliance.	5			
	3/3/21, indicated R required extensive toilet use. In addition	mum Data Set (MDS) dated 4 was cognitively intact, assistance with transfers and on R4's MDS indicated ence with bladder and always			On June 28, 2021 the Resident Car Manager updated R4 s Plan of Car Care Card with a toileting schedule on input from pharmacists related t of onset of action for r4 s prescribe diuretics. Our data shows that durin look-back period for the quarter ass	re and based o time ed ng the			
	indicated R4 requir a two-wheeled wall incontinence dated	vities of daily living ation potential dated 12/8/20, ed stand by assist of one with ker. R4's CAA for urinary 12/8/20, indicated R4 had			when the surveyors were present, I maintained continence when toilete hourly when she rang her call light, will continue with hourly toileting for resident.	₹4 sd so we ∙ this			
	weakness and assibathroom, is also o heart failure.	anal incontinence due to ist of one to get to the on diuretics for congestive ated on 3/23/21, indicated R4			The Nursing Assistants will be prov education on toileting schedules an managing work flow at the Nursing Assistant Meetings on July 7, 2021 July 8, 2021.	ld			
	had impaired mobil unsteady gait and r with a gait belt and walking to the bath	two-wheeled walker for room. R4's care plan further ltered elimination with the			The Director of Nursing or designed review all continent residents to ass whether they have had any instance incontinence by July 2, 2021. If any those residents demonstrate episod	sess es of y of			

Facility ID: 00080

If continuation sheet Page 26 of 33

		E & MEDICAID SERVICES	T				0938-039	
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
			B. WING			C 05/28/2021		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
NORTH SHORE HEALTH				515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 690	Continued From pa	age 26	F 6	90				
	 potential for functional incontinence related to weakness and on diuretics. R4's care plan directed staff to assist R4 to the bathroom hourly and to answer the call light promptly. R4's comprehensive bladder assessment dated 12/19/19, indicated R4 was currently continent of bladder with minor occasional dribbling due to time it takes to get to the bathroom. R4's quarterly bladder assessment dated 3/4/21, indicated R4 was continent of bladder. R4's current orders printed on 5/27/21, indicated R4 was taking spironolactone (medication used to treat high blood pressure and fluid retention) 12.5 milligrams (mg) daily and furosemide (medication used to treat fluid retention) 40 mg twice daily. 				incontinence, a toileting schedule v implemented.	vill be		
					Nursing Assistants and Nurses will continue to chart bladder continence. The first week of charting beginning June 27, 2021, will establish a baseline level of continence for R4 and any other continent residents who have episodes of incontinence. Monitoring will begin on July 5, 2021.			
					The Resident Care Manager or des will audit two residents per week fo month for continence and adherent the toileting schedule and then aud resident per week for one month. Resident Care Manager will also m charting weekly for two months, biv	or one ce to lit one ionitor		
	stated she was awa the bathroom to uri would take her lasi wouldn't come righ soaking through the clothing. R4 stated of days and it made embarrassed. In ac	at 6:55 p.m. R4 was interviewed. R4 was aware of when she needed to use m to urinate, but sometimes after she her lasix (furosemide) pill the staff me right away and she would end up ough the pad, underwear, and stated this would occur every couple it made her feel bad and ed. In addition R4 stated at night she regular underwear with no need for a			for a month, and monthly for three months. If all identified residents co or improve their continence, the mo will be discontinued. The results of monitor will be reported to Quality Improvement/Peer Review quarter the duration of the monitor.	onitor this		
	On 5/26/21, at 8:53 a.m. nursing assistant (NA)-D was interviewed. NA-D stated R4 was continent of bladder 95% of the time unless staff couldn't get to her soon enough because they were "busy."							
		ered nurse (RN)-B was verified it would be a dignity						

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	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	0	(X3) DAT COM	E SURVEY IPLETED
		245384	B. WING					C 28/2021
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIF	, CODE		
NORTH SHORE HEALTH					15 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 690	issue if someone w incontinent because time to assist them verified residents w to be assisted to the avoid bladder accid On 5/27/21, at 11:4 NA-E stated R4 wa staff were unable to NA-E thought R4 ha week because of th feel bad and she we incontinence accide -at 11:54 a.m. licens was interviewed. LF incontinent of urine promptly. LPN-A ve when this occurred tried any type of sch receives lasix. -at 12:38 p.m. RN-0 verified it is a dignit continent of bladder staff can not answe -at 12:53 p.m. the s interviewed. SW-A bladder accident or able to answer her -at 1:05 p.m. the dir interviewed. The D0 continent of bladder accidents.	ho is continent of bladder was e staff couldn't get there in to the bathroom. RN-B ho are on diuretics might need e bathroom on a schedule to ents. 9 a.m. NA-E was interviewed. s continent of urine unless o answer her light right away. ad about three accidents a is. NA-E stated it made R4 ould apologize to staff after an ent. sed practical nurse (LPN)-A PN-A stated R4 would be if staff did not answer her light rified this embarrassed R4 . LPN-A stated they had not neduled voiding after R4 C was interviewed. RN-C y issue when a resident who is r is having bladder accidents if r the call light in time. ocial worker (SW)-A was stated R4 told her about a 15/23/21, when no one was	Fθ	90				

If continuation sheet Page 28 of 33

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/01/2021 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		245384	B. WING		0	C 5/28/2021
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
NORTHS	HORE HEALTH				15 - 5TH AVENUE WEST RAND MARAIS, MN 55604	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	indicated the standa identify individuals w causes of incontine to review medicatio might affect contine frequency of physic assist the resident to the policy indicated regularity. Nurse Aide Peform CFR(s): 483.35(d)(7) §483.35(d)(7) Regu The facility must co of every nurse aide months, and must p education based on reviews. In-service requirements of §48 This REQUIREMEN by: Based on interview facility failed to com evaluations for 3 of NA-F, NA-G)who h facility for over one affect all 37 residen Findings include: An undated employ indicated the followin NA-C's hire date wa performance evaluat 2020.	last approved 3/2/17, ard was to evaluate and with reversible and irreversible nce. The policy directed staff ns particularly those that once, need for type and al assistance as necessary to o access the toilet. In addition a schedule is maintained for Review-12 hr/yr In-Service 7) alar in-service education. mplete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the 33.95(g). NT is not met as evidenced and document review, the plete annual performance 5 nursing assistants (NA-C, ad been employed by the year. This had the potential to ts who resided in the facility.		590	F730 Nurse Aid Performance Review 12 hour/year In-Service Preparation, submission, and implementation of this Plan of Correction does not constitute and admission of, or agreement with, the facts and conclusior set forth in the statement of deficiencies. This Plan of Correction is prepared and/o executed as a means to continuously improve the quality of care, to comply with applicable state and federal regulatory requirements and constitutes the facility s allegation of compliance. During the Department Leadership	s or
					5 ·····F	

Facility ID: 00080

If continuation sheet Page 29 of 33

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO	E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED	
					С		
		245384	B. WING		05/28/2021		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTH	SHORE HEALTH		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(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)	DULD BE	(X5) COMPLETION DATE	
F 730	Continued From pa	age 29	F 730	0			
	2020. NA-G's hire date w performance evalu 2020. On 5/27/21, at 3:37 (DON) was intervie not completed perf the staff listed. The evaluations should The facility policy ti last approved 4/29/	ation had been completed in as 3/31/20. No annual ation had been completed in 7 p.m. the director of nursing wed. The DON stated he had ormance evaluations for the be completed annually. tled Performance Appraisals, /21, indicated all employees rmance appraisal on an annual		 meeting on July 13, 2021, the I Nursing and other Department will receive education on the im of performance reviews. On 6/ DON or designee identified all assistants (NAs) that have not annual review for calendar yea The Director of Nursing has be complete the outstanding NA a reviews and all reviews will be by July 20, 2021. Going forward and working with Resources, the Director of Nur designee will, once a month, id NA that is due for an annual re- next three months. The Director Nursing or designee will compl review by the end of next mont Administrator will audit the con completion of Nurse Aid perform reviews weekly for two months Resources will then monitor qu NA annual reviews that were no completed when due. This will to QI/Peer Review quarterly. If compliance is achieved, this m 	Managers portance 21/21 the nursing had an r 2021. gun to nnual completed n Human sing or entify any view in the pr of ete the h. The tent and mance . Human arterly any ot be reported 100%		
	Food Procurement CFR(s): 483.60(i)(*	,Store/Prepare/Serve-Sanitary 1)(2)	F 81:	be discontinued after two years		7/12/21	
	§483.60(i) Food sa The facility must -	fety requirements.					
		cure food from sources lered satisfactory by federal, prities.					

Facility ID: 00080

If continuation sheet Page 30 of 33

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1	0	MB NO.	0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05/28/2021		
		245384	B. WING				
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTH	SHORE HEALTH		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(X4) ID PREFIX TAG	(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) COMPLETIO DATE	
F 812	from local producer and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and for (iii) This provision de from consuming for §483.60(i)(2) - Stor serve food in accor- standards for food s This REQUIREMEN by: Based on observat review, the facility fa hygiene was followe R19, R11, R13, R30 observed during me Findings include: On 5/24/21, at 5:08 walked into the kitc and without washin silverware out of a - NA-C walked to a different residents, cup in a food cart. - NA-C returned to clean trays, took a to down in front of R11 opened up the crac- the mug and moved the tray. NA-C tool	e food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. loes not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, interview, and document ailed to ensure proper hand ed for 8 of 20 residents (R23, 0, R15, R28, and R17) eal service on the Woods unit.	F 812		of, or clusions ncies. and/or sly ply with tory ager Dietary hand		

Facility ID: 00080

		E & MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		245384	B. WING		C 05/28/2021		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/2	20/2021	
NORTH	SHORE HEALTH		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 812	deliver to R13. -NA-C took the me hallway, removed a delivered it to R30, a cover-up on R30, of R30, removed of packages, buttered milk glass and mug mugs where R30 w them on the tray fo room, pulled the sta and fastened it. -NA-C returned to 1 tray and brought it cover-up on R15, of buttered it, opened to the tray table, me -NA-C returned to 1 tray and entered R stop sign. NA-C m table, placed the m bag in R17's refrige her feet, moved the then went into the B hands. NA-C remo sanitized hands an -NA-C verified at th sanitizing or washin residents and shou would be a risk of o	and handed it to another staff to al tray cart down the 400 a tray from the cart and and set it on the tray table, put , moved the tray table in front overs and opened food d R30's corn bread, lifted the gs by the top of the glass and vould drink from, and moved r R30. NA-C exited R30's op sign across the doorway the meal tray cart, removed a into R15's room, put a opened the corn bread, crackers, moved a tissue box	F 812	 Housekeeping, and Activity Depa In addition to the return demonsi education will be given about wh hygiene is to be performed, inclu during food service. This will be completed by July 12, 2021. The Director of Nursing or desig monitor meal services for evider proper hand washing by staff in resident encounters. This monito July 5, 2021. Monitor will be one breakfast, one dinner, and one s each Household each week for f weeks. Then one meal per Hous week for four weeks will be mon 100% compliance is achieved, n be discontinued. The results of monitor will be reported to Qualit Improvement /Peer Review quar the duration of the monitor. 	ration, en hand iding nee will ice of between or will start upper in our ehold per itored. If nonitor will the y		

If continuation sheet Page 32 of 33

		AND HUMAN SERVICES				FORM	07/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245384	B. WING				_ 28/2021
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
NORTH	SHORE HEALTH				15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	who have patient c food are to follow d order to prevent the facility policy provid hygiene should be when hand hygiene The facility policy H	ontact, and those who serve lirectives for hand hygiene in e spread of infections. The led direction for how hand done, but lacked directives for e should be done. landwashing Protocol revised to perform hand hygiene	Fε	312			

Facility ID: 00080



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 22, 2021

Administrator North Shore Health 515 - 5th Avenue West Grand Marais, MN 55604

Re: State Nursing Home Licensing Orders Event ID: 083011

Dear Administrator:

The above facility was surveyed on May 24, 2021 through May 28, 2021 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_8.html</u>. 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.

North Shore Health June 22, 2021 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:

Terri Ament, Unit Supervisor Duluth District Office 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 Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00080	B. WING		05/2) 8/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	SHORE HEALTH		AVENUE WI			
		GRAND M	ARAIS, MN	55604		
(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 SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	13TTA****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall I 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 from orders provided tha the Department witl	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.				
	was conducted at y the Minnesota Depa facility was found N State Licensure and orders are issued. F electronic plan of co	TS: n 5/28/21, a licensing survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your prrection you have reviewed				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

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6899

If continuation sheet 1 of 31

06/30/21

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00080	B. WING		C 05/28/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NORTH	SHORE HEALTH	515 - 5TH	AVENUE WE	ST		
NORTH		GRAND	MARAIS, MN	55604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	these orders and id be completed.	entify the date when they will				
	The following complaints were found to be UNSUBSTANTIATED:					
	H5384025C (MN67 H5384026C (MN72 H5384027C (MN68 H5384029C (MN72	739) 330)				
	UNSUBSTANTIATE	774), however, a related				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For	hent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for the assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is tary Statement of Deficiencies" to the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met blowing the surveyors findings Method of Correction and trection.				
linnecoto	receipt of State lice the Minnesota Depa Informational Bullet https://www.health. n/infobulletins/ib14_ orders are delineate					

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00080	B. WING	B. WING		C 05/28/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
NORTH	SHORE HEALTH		HAVENUE WE				
(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) COMPLET DATE	
2 000	Continued From pa	ige 2	2 000				
	is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	RD THE HEADING OF THE					
2 285	must provide in-ser education must be continuing compete address areas iden assessment and a must address the s determined by the r home must provide program in rehabilit to promote ambular living; assist in activ of range of motion, positioning; and in t incontinence.	Service Education e education. A nursing home vice education. The in-service sufficient to ensure the ence of employees, must				7/20/21	

If continuation sheet 3 of 31

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00080		LE CONSTRUCTION	`́сом	E SURVEY PLETED C 28/2021
	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE		
			HAVENUE W			
NORTH	SHORE HEALTH		MARAIS, MN			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 285	Continued From pa	ge 3	2 285			
	facility failed to comevaluations for 3 of NA-F, NA-G)who h facility for over one affect all 37 resident	and document review, the plete annual performance 5 nursing assistants (NA-C, ad been employed by the year. This had the potential to ts who resided in the facility.		Corrected		
	Findings include:					
	An undated employ indicated the follow	ee list provided by the facility ing:				
	performance evalua 2020. NA-F's hire date wa performance evalua 2020. NA-G's hire date wa	as 2/17/20. No annual ation had been completed in as 8/25/17. No annual ation had been completed in as 3/31/20. No annual ation had been completed in				
	(DON) was interview not completed perform the staff listed. The evaluations should	p.m. the director of nursing wed. The DON stated he had ormance evaluations for the DON verified performance be completed annually.				
	last approved 4/29/	led Performance Appraisals, 21, indicated all employees mance appraisal on an annua	I			
	director of nursing (director, administra develop, review, an procedures related The DON or design	HOD OF CORRECTION: The DON), human resources tor, or designee could d/or revise policies and to performance reviews. ee could educate all the policies and procedures.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TE SURVEY MPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:		
		00080	B. WING 0	C 5/28/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH		HAVENUE WEST MARAIS, MN 55604		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE	
2 285	Continued From pa	ge 4	2 285		
		ee could develop monitoring ongoing compliance.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565	7/20/21	
		omprehensive plan of care personnel involved in the			
	by: Based on interview facility failed to dev comprehensive per include risk factors	ent is not met as evidenced and document review, the elop and implement a son-centered care plan to and interventions following a esident (R21) reviewed for origin.	Corrected		
	Findings include:				
		nic obstructive pulmonary ft femur fracture, heart failure,			
	4/6/21, indicated R2 transfers, required	imum Data Set (MDS) dated 21 was dependent on staff with extensive assist with bed oileting, personal hygiene, and r impairment.			
	R21's care plan init	iated 1/14/20, indicated R21			

STATEME	Dta Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00080	B. WING		C 05/28/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
NORTH	SHORE HEALTH		HAVENUE WE			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE CON THE APPROPRIATE D	
2 565		-	2 565			
	muscle tone and co a new right knee fra flexed at 90 degree R21's care plan ind assistance with bec and reposition ever and required a Hoy to help with transfe indicated R21 had a fracture, and right k knee brace for sup risk factors which p interventions to pre R21's progress not repositioning. R21's progress not reported her knees R21's progress not continued to compl bilateral legs/knees positioning. R21's Consulting R knee dated 5/10/21 comminuted fractur two pieces) of the co (above the right knee R21's physician not 21 was found to ha previously had a left had no falls and wa from low impact tra	cident (CVA) (stroke) with high ontracture's in knees. R21 had acture, and to keep left knee is with padding with pillows. icated R21 required d mobility, directed staff to turn y two hours, did not ambulate, er lift (an assistive device used rs). R21's care plan further a healed pelvis and left knee snee fracture which required a port. R21's care plan lacks ut R21 at risk for fractures and vent further fractures. e dated 5/6/21, indicated R21 ut during cares and e dated 5/7/21, indicated R21 hurt. e dated 5/9/21, indicated R21 ain of excessive pain in 5 with movement and adiologist report of the right , indicated findings included a re (broken bone in more than listal femoral meta diaphysis				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED	
		00080	B. WING			C 05/28/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
NORTH	SHORE HEALTH		HAVENUE WE				
(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) COMPLET DATE	
2 565	Continued From pa	ige 6	2 565				
	current life expecta months. The physi based on R21's ove fracture as with her based approach, in and consult physica knee brace. R21's Live Event da had been expressir repositioning espec 5/7/21. An X-ray w the results were rec physician ordered a	T to assess for a brace to					
	(NA)-A stated durin R21 began to holle heard before. NA-/ bed bath the previo complain of any pa report on 5/10/21, t complained of in he been a result of not placement and R21 bedrails. NA-A stat wool around her be protection, and the back on when R21 verified R21's care was prone to fracture	5 a.m. nursing assistant g morning cares on 5/10/21, r out in pain like she had never A stated she had given R21 a bus day and R21 did not in. NA-A stated during morning he previous shift reported R21 er leg and thought it may have t having her pillows in proper I's knees bumping against the ted R21 was to have lambs edrails for padding and lambs wool was never put got her new bed. NA-A sheet did not indicate R21 irres or interventions to prevent ctures during cares and	3				
	assessed and treat	8 p.m. PT-A stated she ed R21 for a knee brace after e. PT-A stated R21's knees					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00080	B. WING		C 05/28/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NORTH	SHORE HEALTH		H AVENUE WE MARAIS, MN			
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	had a history of fra- event. PT-A further there was no indicative was a result from a On 05/27/21, at 3:2 osteoporosis, bone history of fractures R21 had been com x-ray and results re above the right kne physician note indic have occurred duri to her osteoporosis were not educated or interventions to p fractures from occu- care plan and care for fractures during	ad severe osteoporosis, and ctures without an traumatic r stated R21 was fragile, and ation R21's right knee fracture a fall or injury. 23 p.m. RN-A stated R21 had es were fragile, and had a from low impact. RN-A stated uplaining of knee pain, had an evealed R21 had a fracture ee. RN-A stated R21's primary cated R21's fracture could ng repositioning and cares due s and fragility. R21 stated staff on R21's risk for fractures and prevent further possible urring. RN-A verified R21's guide did not include R1's risk cares or interventions to ctures while caring for R21.				
	(DON) stated R21 history of fractures event. The DON s guide should include	³ p.m. the director of nursing had fragile bones and had a without signs of a traumatic tated R21's care plan and care le R21's risk for fractures, and more of a gentle approach o R21's condition.	3			
	A policy on care pla provided.	anning was requested, but not				
	director of nursing develop, review, ar procedures related planning.	THOD OF CORRECTION: The (DON) or designee could nd/or revise policies and to comprehensive care nee could educate all	3			

Minnesc	ta Department of He	alth			ORM APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00080	B. WING		C 05/28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
NORTH	SHORE HEALTH		I AVENUE W MARAIS, MN		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLETE DATE
2 565	Continued From pa	ge 8	2 565		
		ee could develop monitoring ongoing compliance.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 835	MN Rule 4658.0520 Proper Nursing Car) Subp. 2 A Adequate and re; Criteria	2 835		7/8/21
	proper care. The c adequate and prope Evidence of adequa	ate care and kind and ent at all times. Privacy must			
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure bladder continence was 2 residents (R4) reviewed for continence.		Corrected	
	Findings include:				
	diagnoses included condition in which the as well as it should) non-Alzheimer's de hemiplegia/hemipar				
6	3/3/21, indicated R4 required extensive toilet use. In additio	num Data Set (MDS) dated 4 was cognitively intact, assistance with transfers and n R4's MDS indicated ence with bladder and always			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
NORTH	SHORE HEALTH		H AVENUE WE MARAIS, MN 🖇	-		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 835	Continued From pa	age 9	2 835			
	continent of bowel.					
	assessment of acti functional/rehabilita indicated R4 requir a two-wheeled wal incontinence dated potential for function weakness and ass	essment (CAA) for ivities of daily living ation potential dated 12/8/20, red stand by assist of one with ker. R4's CAA for urinary I 12/8/20, indicated R4 had onal incontinence due to ist of one to get to the on diuretics for congestive				
	had impaired mobi unsteady gait and i with a gait belt and walking to the bath indicated R4 had a potential for function weakness and on o	lated on 3/23/21, indicated R4 lity related to weakness and ar required the assistance of one two-wheeled walker for froom. R4's care plan further litered elimination with the onal incontinence related to diuretics. R4's care plan sist R4 to the bathroom hourly call light promptly.				
	12/19/19, indicated bladder with minor time it takes to get quarterly bladder a	ve bladder assessment dated I R4 was currently continent of occasional dribbling due to to the bathroom. R4's ssessment dated 3/4/21, continent of bladder.				
	R4 was taking spir treat high blood pre milligrams (mg) da	s printed on 5/27/21, indicated onolactone (medication used to essure and fluid retention) 12.5 illy and furosemide (medication retention) 40 mg twice daily.	5			
		5 p.m. R4 was interviewed. R4 are of when she needed to use				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED	
		00080	B. WING		05/28/2021	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
NORTH	SHORE HEALTH		AVENUE WE			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 835	the bathroom to uri would take her lasix wouldn't come right soaking through the clothing. R4 stated of days and it made embarrassed. In ad would wear regular pad. On 5/26/21, at 8:53 was interviewed. In ad would wear regular pad. On 5/26/21, at 8:53 was interviewed. N, of bladder 95% of ti get to her soon end "busy." -at 1:34 p.m. registe interviewed. RN-B v issue if someone w incontinent because time to assist them verified residents w to be assisted to the avoid bladder accid On 5/27/21, at 11:4 NA-E stated R4 wa staff were unable to NA-E thought R4 has week because of th feel bad and she we incontinence accide -at 11:54 a.m. licen was interviewed. LF	 nate, but sometimes after she x (furosemide) pill the staff t away and she would end up pad, underwear, and this would occur every couple her feel bad and dition R4 stated at night she underwear with no need for a a.m. nursing assistant (NA)-D A-D stated R4 was continent he time unless staff couldn't bugh because they were ered nurse (RN)-B was verified it would be a dignity tho is continent of bladder was e staff couldn't get there in to the bathroom. RN-B tho are on diuretics might need e bathroom on a schedule to lents. 9 a.m. NA-E was interviewed. s continent of urine unless o answer her light right away. ad about three accidents a nis. NA-E stated it made R4 ould apologize to staff after an		DEFICIENC	ΣΥ)	

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00080	B. WING		05/28/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		AVENUE WE			
(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 THE APPROPRIATE	(X5) COMPLET DATE
2 835	Continued From pa	age 11	2 835			
	-at 12:38 p.m. RN-C was interviewed. RN-C verified it is a dignity issue when a resident who is continent of bladder is having bladder accidents if staff can not answer the call light in time. -at 12:53 p.m. the social worker (SW)-A was interviewed. SW-A stated R4 told her about a bladder accident on 5/23/21, when no one was					
	bladder accident or able to answer her					
	interviewed. The D	rector of nursing (DON) was ON verified residents who are r should not be having bladder				
	Bowel and Bladder indicated the stand identify individuals causes of incontine to review medication might affect contine frequency of physic assist the resident	assessment, Comprehensive last approved 3/2/17, ard was to evaluate and with reversible and irreversible ence. The policy directed staff ons particularly those that ence, need for type and cal assistance as necessary to to access the toilet. In addition a schedule is maintained for				
	director of nursing develop, review, an procedures related bladder programs t The DON or design appropriate staff or The DON or design	THOD OF CORRECTION: The (DON) or designee could ad/or revise policies and to development of bowel and to maintain continence . The could educate all the policies and procedures. The could develop monitoring ongoing compliance.				
	TIME PERIOD FOR (21) days. epartment of Health	R CORRECTION: Twenty-one				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00080	B. WING		05/28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
NORTH	SHORE HEALTH		AVENUE W ARAIS, MN		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 890	MN Rule 4658.0528 Motion	5 Subp. 2 A Rehab - Range of	2 890		7/20/21
	that is directed towa through positioning implemented and m comprehensive res of nursing services development of a n provides that: A. a resident w without a limited ran experience reduction	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which ho enters the nursing home nge of motion does not on in range of motion unless al condition demonstrates range of motion is			
	by: Based on interview facility failed to ensi implemented, reass resident needs to m motion (ROM) and	ent is not met as evidenced and document review, the ure a restorative program was sessed, and revised to meet naintain or improve range of functional mobility for 1 of 4 iewed for restorative		Corrected	
	Findings include:				
	assessment dated a moderate cognitive of care behaviors d required extensive and ambulation in h the hallway. R17's	num Data Set (MDS) 3/17/21, indicated R17 had a impairment, had no rejection uring the assessment period, assist of one staff for transfers her room, and did not walk in comprehensive assessment a ROM deficit of upper and			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00080	B. WING		C 05/28/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NORTH	SHORE HEALTH		AVENUE WE			
(X4) ID	SUMMARY STA	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 ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETI DATE
2 890	Continued From pa	ige 13	2 890			
	not participate in a	n one side of the body, and did restorative program such as tion during the assessment				
	of Daily Living (ADL Potential indicated total knee arthropla and Parkinson's, ar mobility. R17's CA restorative program NuStep Arms, level with front-wheeled dining room with co	ssessment (CAA) for Activities) Functional/Rehabilitation R17 had a history of bilateral asties, rotator cuff surgeries and required assistance with A indicated R17 had a a that included using the 3 for 10 to 20 minutes, walk walker (FWW) in her room to ontact guard assist of one with blow, for 40-80 feet, as				
	had impaired mobil complete the NuSte helps strengthen m bone strength, incre stiffness) arms prog walking rehab prog	iated 4/26/18, indicated R17 ity and directed staff for R17 to ep (exercise machine that uscles around joints, build ease ROM, reduce pain and gram for 10 to 20 minutes, a ram with her FWW to the ontact guard assist of one for e as tolerated.				
	6/1/18, indicated R	apy discharge summary dated 17 was able to ambulate with assist and wheeled walker for				
	R17 had a nursing directed staff to hav from her room to th guard assist of one	sheet dated 4/8/21, indicated rehabilitation program and ve resident walk with the FWW he dining room with contact with the wheelchair to follow e as tolerated, and had a				

Minnesc	ota Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00080	B. WING		C 05/28/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	SHORE HEALTH	515 - 5TH	AVENUE WE	ST		
NORTH	SHORE HEALTH	GRAND	MARAIS, MN	55604		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	Continued From pa	ige 14	2 890			
	indicated R17 was	ogress note dated 4/21/21, not ambulatory related to gnificant osteoarthritis.				
	R17's History and Physical (H&P) dated 5/17/21, indicated R17's diagnoses included Parkinson's disease, history of a stroke, severe spinal stenosis (narrowing of the spaces in the spine, which can put pressure on the nerves), scoliosis (curvature of the spine), degenerative joint disease of the cervical spine (neck) and knees, and osteoporosis (loss of bone, leading to weak and fragile bones). R17's H&P indicated R17 was at her baseline with continued pain in her knees and lower extremities, and a gradual decline in ambulation related to Parkinson's disease, with an intolerance to increased dosage of Sinemet (medication for Parkinson's disease of syndrome). R17's H&P indicated R17 was very ambulatory due to Parkinson's and significant osteoarthritis.	r				
	indicated R17 had I previous week due R17 walked approx that time. R17's pro physician had been	rapy note dated 3/20/19, been refusing to walk for the to severe leg and knee pain. timately 30 feet with therapy at ogress note indicated the working on pain management cumented that there was could offer.				
	1/2020 through 12/2 1/2020: R17 ambu days out of 31 poss 2/2020: R17 ambu days out of 29 poss	lated 6 days, and refused 6 sible opportunities. lated 22 days, and refused 8				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00080	B. WING		05/28/2021	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ORTHS	SHORE HEALTH		I AVENUE WE MARAIS, MN ↔			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	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 1 DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 890	Continued From pa	ige 15	2 890			
	days out of 30 poss 5/2020: R17 walke day out of 31 poten 6/2020: R17 walke of 30 potential oppo 7/2020: R17 walke of 31 potential oppo 8/2020: R17 walke out of 31 potential o 9/2020: R17 walke out of 30 potential o 10/2020: R17 walk out of 31 potential o 11/2020: R17 walk out of 30 potential o 12/2020: R17 walk days out of 31 potential o	ed 10 days and refused one tial opportunities. ed 6 days and refused none our ortunities. ed 3 days and refused none our ortunities. ed 2 days and refused 3 days opportunities. ed 2 days and refused 2 days opportunities. ed 3 days and refused 1 day opportunities. ed no days and refused none opportunities. ed no days and refused 2 ntial opportunities.				
	days out of 31 pote 2/2020: R17 did th days out of 29 pote 3/2020: R17 did th 7 days out of 31 po	e NuStep 1 day and refused 6 ntial opportunities. e NuStep no days and refused tential opportunities.				
	4 days out of 30 po 5/2020: R17 did th	e NuStep 3 days and refused tential opportunities. e NuStep 4 days and refused ential opportunities.				
	6/2020: R17 did th none out of 30 pote 7/2020: R17 did th day out of 31 poten	e NuStep 3 days and refused ential opportunities. e NuStep 1 day and refused 1				
	1 day out of 31 pote	ential opportunities. e NuStep 1 day and refused ential opportunities.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED C
		00080	B. WING			28/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NORTH	SHORE HEALTH		H AVENUE WE MARAIS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 890	Continued From pa	ge 16	2 890			
	opportunities 11/2020: R17 had participation or refu opportunities 12/2020: R17 refus had no documented opportunities. R17's documentation reason for non-part R17's medical reco documentation for R17's Rounds Revi nursing rehabilitation R17's care conferent dated 4/7/21, indica R17's progress notor regarding R17's lact in status regarding planned. R17's Rounds Revi nursing rehabilitation R17's Rounds Revi regarding R17's lact in status regarding planned. R17's Rounds Revi	rd lacked restorative 1/2021 through 5/2021. ew progress notes regarding on dated 2/15/21, indicated ulating less, and was using more frequently for trips to the ew progress notes regarding on dated 3/23/21, indicated oulating, and was using the trips to the bathroom per ex. Ince review progress note ated R17 was not walking. e lacked documentation is of participation and change restorative programs as care ew progress notes regarding on dated 4/19/21, indicated oulating, and was using the trips to the bathroom per				
	R17's Rounds Revi	ew progress notes regarding				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00080	B. WING		C 05/28/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		HAVENUE WE			
(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) COMPLET DATE
2 890	Continued From pa	age 17	2 890			
	R17 was rarely wal	on dated 5/16/21, indicated king, and used the trips to the bathroom per her				
	A review of R17's medical record revealed a lack of restorative program participation, assessment and evaluation of R17's lack of participation, and a lack of revision of R17's restorative programs and care plan.					
	difficulty moving he falling in the past. exercises and said	a.m. R17 stated she had r left arm, and said it was from R17 stated she did not get any staff walked with her said she should walk more.				
	(RN)-A stated R17 to her knees being Parkinson's. RN-A used the stand-ass maybe go back to t dressed by staff an shoulder hurting he have a restorative a	00 a.m. registered nurse did not do her programs due so bad, and tremors from stated R17 tried to walk, but ist lift, and thought she could herapy. RN-A stated R17 is d did not complain about her er. RN-A stated they do not aide at this time, so the nursing do the restorative programs or				
	(NA)-B stated R17 was using the stand if a resident was or	6 a.m. nursing assistant had not walked for awhile, and d-assist lift more. NA-B stated a restorative program and cipate, she would report it to				
	easy chair in her ro walk alone; only wh	20 a.m. R17 was sitting in her oom and stated she could not hen staff were there with her. hs were stiff and she was				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	COM	E SURVEY PLETED	
		00080	B. WING			C 05/28/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IORTH S	SHORE HEALTH		HAVENUE WE				
(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 AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 890	Continued From pa	age 18	2 890				
	unable to reach he	r phone half the time.					
	(RN)-A stated R17 gradual change, ar longer appropriate. reassess a residen restorative program assessments. RN- had declined and h her ability to partici and re-evaluated for the program is not assess and have th stated she believed related to her Park because she did no R17 was at her hig Sinemet. RN-A sta	28 a.m. registered nurse used to walk, but has had a nd her walking program was no . RN-A stated they should nt's ability to participate in their ns during the quarterly -A verified R17's participation ner restorative programs and pate had not been assessed or over a year. RN-A stated if appropriate, they should nerapy re-evaluate. RN-A d R17's ability to walk declined inson's disease and not likely of get restorative , and stated hest therapeutic level of ted R17 wanted to use the d refused to walk now.					
	Rehabilitation Prog the purpose of the was to "maximize e independence." Th nursing to reasses changes in a reside quarterly and base resident's plan of c the resident's curre and procedure dire program to be mor rehabilitation work was to be documen notes. If a residen	and procedure for Nursing gram revised 9/1/14, indicated nursing rehabilitation program each resident's functional he facility policy directed s and evaluate possible ent's mobility needs at least d on the assessment, the eare would be revised to reflect ent needs. The facility policy ected the nursing rehabilitation hitored on the nursing sheet and weekly progress nted weekly in the progress t refused to participate, the d be informed of the resident's					
	refusal and reason document the resid	for refusal, who would then dent's refusal. Physical therapy consult if a resident					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00080	B. WING			C 28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
NORTH	SHORE HEALTH		I AVENUE WI MARAIS, MN			
(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
2 890	- 1	ge 19 d or there was a change in	2 890			
	director of nursing (develop, review, an procedures related and care plan revis The DON or design appropriate staff on The DON or design systems to ensure	THOD OF CORRECTION: The (DON) or designee could (d/or revise policies and to assessments, re-evaluation ion for restorative programs. the could educate all the policies and procedures. the could develop monitoring ongoing compliance. R CORRECTION: Twenty-one				
21000	Requirements-Hygi Subp. 4. Hygiene. wash their hands at their arms with soa washing facility befu as often as is necess after smoking, eatir handling soiled equi	Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or ipment or utensils. Dietary				7/12/21
	trimmed. This MN Requireme by: Based on observati review, the facility f hygiene was followe R19, R11, R13, R30	ir fingernails clean and ent is not met as evidenced ion, interview, and document ailed to ensure proper hand ed for 8 of 20 residents (R23, 0, R15, R28, and R17) eal service on the Woods unit.		Corrected		

Minnesota Department of Health STATE FORM

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If continuation sheet 20 of 31

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		08000	B. WING			28/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		AVENUE WE			
(X4) ID SUMMARY S		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLET DATE
21000	Continued From page	ge 20	21000			
	walked into the kitch and without washing silverware out of a c - NA-C walked to a different residents, I cup in a food cart. - NA-C returned to t clean trays, took a t down in front of R11 opened up the crac the mug and moved the tray. NA-C took placed one on R11, residents sitting at t -NA-C returned to th tray from the cart ar deliver to R13. -NA-C took the mea hallway, removed a delivered it to R30, a cover-up on R30, of R30, removed co packages, buttered milk glass and mug mugs where R30 withem on the tray for room, pulled the sto and fastened it. -NA-C returned to th tray and brought it in cover-up on R15, op buttered it, opened to the tray table, mo -NA-C returned to th tray and entered R1 stop sign. NA-C mo	table to put cover-ups on two R23 and R19, then placed a the meal service cart with the ray from the cart and set it I, uncovered R11's food and kers, removed the cover from d the cup to the center, top of a some more cover ups and and offered one to other ables in the dining room. The meal tray cart, removed a nd handed it to another staff to al tray cart down the 400 tray from the cart and and set it on the tray table, put moved the tray table in front overs and opened food R30's corn bread, lifted the s by the top of the glass and ould drink from, and moved rR30. NA-C exited R30's op sign across the doorway the meal tray cart, removed a nto R15's room, put a pened the corn bread, crackers, moved a tissue box				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLE	
00080 B. WING 05/28	3/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTH SHORE HEALTH 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21000 Continued From page 21 21000 her feet, moved the tray table in front of her, and ther went into the bathroom and sanitized her hands. NA-C removed covers from R17's food, sanitized hands and exited R17's room. -NA-C verified at that time that she had not been sanitizing or washing her hands between residents and should have. NA-C verified there would be a risk of cross contamination. On 5/27/21, at 4:01 p.m. the director of nursing (DON) verified staff should wash or sanitize hands between serving or assisting each resident during meal service. The facility policy and procedure for Hand Hygiene. Dietary, reviewed 1/21, directed all staff who have patient contact, and those who serve food are to follow directives for hand hygiene in order to prevent the spread of infections. The facility policy provided direction for how hand hygiene should be done. The facility policy Handwashing Protocol revised 7/20, directed staff to perform hand hygiene between patient contacts. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), dietary manager, or designee could develop, review, and/or revise policies and procedures related to hand hygiene during meal service. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		00080	B. WING			C 2 8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	SHORE HEALTH	515 - 5TH	AVENUE WE	EST		
NORTH		GRAND I	MARAIS, MN	55604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 22	21830			
21830	MN St. Statute 144 Residents of HC Fa	651 Subd. 10 Patients & ac.Bill of Rights	21830			7/7/21
	Subd. 10. Particip notification of family	eation in planning treatment; / members.				
	in the planning of th includes the opport alternatives with inc opportunity to reque	I have the right to participate leir health care. This right unity to discuss treatment and lividual caregivers, the est and participate in formal and the right to include a				
	family member or o both. In the event t present, a family me	ther chosen representative or hat the resident cannot be ember or other representative lent may be included in such				
	(b) If a resident w unconscious or con communicate, the f	who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify				
	either a family mem writing by the reside an emergency that	ber or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the				
	family member to p planning, unless the to believe the reside	articipate in treatment e facility knows or has reason ent has an effective advance				
	specified in writing t member included in	rary or knows the resident has that they do not want a family a treatment planning. After ember but prior to allowing a				
	family member to p planning, the facility	articipate in treatment must make reasonable vith reasonable medical				
	practice, to determi executed an advane	ne if the resident has ce directive relative to the e decisions. For purposes of				
		isonable efforts" include:				

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00080	B. WING			C 28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NODTU		515 - 5TH	AVENUE WE	ST		
NORTH	SHORE HEALTH	GRAND N	ARAIS, MN	55604		
(X4) ID	-	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE
21830	Continued From pa	ge 23	21830			
	(1) examining the resident;	e personal effects of the				
		e medical records of the				
		session of the facility;				
		ny emergency contact or				
	family member con	tacted under this section				
		nt has executed an advance				
		er the resident has a				
		the resident normally goes for				
	care; and	e physician to whom the				
		oes for care, if known,				
		nt has executed an advance				
		y notifies a family member or				
		ncy contact or allows a family				
		ate in treatment planning in				
		s paragraph, the facility is not				
		r damages on the grounds that				
		e family member or				
		or the participation of the improper or violated the				
	patient's privacy rig					
		isonable efforts to notify a				
	family member or d	lesignated emergency contact, empt to identify family				
		gnated emergency contact by				
	examining the pers	onal effects of the resident				
		cords of the resident in the				
		acility. If the facility is unable				
		ember or designated				
		within 24 hours after the				
		ity shall notify the county				
		cy or local law enforcement ident has been admitted and				
		n unable to notify a family				
	5	ited emergency contact. The				
		e agency and local law				
		y shall assist the facility in				
		ying a family member or				
	opartmont of Hoalth					

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00080	B. WING			C 28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
NORTH	SHORE HEALTH		H AVENUE W MARAIS, MN			
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21830	designated emerge	age 24 ency contact. A county social ocal law enforcement agency	21830			
	that assists a facilit subdivision is not lia damages on the gr the family member	y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper				
	by: Based on interview facility failed to follo notify the physician reviewed for unnec addition, the facility representative was	ent is not met as evidenced and document review, the ow up on low blood sugars and for 1 of 5 residents (R22) ressary medications. In failed to ensure a resident notified following a fall for 1 of eviewed for accidents.		Corrected		
	Findings include:					
	4/7/21, indicated Radiagnoses included	nimum Data Set (MDS) dated 22 was cognitively intact, I diabetes and renal eceived insulin daily.				
	monitored for diabe appropriate self-ad care plan lacked pa	licated R22 was clinically etes and was monitored for ministration of insulin. R22's arameters for notification of out lying blood glucose.				
	-insulin glargine (La units subcutaneous -insulin human lispi	ders printed 5/27/21, included: antus-long acting insulin) 23 sly twice daily ro (Humalog-short acting cutaneously three times daily				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00080	B. WING			28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		HAVENUE WE			
(X4) ID	SUMMARY STA	TEMENT 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
21830	Continued From pa	ge 25	21830			
	indicated R22's dia R22's blood sugars increasing hemoglo measures your ave the past 3 months). add insulin at meal R22's physician pro- indicated R22 had s related to increased ordered the previou had been decrease blood sugars and h blood glucose at the on 5/5/21. R22's pl noted that R22 was intake and was hap R22's Blood Glucos	bgress notes dated 4/5/21, gnoses included diabetes, and were elevated with an obin A1C (a blood test that rage blood sugar levels over . R22's physician planned to time. bgress notes dated 5/5/21, some low blood glucose d insulin at meal time as is month, so insulin dosing d in response to R22's low ad not had any further low e time of the physician's visit hysician progress notes further working on decreasing her opy with some weight loss. se Record between 4/6/21, 22's increase in insulin at				
	meals, indicated R2 before breakfast ra (mg)/deciliter (dl) to	22's morning blood glucose nged from 62 milligrams o 167 mg/dl, with 5 od glucose values in the 60's,				
	p.m. indicated R22 had numbness in h and had severe itch was 57 mg/dl, and	es dated 4/28/21, at 10:00 was shaking, sweating, and er left leg and foot, was crying niness. R22's blood glucose she was given a snack. No cose was documented.				
	received 23 units o insulin) twice daily, Novalog insulin (ra	es dated 5/3/21, indicated R22 f Lantus insulin (long acting and R22's Humalog or bid acting insulin) had been units to 5 units three times	2			

Minnes	ota Department of He	alth			FORM	APPROVED
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		00080	B. WING			C 2 8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NORTH	SHORE HEALTH		I AVENUE WE MARAIS, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
21830	Continued From pa	ge 26	21830			
	daily on 4/29/21, du results.	e to some low blood glucose				
Minnecoto	5/27/21, following a indicated R22's bloc response to blood g -5/6/21, at 7:35 a.m "powders" with pills blood glucose was -5/14/21, at 6:32 a.r 180 milliliters (ml) o recorded -5/15/21, at 7:04 a.r no follow up record -5/16/21, at 6:34 a.r no follow up record -5/18/21, at 7:45 a.r no follow up record -5/19/21, at 8:00 a.r no follow up record -5/20/21, at 7:35 a.r no follow up record -5/21/21, no blood g -5/23/21, at 5:51 a.r orange juice to hold follow up record -5/24/21, at 5:58 a.r orange juice; follow 7:12 a.m. was 92 m -5/25/21, at 5:48 a.r orange juice; follow 6:58 a.m. was 116 n R22's progress note R22's blood glucos of orange juice and	 m.: 64 mg/dl; R22 received range juice, no follow up was m. 59 mg/dl; no action taken, ed m.: 55 mg/dl: no action taken, ed m.; 66 mg/dl; no action taken, ed m.; 79 mg/dl: no action taken, ed m.; 77 mg/dl; no action taken, ed glucose recorded m.; 80 mg/dl; had 60 ml I her over until breakfast, no m.; 52 mg/dl; drank 240 ml up blood glucose recorded at ng/dl m.; 68 mg/dl; drank 240 ml of up blood glucose recorded at mg/dl. 				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED C
		00080	B. WING		05/	28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		H AVENUE WE MARAIS, MN ↔			
(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) COMPLETI DATE
21830	Continued From pa	ge 27	21830			
	R22's blood glucos 240 ml orange juice said she did not eat before. R22 had a mg/dl. R22's progress not R22's blood glucos ml of orange juice, and 240 ml of milk. could not remembe supper the previous R22's progress not	es lacked indication R22's notified of R22's continued				
	stated R22's param physician for a bloo mg/dl, but lacked p for low blood glucos R22's physician had low blood glucose s R22's insulin on 4/2 glucose. RN-B stat to eat or drink with RN-B verified R22's documentation of ir blood glucose for m glucose. RN-B furt would be unable to regarding diabetes	am. registered nurse (RN)-B neters were to call the od glucose greater than 200 arameters to call the physician se results. RN-B verified d not been notified of R22's since the physician decreased 29/21, due to low blood ted they give R22 something low blood glucose results. Is medical record lacked interventions and follow-up nost occurrences of low blood her verified the physician make appropriate decisions and insulin management if the ified of R22's low or high blood				
	expectation was to	9 a.m. RN-A stated the do a follow-up and blood glucose. RN-A verified				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00080	B. WING			28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		H AVENUE WES MARAIS, MN			
(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
21830	follow-up blood glu expect a follow-up of the low blood glu R22 would be at ris glucose. RN-A verit notify the physician diabetes and insulti notify R22's physici The facility policyHy directed follow up b minutes if a blood g twice and had sym a blood glucose is a provide a snack of facility policy lacked between 60 and 85 lacked guidance wh continued low blood R16's diagnoses in degeneration, legal R16's quarterly Min 3/17/21, indicated F impairment, was in required supervisio ambulation. R16's care plan init had impaired mobil	w blood glucose without cose. RN-A stated she would blood glucose within an hour icose result. RN-A verified ik for a continued drop in blood fied it would be beneficial to for better management of n, and stated it was time to an. ypoglycemia reviewed 5/22, blood glucose within 15 glucose is below 60 mg/dl btoms of hypoglycemia, and if above 85 mg/dl, staff was to a complex carbohydrate. The d guidance for blood glucose mg/dl. The facility further nen to notify a physician of d glucose. clude dementia, macular blindness, and osteoarthritis. imum data Set (MDS) dated R16 had severe cognitive dependent in bed mobility, and n with transfers, and iated 4/18/16, indicated R16 ity, was at risk for falls, valker, and required hourly				
	5/16/21, indicated F her room and had r	nvestigation (FSI) dated R16 was found on the floor in no apparent injury. R16's FSI 16's representative was not I.				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			Сом	E SURVEY PLETED C
	00080	B. WING			28/2021
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SHORE HEALTH					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 29	21830			
was yelling from he floor", and was assi staff. R16's Fall Ev representative was R16's progress note	r room "help get me off the sted back into bed by two ent indicated R16's not notified of fall. e dated 5/16/21, R16 was				
floor sitting in front of complained of right broken, it hurts inside bed, a head-to-toe a and no reddened on R16's progress note	of her a recliner chair. R16 leg pain and stated, "it is not de". R16 was assisted into assessment was completed opened areas were found. es lacked evidence R16's	3			
resident's family an notified of any resid R16's Fall Event, F3 documentation R16	d/or representatives should be ent falls. The DON verified SI, and progress notes lacked 's representative was notified				
12/19/18, directed s	staff to notify a resident's				
director of nursing (develop, review, an procedures related physician and/or res The DON or design	DON) or designee could d/or revise policies and to notification of change to sident representative. ee could educate all				
	(EACH DEFICIENCY REGULATORY OR LS Continued From pa R16's Fall Event da was yelling from he floor", and was assi staff. R16's Fall Ever representative was R16's progress note heard yelling from h floor sitting in front of complained of right broken, it hurts inside bed, a head-to-toe a and no reddened or R16's progress note representative was On 5/25/21, at 9:50 stated he had not b the past two years. On 5/27/21, the direct resident's family an notified of any reside R16's Fall Event, F3 documentation R16 of R16's fall on 5/16 The facility Fall Polit 12/19/18, directed as family and physician SUGGESTED MET director of nursing (develop, review, an procedures related physician and/or rest The DON or design	OF CORRECTION IDENTIFICATION NUMBER: 00080 00080 PROVIDER OR SUPPLIER STREET AI SHORE HEALTH 515 - 5TH GRAND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 R16's Fall Event dated 5/16/21, indicated R16 was yelling from her room "help get me off the floor", and was assisted back into bed by two staff. R16's Fall Event indicated R16's representative was not notified of fall. R16's progress note dated 5/16/21, R16 was heard yelling from her room and was found on the floor sitting in front of her a recliner chair. R16 complained of right leg pain and stated, "it is not broken, it hurts inside". R16 was assisted into bed, a head-to-toe assessment was completed and no reddened or opened areas were found. R16's progress notes lacked evidence R16's representative was notified at time of fall. On 5/25/21, at 9:50 a.m. family member (FM)-A stated he had not been notified of R16's falling in the past two years. On 5/27/21, the director or nursing (DON) stated resident's family and/or representatives should be notified of any resident falls. The DON verified R16's Fall Event, FSI, and progress notes lacked documentation R16's representative was notified of R16's fall on 5/16/21. The facility Fall Policy and Procedure revised 12/19/18, directed staff to notify a resident's family and physician when a resident falls.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER A BUILDING: 00080 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SHORE HEALTH S15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CROSS-REFERENCED TO DEFICIENCY (EACH OCRECITIVE AG (EACH CORRECITIVE	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00080 B. WING 057 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SHORE HEALTH STREET ADDRESS, CITY, STATE, ZIP CODE PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION IREQUARTY ON LSC IDENTIFYING INFORMATION PRETX REACH CORRECTION THAT SHOULD BE CONSISTER FLAN OF CORRECTION REGULTION ON LSC IDENTIFYING INFORMATION ID PRETX REACH CORRECTION THAT SHOULD BE CONSISTER FLAN OF CORRECTION Continued From page 29 21830 Continued From Page 29 Z1830 Continued From page 29 21830 EFFICIENCY DEFICIENCY Continued From page 29 Z1830 EFFICIENCY DEFICIENCY Continued From page 29 Z1830 EFFICIENCY EFFICIENCY Continue Toro in the real realing in the roon and was found on the floor stating in the

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00080	B. WING			28/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
NORTH	SHORE HEALTH		HAVENUE WE			
(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 TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	age 30	21830			
	systems to ensure	ongoing compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				

CENTERS FOR MEDICARE				0		APPROVED 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP			E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	` '		6 04 - NORTH SHORE HEALTH		IPLETED
	245384	B. WING			05/	26/2021
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST		
NORTH SHORE HEALTH				GRAND MARAIS, MN 55604		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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
K 000 INITIAL COMMEN	TS	K	000			
Minnesota Departri Fire Marshal Divisi Cook County North found not in compli participation in Mee Subpart 483.70(a), 2012 edition of Nati Association (NFPA Code (LSC), Chap and the 2012 edition Code (LSC), Chap and the 2012 edition Code (NFPA 99). THE FACILITY'S F ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM VERIFICATION OF UPON RECEIPT CO ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W IF OPTING TO US OF THE PLAN OF REQUIRED. PLEASE RETURN CORRECTION FC DEFICIENCIES (K	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN 'ITH YOUR VERIFICATION. EE AN EPOC, A PAPER COPY CORRECTION IS NOT					
LABORATORY DIRECTOR'S OR PROVI Electronically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 07/01/2021

Electronically Signed

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	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA					0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - NORTH SHORE HEALTH			(X3) DATE SURVEY COMPLETED		
		245384	B. WING			05/:	26/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	SHORE HEALTH				515 - 5TH AVENUE WEST		
				(GRAND MARAIS, MN 55604		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510 By e-mail to: FM.HC.Inspections THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A detailed descri taken or planned to 2. Address the mea to ensure the deficie 3. Indicate how the performance to ensure 4. Identify who is re actions and monitor 5. The actual or pro- the remedy. The facility was insp Cook County North 1-story building with 400 wings of the fac and was determined construction. In 201	ge 1 SHAL DIVISION STREET, SUITE 145 01-5145, or @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: iption of the corrective action correct the deficiency. asures that will be put in place ency does not reoccur. facility plans to monitor future sure solutions are sustained. esponsible for the corrective ring of compliance. oposed date for completion of pected as one building: shore Hospital C & NC, is a n no basement. The 100 and cility were constructed in 2016 d to be of Type II(111) 17 the 200 and 300 wings were building that were determined	K		DEFICIENCY)		
	100,200,300, & 400 replace the original	o wings were constructed to facility and the plans for these ed on 04/30/2015, prior to the					

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES			FORM	: 07/07/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>	IPLE CONSTRUCTION NG 04 - NORTH SHORE HEALTH	` ´	TE SURVEY MPLETED
		245384	B. WING		05	/26/2021
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE	, ZIP CODE	
NORTH	SHORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 5560)4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE)	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
K 000 K 345 SS=F	2012 code adoptior existing constructio a hospital and is pre- fire rated separation into 2 smoke comp smoke barrier. The building is fully facility has a fire ala detection in the cor corridors that is mo department notifica detection in all resid The facility has a ca census of 37 at the The requirements a are NOT MET. Fire Alarm System CFR(s): NFPA 101 Fire Alarm System A fire alarm system accordance with an with the requiremer Electric Code, and and Signaling Code acceptance, mainte available. 9.6.1.3, 9.6.1.5, NF This REQUIREMEN by: Based on staff inte available document	 and are considered to be of n. The building is attached to operly separated by a 2 hour n. The building is separated artments by a 1 hour fire rated sprinklered throughout, the arm system with smoke ridors and spaces open to the nitored for automatic fire tion. It also has smoke dent rooms. apacity of 37 beds and had a time of the survey. at 42 CFR Subpart 483.70(a) Testing and Maintenance is tested and maintained in approved program complying nts of NFPA 70, National NFPA 72, National Fire Alarm ance and testing are readily 	К 0			6/21/21

Facility ID: 00080

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES			FORM	07/07/202 ⁻ APPROVEE 0938-039 ⁻
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 04 - NORTH SHORE HEALTH	(X3) DAT	E SURVEY IPLETED
		245384	B. WING		05/	26/2021
NAME OF F	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	HORE HEALTH			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 345	NFPA 72 National F section 14.3.1. This 37 of 37 residents. Findings include: On 05/27/2021, at 7 of all available fire a documentation for 1 interview with the M revealed that the fa semi-annual visual initiating devices.	nentation in accordance with Fire Alarm Code 2010 edition, a deficient practice could affect 10:30 a.m., during the review alarm maintenance and testing the last 12 months, and an Maintenance Supervisor it was icility did not conduct a inspection of the fire alarm	К 3-	 does not constitute an admission agreement with, the facts and conset forth in the statement of definition of the facts and conset forth in the statement of definition of the fact of the executed as a means to continue improve the quality of care, to constitute and federal more quirements and constitutes the facility is allegation of compliant. The visual inspection of the fire a initiating devices is conducted more for the month of June 2021, the inspection was conducted on Ju 2021. The information was and date and in its own book per the Marshall recommendations in 2000. We will continue to perform the more for the fire alarm initiating devices the minimisemiannual inspection. This information was and date and the fire alarm initiating devices which exceeds the minimisemiannual inspection. This information was and will be forwarded to the Quality Improvement/Peer Review Commendations in 2000. 	onclusions ciencies. red and/or ously omply with egulatory e. alarm onthly. visual ne 21, is up to Fire 018. monthly ating num rmation	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101		K 3	quarterly for one year. 63		5/28/21
	required enclosures hazardous areas re and are made of 1 wood or other mate at least 20 minutes smoke compartment the passage of smo	orridor openings in other than s of vertical openings, exits, or esist the passage of smoke 3/4 inch solid-bonded core erial capable of resisting fire for . Doors in fully sprinklered nts are only required to resist oke. Corridor doors and doors g flammable or combustible				

Facility ID: 00080

If continuation sheet Page 4 of 6

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM OMB NO.	APPROVE 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 04 - NORTH SHORE HEALTH	(X3) DATE	E SURVEY PLETED
		245384	B. WING _		05/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER	- -		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	SHORE HEALTH			515 - 5TH AVENUE WEST		
NORTHS				GRAND MARAIS, MN 55604		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
K 363	Continued From pa	age 4	K 36	3		
		itive latching hardware. Roller				
		ted by CMS regulation. These				
		ot apply to auxiliary spaces that	t			
		mable or combustible material	l.			
		h bottom of door and floor				
		eeding 1 inch. Powered doors				
		.1.9 are permissible if provided ble of keeping the door closed				
		bf is applied. There is no				
		closing of the doors. Hold oper	ı			
		e when the door is pushed or				
		d. Nonrated protective plates				
		are permitted. Dutch doors				
		are permitted. Door frames				
		d made of steel or other ance with 8.3, unless the				
		nt is sprinklered. Fixed fire				
		s are allowed per 8.3. In				
		rtments there are no				
		or fire resistance of glass or				
	frames in window a	assemblies.				
	and 485	Parts 403, 418, 460, 482, 483,				
		S details of doors such as fire				
	protection ratings, a etc.	automatics closing devices,				
	This REQUIREME	NT is not met as evidenced				
		tion and staff interview the		K363		
	facility failed to pro	vide one corridor door with a		Preparation, submission and		
		keeping the door closed and		implementation of this Plan		
	resist the passage	of smoke in accordance with		does not constitute an admi		
		ty Code (NFPA 101) section		agreement with, the facts an		
		3.3.5. This deficient practice oke to enter the corridor		set forth in the statement of		
		o exit in the case of fire,		This Plan of Correction is prevented as a means to cor		
	affecting 10 of the			improve the quality of care,		

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 04 - NORTH SHORE HEALTH	(X3) DATE	0938-039 SURVEY PLETED
		245384	B. WING		05/2	26/2021
	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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) COMPLETIO DATE
K 363	revealed that the do 1/4 inch gap betwee the door did not fit t found that the door door gasket betwee limit the transfer of	12:45 a.m., observations foor to resident room 106 had a en the door and the frame and ightly in the frame. It was also did not have any approved en the door and the frame to smoke. tion was confirmed by a	K 363	requirements and constitutes the facility s allegation of compliance. The repair to the resident room 10 was performed on 05/28/21 at 09: the strike was replaced and the do meets the 1/8 or less requirement smoke gasket was present at the t repair and in good working order. remaining corridor doors were also reviewed on 05/28/21 and were in compliance. The Maintenance Department Mar his designee will conduct a door inspection during the first week of quarter (January, April, July, and October). This requirement will als added to the building Preventive Maintenance software to provide a reminder for completion and a loca documentation of completion. The summary of the door inspections w forwarded to the Quality Improvement/Peer Review Commi- quarterly for one year.	6 door 12am or now . The ime of All o hager or each o be ation for	

Facility ID: 00080

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