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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O830

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00080

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245384**
2.STATE VENDOR OR MEDICAID NO.
(L2) **365745100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/27/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 07/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/27/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/14/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

DEPARTMENT OF HEALTH

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O830

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Facility ID: 00080

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(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/28/2021** (L34)

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12/31

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Colleen Johnson HFE - NE II 07/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/12/2021 (L20)

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

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X 1. Facility is Eligible to Participate
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/24/21, through 5/28/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/24/21, through 5/28/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5384025C (MN67784) H5384026C (MN72739) H5384027C (MN68330) H5384029C (MN72732) The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H5384028C (MN72774), with a deficiency cited at (F656). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 06/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		7/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 2 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on low blood sugars and notify the physician for 1 of 5 residents (R22) reviewed for unnecessary medications. In addition, the facility failed to ensure a resident representative was notified following a fall for 1 of 4 residents (R16) reviewed for accidents. Findings include: R22's quarterly Minimum Data Set (MDS) dated 4/7/21, indicated R22 was cognitively intact, diagnoses included diabetes and renal insufficiency, and received insulin daily. R22's care plan indicated R22 was clinically	F 580	F580 Notification of Changes 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 deficiencies. This Plan of Correction is prepared and/or 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. On May 27, 2021, the Resident Care Manager notified R22□s primary provider	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 monitored for diabetes and was monitored for appropriate self-administration of insulin. R22's care plan lacked parameters for notification of R22's physician of out lying blood glucose. R22's physician orders printed 5/27/21, included: -insulin glargine (Lantus-long acting insulin) 23 units subcutaneously twice daily -insulin human lispro (Humalog-short acting insulin) 5 units subcutaneously three times daily with meals R22's physician progress notes dated 4/5/21, indicated R22's diagnoses included diabetes, and R22's blood sugars were elevated with an increasing hemoglobin A1C (a blood test that measures your average blood sugar levels over the past 3 months). R22's physician planned to add insulin at meal time. R22's physician progress notes dated 5/5/21, indicated R22 had some low blood glucose related to increased insulin at meal time as ordered the previous month, so insulin dosing had been decreased in response to R22's low blood sugars and had not had any further low blood glucose at the time of the physician's visit on 5/5/21. R22's physician progress notes further noted that R22 was working on decreasing her intake and was happy with some weight loss. R22's Blood Glucose Record between 4/6/21, and 5/5/21, after R22's increase in insulin at meals, indicated R22's morning blood glucose before breakfast ranged from 62 milligrams (mg)/deciliter (dl) to 167 mg/dl, with 5 occurrences of blood glucose values in the 60's, 2 in the 70's, and 8 in the 80's.	F 580	of the low blood sugars. New orders were received May 28, 2021. On May 27, 2021, the Director of Nursing notified the family of R16 about the fall. On June 14, 2021, the Resident Care Manager reviewed all charts of residents who have diabetes with insulin therapy for need to notify provider of low blood sugars. Documentation from the last 30 days was reviewed for five of five resident charts. This did not include R22 as she had already been reviewed. Two of five residents had an isolated low blood sugar reading with effective intervention by the Charge Nurse and no notification of the provider. None of the resident charts met the criteria of the Hypoglycemia policy for need to notify provider. Nurses were educated to inform provider of low blood sugars when there are low sugars two days in a row or if there are two low blood sugars in a seven day period. These parameters came from R22□s primary provider and were reviewed and approved by the Medical Director. The Hypoglycemia policy has been updated to reflect these parameters, and will be reviewed with Care Center nurses at their next monthly meeting on July 7, 2021. On June 14, 2021, the Resident Care Manager reviewed the fall investigation reports for the past 30 days. Three of nineteen falls had no documentation of notification of the family including the fall involving R 16. In the other two situations, falls occurred in the evening or night and, family was notified but it was several days	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

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F 580	Continued From page 4 R22's progress notes dated 4/28/21, at 10:00 p.m. indicated R22 was shaking, sweating, and had numbness in her left leg and foot, was crying and had severe itchiness. R22's blood glucose was 57 mg/dl, and she was given a snack. No follow up blood glucose was documented. 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. R22's Blood Glucose Record between 5/6/21 and 5/27/21, following a decrease in insulin dosing, indicated R22's blood glucose and the nursing response to blood glucose below 90 mg/dl: -5/6/21, at 7:35 a.m. : 65 mg/dl; R22 drank her "powders" with pills per her request. No follow up blood glucose was recorded. -5/14/21, at 6:32 a.m.: 64 mg/dl; R22 received 180 milliliters (ml) orange juice, no follow up was recorded -5/15/21, at 7:04 a.m. 59 mg/dl; no action taken, no follow up recorded -5/16/21, at 6:34 a.m.: 55 mg/dl: no action taken, no follow up recorded -5/18/21, at 7:45 a.m.; 66 mg/dl; no action taken, no follow up recorded -5/19/21, at 8:00 a.m.; 79 mg/dl: no action taken, no follow up recorded -5/20/21, at 7:35 a.m.; 77 mg/dl; no action taken, no follow up recorded -5/21/21, no blood glucose recorded -5/23/21, at 5:51 a.m.; 80 mg/dl; had 60 ml orange juice to hold her over until breakfast, no follow up recorded	F 580	later. Our current fall investigation report document prompts nurses to notify family at the time of the fall and provides a place to record that it was done. IDT members meet multiple times a week and review all aspects of the investigation reports, including whether family members were notified. If documentation is unclear about whether the family notified at the time of the fall, IDT members will assure it is done at the next time IDT meets. By July 2, 2021, electronic access to Care Center family email contacts will be available to Care Center Nurses. Education about this access will be provided to nurses at their monthly meeting on July 7, 2021. The ability to email family members any time of the day or night to notify them of a fall with no injury, or with only minor injury, will allow overnight nurses to take care of the notification and not rely on passing the notification duties on to the next shift. The Director of Nursing or designee will monitor the electronic charts of each resident with diabetes and insulin therapy for episodes of low blood sugar two days in a row or two times in any seven day period with notification of provider. This monitor starts on June 28, 2021, weekly for one month. If 100% compliance is achieved we will transition to monitoring monthly for three months. If 100% compliance is achieved, we will discontinue the monitor. Results of the	

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	245384	A. BUILDING _____ B. WING _____	C 05/28/2021

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F 580	Continued From page 5 -5/24/21, at 5:58 a.m.; 52 mg/dl; drank 240 ml orange juice; follow up blood glucose recorded at 7:12 a.m. was 92 mg/dl -5/25/21, at 5:48 a.m.; 68 mg/dl; drank 240 ml of orange juice; follow up blood glucose recorded at 6:58 a.m. was 116 mg/dl. R22's progress notes dated 5/24/21, indicated R22's blood glucose was 52 mg/dl, drank 240 ml of orange juice and stated she did not eat dinner the night before. R22's follow up blood glucose was 92 mg/dl, and R22 was sleeping. R22's progress note dated 5/25/21, indicated R22's blood glucose was 68 mg/dl, R22 drank 240 ml orange juice and was asymptomatic, and said she did not eat much for dinner the night before. R22 had a follow up blood glucose of 116 mg/dl. R22's progress notes dated 5/26/21, indicated R22's blood glucose was 59 mg/dl and drank 240 ml of orange juice, ate a piece of toast with butter, and 240 ml of milk. R22 was asymptomatic and could not remember what she had eaten for supper the previous night. R22's progress notes lacked indication R22's physician had been notified of R22's continued pattern of low blood glucose. On 5/27/21, at 9:44 am. registered nurse (RN)-B stated R22's parameters were to call the physician for a blood glucose greater than 200 mg/dl, but lacked parameters to call the physician for low blood glucose results. RN-B verified R22's physician had not been notified of R22's low blood glucose since the physician decreased R22's insulin on 4/29/21, due to low blood	F 580	monitor will be reported to Quality Improvement/Peer Review quarterly for the length of the monitor. The Director of Nursing or designee will monitor all fall investigation reports for evidence of family being notified. The monitor began June 1, 2021 and will continue for three months. If 100% compliance is achieved, monitor will be discontinued. Reports of this monitored will reported to Quality Improvement/Peer Review quarterly for the length of the monitor.	

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F 580	Continued From page 6	F 580		

glucose. RN-B stated they give R22 something to eat or drink with low blood glucose results. RN-B verified R22's medical record lacked documentation of interventions and follow-up blood glucose for most occurrences of low blood glucose. RN-B further verified the physician would be unable to make appropriate decisions regarding diabetes and insulin management if the physician is not notified of R22's low or high blood glucose.

On 5/27/21, at 11:09 a.m. RN-A stated the expectation was to do a follow-up and intervention for low blood glucose. RN-A verified R22 had several low blood glucose without follow-up blood glucose. RN-A stated she would expect a follow-up blood glucose within an hour of the low blood glucose result. RN-A verified R22 would be at risk for a continued drop in blood glucose. RN-A verified it would be beneficial to notify the physician for better management of diabetes and insulin, and stated it was time to notify R22's physician.

The facility policyHypoglycemia reviewed 5/22, directed follow up blood glucose within 15 minutes if a blood glucose is below 60 mg/dl twice and had symptoms of hypoglycemia, and if a blood glucose is above 85 mg/dl, staff was to provide a snack of a complex carbohydrate. The facility policy lacked guidance for blood glucose between 60 and 85 mg/dl. The facility further lacked guidance when to notify a physician of continued low blood glucose.

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R16's diagnoses include dementia, macular degeneration, legal blindness, and osteoarthritis.

R16's quarterly Minimum data Set (MDS) dated 3/17/21, indicated R16 had severe cognitive impairment, was independent in bed mobility, and required supervision with transfers, and ambulation.

R16's care plan initiated 4/18/16, indicated R16 had impaired mobility, was at risk for falls, independent with walker, and required hourly rounds for safety while in her room.

R16's Fall Scene Investigation (FSI) dated 5/16/21, indicated R16 was found on the floor in her room and had no apparent injury. R16's FSI further indicated, R16's representative was not notified of R16's fall.

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.

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F 580	Continued From page 8 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.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		7/20/21

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F 656	Continued From page 9 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan to include risk factors and interventions following a fracture for 1 of 1 resident (R21) reviewed for injuries of unknown origin. Findings include: R21's diagnoses included age related osteoporosis, chronic obstructive pulmonary disease (COPD), left femur fracture, heart failure, dementia, and right knee fracture. R21's quarterly Minimum Data Set (MDS) dated 4/6/21, indicated R21 was dependent on staff with transfers, required extensive assist with bed	F 656	F656 Develop/Implement Comprehensive Care Plan 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 deficiencies. This Plan of Correction is prepared and/or 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. The Care Card and Plan of Care for R21 were updated with identified risk factors	

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F 656	Continued From page 10 mobility, dressing, toileting, personal hygiene, and had lower extremity impairment. R21's care plan initiated 1/14/20, indicated R21 had impaired mobility related to right cerebrovascular accident (CVA) (stroke) with high muscle tone and contracture's in knees. R21 had a new right knee fracture, and to keep left knee flexed at 90 degrees with padding with pillows. R21's care plan indicated R21 required assistance with bed mobility, directed staff to turn and reposition every two hours, did not ambulate, and required a Hoyer lift (an assistive device used to help with transfers). R21's care plan further indicated R21 had a healed pelvis and left knee fracture, and right knee fracture which required a knee brace for support. R21's care plan lacks risk factors which put R21 at risk for fractures and interventions to prevent further fractures. R21's progress note dated 5/6/21, indicated R21 winced and cried out during cares and repositioning. R21's progress note dated 5/7/21, indicated R21 reported her knees hurt. R21's progress note dated 5/9/21, indicated R21 continued to complain of excessive pain in bilateral legs/knees with movement and positioning. R21's Consulting Radiologist report of the right knee dated 5/10/21, indicated findings included a comminuted fracture (broken bone in more than two pieces) of the distal femoral meta diaphysis (above the right knee). R21's physician note dated 5/12/21, indicated R	F 656	and interventions to prevent future fractures on June 6, 2021. The Resident Care Manager will review and update the Plans of Care of all residents that have experienced a major injury in the past three months to determine if all risk factors are accounted for and appropriate interventions are in place to reduce the risk of further injury by July 2, 2021. A facility Care Planning Policy will be developed outlining the procedure for developing a comprehensive, person-centered care plan and identifying the parameters of when care plans need to be updated by July 20, 2021. The Nurse and Nursing Assistants will be provided education on implementing the interventions delineated on the Care Card and Plan of Care during the Nurse Meeting on July 7, 2021 and the Nursing Assistant Meetings on July 7, 2021 and July 8, 2021. The Director of Nursing or designee will audit two Care Cards and Plans of Cares per week for one month; one per each Household and will then audit one Care Card and Plan of Care for another month. The audit will evaluate the pertinence and accuracy of the Care Card and Plan of Care for the care and services needed and received by the residents and appropriate implementation. The Director of Nursing or designee will also monitor quarterly the Plans of Care	

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F 656	Continued From page 11 21 was found to have a right knee fracture and previously had a left knee fracture last year. R21 had no falls and was presumed the fracture was from low impact trauma, perhaps during repositioning and cares. R1 had profound osteoporosis, was frail, and believed R21's current life expectancy was to be less than 6 months. The physician note further indicated based on R21's overall health, would treat the fracture as with her last two fractures with comfort based approach, increase scheduled narcotics, and consult physical therapy (PT) for a protective knee brace. R21's Live Event dated 5/12/21, indicated R21 had been expressing severe pain during repositioning especially in knees starting on 5/7/21. An X-ray was ordered on 5/10/21, and the results were received 5/12/21. R21's physician ordered an increase in pain medications, and PT to assess for a brace to immobilize the right knee. On 5/26/21, at 9:35 a.m. nursing assistant (NA)-A stated during morning cares on 5/10/21, R21 began to holler out in pain like she had never heard before. NA-A stated she had given R21 a bed bath the previous day and R21 did not complain of any pain. NA-A stated during morning report on 5/10/21, the previous shift reported R21 complained of in her leg and thought it may have been a result of not having her pillows in proper placement and R21's knees bumping against the bedrails. NA-A stated R21 was to have lambs wool around her bedrails for padding and protection, and the lambs wool was never put back on when R21 got her new bed. NA-A verified R21's care sheet did not indicate R21 was prone to fractures or interventions to prevent	F 656	(POC) of residents with a significant event with each MDS assessment/Care Conference window to assure their POC had been updated per Care Planning Policy at the time(s) of significant event(s). The monitoring will take place for six months, and if 100% compliance is achieved, we will discontinue monitoring. Monitoring will be reported quarterly to Quality Improvement/Peer Review for the duration of the monitor.	

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possible further fractures during cares and repositioning.

On 5/27/21, at 12:28 p.m. PT-A stated she assessed and treated R21 for a knee brace after a right knee fracture. PT-A stated R21's knees were contracted, had severe osteoporosis, and had a history of fractures without an traumatic event. PT-A further stated R21 was fragile, and there was no indication R21's right knee fracture was a result from a fall or injury.

On 05/27/21, at 3:23 p.m. RN-A stated R21 had osteoporosis, bones were fragile, and had a history of fractures from low impact. RN-A stated R21 had been complaining of knee pain, had an x-ray and results revealed R21 had a fracture above the right knee. RN-A stated R21's primary physician note indicated R21's fracture could have occurred during repositioning and cares due to her osteoporosis and fragility. R21 stated staff were not educated on R21's risk for fractures and or interventions to prevent further possible fractures from occurring. RN-A verified R21's care plan and care guide did not include R1's risk for fractures during cares or interventions to prevent further fractures while caring for R21.

On 5/27/21, at 4:58 p.m. the director of nursing (DON) stated R21 had fragile bones and had a history of fractures without signs of a traumatic event. The DON stated R21's care plan and care guide should include R21's risk for fractures, and direct staff to have more of a gentle approach during cares due to R21's condition.

A policy on care planning was requested, but not provided.

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F 684	Continued From page 13	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reassess the need for positioning support for 1 of 1 resident (R6) reviewed for positioning. Finding include: R6's diagnoses included hypertension, anxiety, depression, and dementia. R6's quarterly Minimum Data Set (MDS) dated 3/9/21, indicated R6 had severe impaired cognition, required extensive assist with bed mobility, transfers, and had no range of motion impairment. R6's care plan printed 5/27/21, indicated R6 had impaired mobility related to the need for mobility monitoring, assistance related to dementia with psychosis, and had recovered largely from falls and "leaning". R6's functional mobility indicated R6 would not cooperate with physical therapy (PT) or nursing rehab. R6's care plan for pain indicated R6 had scoliosis of the back, which had no impact on functioning activities of daily living	F 684	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 conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with 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 Plan 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	7/20/21

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F 684	Continued From page 14 (ADLs), mobility, or cognitive effects. R6's care guide printed 5/25/21, lacked information about R6's positioning needs of leaning to the left or the use of a pillow for support when R6 was observed leaning. PT note dated 3/9/21, indicated PT-A saw R6 for spinal mobility, and was observed leaning into the right of the armrest. PT-A recommended a pillow on R6's right side when sitting to support her lean. PT note dated 3/15/17, indicated R6 continued to lean to the right, and PT-A reminded staff to position a pillow under R6's right arm. On 5/24/21, at 3:07 p.m. R6 was observed sitting in a stationary chair in her room leaning significantly to the left. On 5/24/21, at 5:04 p.m. R6 was observed sitting in a chair in the dining room leaning to the left with a small square decorative pillow propped underneath R6's left arm. On 5/24/21, at 5:49 p.m. R6 was continued to lean to the left while attempting to eat supper. On 5/26/21, at 9:14 a.m. R6 was observed sitting in a stationary chair in her room in front of the television, leaning to the left, with no support cushion in place. On 5/26/21, at 10:27 a.m. R6 was observed sitting in a stationary chair in her room leaning to the left. A cushion was observed on the left arm of the chair, and a triangle wedge cushion was observed on R6's left side.	F 684	the Nursing Assistants. Each resident is reviewed once in every two week time period. An official facility correspondence was sent out to all nursing assistants and nurses on June 28, 2021 asking for input on any recent changes in functional needs in residents that have not yet been assessed, and to email Resident Assessment Coordinator with information by July 2, 2021. Any resident identified will have a Rehab Assessment performed and Physical Therapy referrals will be made accordingly. A policy will be created to outline the procedure for obtaining a Physical Therapy evaluation for a resident with a change of function by July 20, 2021. The Nursing Assistants will be provided education on North Shore Health□s positioning policy during the Nursing Assistant Meetings on July 7, 2021 and July 8, 2021. The Director of Nursing or designee will audit two residents per week for positioning in compliance with their Plan of Care for one month and will then audit one resident per week for another month. The Director of Nursing or designee will also monitor the Plans of Care of residents with a functional change quarterly with each MDS assessment/Care Conference window to assure their POC had been updated per Care Planning Policy for a change in function and positioning needs. The monitoring will take place for six months,	

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F 684	Continued From page 15 On 5/27/21, at 10:17 a.m. nursing assistant (NA)-A stated R6 had a cushion on the right side of her armchair for support, and a wedge cushion to help keep her sit straight up. NA-A stated R6's care guide did not address R6's positioning needs or direct staff to place a wedge cushion for support when R6 was leaning. NA-A was unsure where the support devices came from. On 5/27/21, at 12:05 p.m. physical therapist (PT)-A stated R6 had significant scoliosis and was seen on 3/9/17, for spinal mobility and assessed for a walker. PT-A stated R6 was non compliant with therapy sessions and refused to use the walker. PT-A reviewed R6's therapy notes, and stated PT-A's notes from 3/9/17, and 3/15/17, identified R6 leaned to the right, and recommended a pillow to be placed on R6's right side when sitting to support her lean. PT-A stated she did not order a wedge pillow for R6 for positioning, and further stated she was unaware R6 was leaning to the left while sitting. PT-A verified R6 had not been seen by therapy since 6/16/17, and there were no recent referrals to see R6 for positioning. On 5/27/21, at 12:42 p.m. licensed practical nurse (LPN)-A stated R6 tended to lean on days R6 was tired. LPN-A stated staff would lay R6 down or place a pillow under her left arm to help with her positioning. LPN-A stated she was not aware R6 had a wedge cushion used for positioning. LPN-A went into R6's room and observed a wedge cushion along R6's left side. LPN-A stated the wedge cushion must have been new. On 5/27/21, at 3:41 p.m. registered nurse (RN)-A	F 684	and if 100% compliance is achieved the monitoring will be discontinued. Monitoring will be reported quarterly to QI/Peer Review.	

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F 684	Continued From page 16 was unsure when RN-A was assessed last for positioning. RN-A stated R6 had scoliosis 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 nurse to assess the resident, notify physician if warranted, 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 in consultation with the physical therapy department. Effectiveness, or lack of it, in maintaining a desired position is reviewed and updated as necessary but at least quarterly.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		7/20/21

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F 688	Continued From page 17 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a restorative program was implemented, reassessed, and revised to meet resident needs to maintain or improve range of motion (ROM) and functional mobility for 1 of 4 residents (R17) reviewed for restorative programs. Findings include: R17's annual Minimum Data Set (MDS) assessment dated 3/17/21, indicated R17 had a moderate cognitive impairment, had no rejection of care behaviors during the assessment period, required extensive assist of one staff for transfers and ambulation in her room, and did not walk in the hallway. R17's comprehensive assessment indicated R17 had a ROM deficit of upper and lower extremities on one side of the body, and did not participate in a restorative program such as for ROM or ambulation during the assessment period. R17's Care Area Assessment (CAA) for Activities of Daily Living (ADL) Functional/Rehabilitation Potential indicated R17 had a history of bilateral total knee arthroplasties, rotator cuff surgeries	F 688	F688 Increase/Prevent Decrease in ROM/Mobility 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 deficiencies. This Plan of Correction is prepared and/or 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. On June 28, 2021, R17 was reassessed by the Resident Care Manger for rehabilitative needs and a request for a Physical Therapy referral was made to her Primary Physician. The Director of Nursing or designee will review all 37 residents□ Plans of Care and charting to assess that their current nursing rehab programs are appropriate for their status by July 20, 2021.	

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F 688	Continued From page 18 and Parkinson's, and required assistance with mobility. R17's CAA indicated R17 had a restorative program that included using the NuStep Arms, level 3 for 10 to 20 minutes, walk with front-wheeled walker (FWW) in her room to dining room with contact guard assist of one with the wheelchair to follow, for 40-80 feet, as tolerated. R17's care plan initiated 4/26/18, indicated R17 had impaired mobility and directed staff for R17 to complete the NuStep (exercise machine that helps strengthen muscles around joints, build bone strength, increase ROM, reduce pain and stiffness) arms program for 10 to 20 minutes, a walking rehab program with her FWW to the dining room with contact guard assist of one for 40-80 feet, distance as tolerated. R17's physical therapy discharge summary dated 6/1/18, indicated R17 was able to ambulate with one contact guard assist and wheeled walker for 200 feet. R17's Care Guide sheet dated 4/8/21, indicated R17 had a nursing rehabilitation program and directed staff to have resident walk with the FWW from her room to the dining room with contact guard assist of one with the wheelchair to follow 40-80 feet, distance as tolerated, and had a NuStep program. R17's physician progress note dated 4/21/21, indicated R17 was not ambulatory related to Parkinson's and significant 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	F 688	The Director of Nursing or designee will create a document outlining the procedure for obtaining a Physical Therapy evaluation for a resident with a change of function by July 20, 2021. The Nursing Assistants will be provided education on the implementation of the Nursing Rehab Programs and managing work flow during the Nursing Assistant Meetings on July 7, 2021 and July 8, 2021. The Director of Nursing or designee will audit resident participation and program suitability of four residents per week in their Nursing Rehab Programs for one month and will then audit two residents per week for another month. The Director of Nursing, or designee, will also monitor quarterly the Plans of Care of residents with a functional change with each MDS assessment/Care Conference window to assure their Plan of Care had been updated per Care Planning Policy for a change in function and rehab program needs. The monitor will take place for six months, and if 100% compliance is achieved, the monitoring will be discontinued. The results of the monitor will be reported quarterly to QI/Peer Review.	

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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 or syndrome). R17's H&P indicated R17 was very ambulatory due to Parkinson's and significant osteoarthritis.

R17's physical therapy note dated 3/20/19, indicated R17 had been refusing to walk for the previous week due to severe leg and knee pain. R17 walked approximately 30 feet with therapy at that time. R17's progress note indicated the physician had been working on pain management for R17, and PT documented that there was nothing further PT could offer.

R17's restorative walking documentation dated 1/2020 through 12/2020, indicated the following:
1/2020: R17 ambulated 5 days and refused 3 days out of 31 possible opportunities.
2/2020: R17 ambulated 6 days, and refused 6 days out of 29 possible opportunities.
3/2020: R17 ambulated 22 days, and refused 8 days out of 31 possible opportunities.
4/2020: R17 ambulated 7 days and refused 6 days out of 30 possible opportunities.
5/2020: R17 walked 10 days and refused one day out of 31 potential opportunities.
6/2020: R17 walked 6 days and refused none out of 30 potential opportunities.
7/2020: R17 walked 3 days and refused none out

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of 31 potential opportunities.
8/2020: R17 walked 2 days and refused 3 days out of 31 potential opportunities.
9/2020: R17 walked 2 days and refused 2 days out of 30 potential opportunities.
10/2020: R17 walked 3 days and refused 1 day out of 31 potential opportunities.
11/2020: R17 walked no days and refused none out of 30 potential opportunities.
12/2020: R17 walked no days and refused 2 days out of 31 potential opportunities.

R17's restorative documentation for her NuStep program, indicated the following:
1/2020: R17 did the NuStep 5 days and refused 3 days out of 31 potential opportunities.
2/2020: R17 did the NuStep 1 day and refused 6 days out of 29 potential opportunities.
3/2020: R17 did the NuStep no days and refused 7 days out of 31 potential opportunities.
4/2020: R17 did the NuStep 3 days and refused 4 days out of 30 potential opportunities.
5/2020: R17 did the NuStep 4 days and refused 1 day out of 31 potential opportunities.
6/2020: R17 did the NuStep 3 days and refused none out of 30 potential opportunities.
7/2020: R17 did the NuStep 1 day and refused 1 day out of 31 potential opportunities.
8/2020: R17 did the NuStep 2 days and refused 1 day out of 31 potential opportunities.
9/2020: R17 did the NuStep 1 day and refused none out of 31 potential opportunities.
10/2020: R17 had no documented days of participation or refusals out of 31 potential opportunities..
11/2020: R17 had no documented days of participation or refusals out of 30 potential opportunities..
12/2020: R17 refused the NuStep 2 days and

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had no documented refusals out of 31 potential opportunities.
R17's documentation had several "no's" without a reason for non-participation.

R17's medical record lacked restorative documentation for 1/2021 through 5/2021.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 2/15/21, indicated R17 had been ambulating less, and was using the stand-assist lift more frequently for trips to the bathroom.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 3/23/21, indicated R17 was rarely ambulating, and was using the stand-assist lift for trips to the bathroom per resident preference.

R17's care conference review progress note dated 4/7/21, indicated R17 was not walking. R17's progress note lacked documentation regarding R17's lack of participation and change in status regarding restorative programs as care planned.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 4/19/21, indicated R17 was rarely ambulating, and was using the stand-assist lift for trips to the bathroom per resident preference.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 5/16/21, indicated R17 was rarely walking, and used the stand-assist lift for trips to the bathroom per her preference.

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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.

On 5/25/21, at 9:32 a.m. R17 stated she had difficulty moving her left arm, and said it was from falling in the past. R17 stated she did not get any exercises and said staff walked with her side-by-side. R17 said she should walk more.

On 5/27/21, at 10:00 a.m. registered nurse (RN)-A stated R17 did not do her programs due to her knees being so bad, and tremors from Parkinson's. RN-A stated R17 tried to walk, but used the stand-assist lift, and thought she could maybe go back to therapy. RN-A stated R17 is dressed by staff and did not complain about her shoulder hurting her. RN-A stated they do not have a restorative aide at this time, so the nursing assistants have to do the restorative programs or ROM.

On 5/27/21, at 10:16 a.m. nursing assistant (NA)-B stated R17 had not walked for awhile, and was using the stand-assist lift more. NA-B stated if a resident was on a restorative program and was unable to participate, she would report it to the charge nurse.

On 5/27/21, at 10:20 a.m. R17 was sitting in her easy chair in her room and stated she could not walk alone; only when staff were there with her. R17 stated her arms were stiff and she was unable to reach her phone half the time.

On 5/27/21, at 11:28 a.m. registered nurse (RN)-A stated R17 used to walk, but has had a

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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, who would then document the resident's refusal. Physical therapy was to be asked to consult if a resident consistently refused or there was a change in functional status.

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F 690	Continued From page 24	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		7/8/21

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F 690	Continued From page 25 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 hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body). R4's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R4 was cognitively intact, required extensive assistance with transfers and toilet use. In addition R4's MDS indicated occasional incontinence with bladder and always continent of bowel. R4's care area assessment (CAA) for assessment of activities of daily living functional/rehabilitation potential dated 12/8/20, indicated R4 required stand by assist of one with a two-wheeled walker. R4's CAA for urinary incontinence dated 12/8/20, indicated R4 had potential for functional incontinence due to weakness and assist of one to get to the bathroom, is also on diuretics for congestive heart failure. R4's care plan updated on 3/23/21, indicated R4 had impaired mobility related to weakness and an unsteady gait and required the assistance of one with a gait belt and two-wheeled walker for walking to the bathroom. R4's care plan further indicated R4 had altered elimination with the	F 690	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 deficiencies. This Plan of Correction is prepared and/or 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. On June 28, 2021 the Resident Care Manager updated R4□s Plan of Care and Care Card with a toileting schedule based on input from pharmacists related to time of onset of action for r4□s prescribed diuretics. Our data shows that during the look-back period for the quarter assessed when the surveyors were present, R4 maintained continence when toileted hourly when she rang her call light, so we will continue with hourly toileting for this resident. The Nursing Assistants will be provided education on toileting schedules and managing work flow at the Nursing Assistant Meetings on July 7, 2021 and July 8, 2021. The Director of Nursing or designee will review all continent residents to assess whether they have had any instances of incontinence by July 2, 2021. If any of those residents demonstrate episodes of	

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F 690	Continued From page 26 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. On 5/24/21, at 6:55 p.m. R4 was interviewed. R4 stated she was aware of when she needed to use the bathroom to urinate, but sometimes after she would take her lasix (furosemide) pill the staff wouldn't come right away and she would end up soaking through the pad, underwear, and clothing. R4 stated this would occur every couple of days and it made her feel bad and embarrassed. In addition R4 stated at night she would wear regular underwear with no need for a pad. 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." -at 1:34 p.m. registered nurse (RN)-B was interviewed. RN-B verified it would be a dignity	F 690	incontinence, a toileting schedule will be implemented. 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 designee will audit two residents per week for one month for continence and adherence to the toileting schedule and then audit one resident per week for one month. Resident Care Manager will also monitor charting weekly for two months, biweekly for a month, and monthly for three months. If all identified residents continue or improve their continence, the monitor will be discontinued. The results of this monitor will be reported to Quality Improvement/Peer Review quarterly for the duration of the monitor.	

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	245384	A. BUILDING _____ B. WING _____	C 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

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F 690	Continued From page 27	F 690		

issue if someone who is continent of bladder was incontinent because staff couldn't get there in time to assist them to the bathroom. RN-B verified residents who are on diuretics might need to be assisted to the bathroom on a schedule to avoid bladder accidents.

On 5/27/21, at 11:49 a.m. NA-E was interviewed. NA-E stated R4 was continent of urine unless staff were unable to answer her light right away. NA-E thought R4 had about three accidents a week because of this. NA-E stated it made R4 feel bad and she would apologize to staff after an incontinence accident.

-at 11:54 a.m. licensed practical nurse (LPN)-A was interviewed. LPN-A stated R4 would be incontinent of urine if staff did not answer her light promptly. LPN-A verified this embarrassed R4 when this occurred. LPN-A stated they had not tried any type of scheduled voiding after R4 receives lasix.

-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 able to answer her call light.

-at 1:05 p.m. the director of nursing (DON) was interviewed. The DON verified residents who are continent of bladder should not be having bladder accidents.

The facility policy Assessment, Comprehensive

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F 690	Continued From page 28 Bowel and Bladder last approved 3/2/17, indicated the standard was to evaluate and identify individuals with reversible and irreversible causes of incontinence. The policy directed staff to review medications particularly those that might affect continence, need for type and frequency of physical assistance as necessary to assist the resident to access the toilet. In addition the policy indicated a schedule is maintained for regularity.	F 690		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations for 3 of 5 nursing assistants (NA-C, NA-F, NA-G)who had been employed by the facility for over one year. This had the potential to affect all 37 residents who resided in the facility. Findings include: An undated employee list provided by the facility indicated the following: NA-C's hire date was 2/17/20. No annual performance evaluation had been completed in 2020. NA-F's hire date was 8/25/17. No annual	F 730	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 conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. During the Department Leadership	7/20/21

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F 730	Continued From page 29 performance evaluation had been completed in 2020. NA-G's hire date was 3/31/20. No annual performance evaluation had been completed in 2020. On 5/27/21, at 3:37 p.m. the director of nursing (DON) was interviewed. The DON stated he had not completed performance evaluations for the the staff listed. The DON verified performance evaluations should be completed annually. The facility policy titled Performance Appraisals, last approved 4/29/21, indicated all employees will receive a performance appraisal on an annual basis.	F 730	meeting on July 13, 2021, the Director of Nursing and other Department Managers will receive education on the importance of performance reviews. On 6/21/21 the DON or designee identified all nursing assistants (NAs) that have not had an annual review for calendar year 2021. The Director of Nursing has begun to complete the outstanding NA annual reviews and all reviews will be completed by July 20, 2021. Going forward and working with Human Resources, the Director of Nursing or designee will, once a month, identify any NA that is due for an annual review in the next three months. The Director of Nursing or designee will complete the review by the end of next month. The Administrator will audit the content and completion of Nurse Aid performance reviews weekly for two months. Human Resources will then monitor quarterly any NA annual reviews that were not completed when due. This will be reported to QI/Peer Review quarterly. If 100% compliance is achieved, this monitor will be discontinued after two years.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		7/12/21

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F 812	Continued From page 30 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was followed for 8 of 20 residents (R23, R19, R11, R13, R30, R15, R28, and R17) observed during meal service on the Woods unit. Findings include: On 5/24/21, at 5:08 p.m. nursing assistant (NA)-C walked into the kitchen area on the Woods unit, and without washing or sanitizing hands, took silverware out of a drawer. - NA-C walked to a table to put cover-ups on two different residents, R23 and R19, then placed a cup in a food cart. - NA-C returned to the meal service cart with the clean trays, took a tray from the cart and set it down in front of R11, uncovered R11's food and opened up the crackers, removed the cover from the mug and moved the cup to the center, top of the tray. NA-C took some more cover ups and placed one on R11, and offered one to other residents sitting at tables in the dining room. -NA-C returned to the meal tray cart, removed a	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 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 deficiencies. This Plan of Correction is prepared and/or 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. On June 24, 2021 the Dietary Manager updated the policy Hand washing, Dietary to include a clear directive on when hand hygiene should be performed. The Infection Control Nurse or designee will provide hand washing education and return demonstrations for each employee of the Care Center, Dietary,	

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F 812	Continued From page 31 tray from the cart and handed it to another staff to deliver to R13. -NA-C took the meal tray cart down the 400 hallway, removed a tray from the cart and delivered it to R30, and set it on the tray table, put a cover-up on R30, moved the tray table in front of R30, removed covers and opened food packages, buttered R30's corn bread, lifted the milk glass and mugs by the top of the glass and mugs where R30 would drink from, and moved them on the tray for R30. NA-C exited R30's room, pulled the stop sign across the doorway and fastened it. -NA-C returned to the meal tray cart, removed a tray and brought it into R15's room, put a cover-up on R15, opened the corn bread, buttered it, opened crackers, moved a tissue box to the tray table, moved R15's mugs. -NA-C returned to the meal tray cart, removed a tray and entered R17's room after opening the stop sign. NA-C moved the items on R17's tray table, placed the meal tray on the tray table, put a bag in R17's refrigerator, assisted R17 to pick up her feet, moved the tray table in front of her, and then 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	F 812	Housekeeping, and Activity Departments. In addition to the return demonstration, education will be given about when hand hygiene is to be performed, including during food service. This will be completed by July 12, 2021. The Director of Nursing or designee will monitor meal services for evidence of proper hand washing by staff in between resident encounters. This monitor will start July 5, 2021. Monitor will be one breakfast, one dinner, and one supper in each Household each week for four weeks. Then one meal per Household per week for four weeks will be monitored. If 100% compliance is achieved, monitor will be discontinued. The results of the monitor will be reported to Quality Improvement /Peer Review quarterly for the duration of the monitor.	

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F 812	Continued From page 32 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, but lacked directives for when hand hygiene should be done. The facility policy Handwashing Protocol revised 7/20, directed staff to perform hand hygiene between patient contacts.	F 812		

DEPARTMENT OF HEALTH

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: O83011

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00080	A. BUILDING: _____ B. WING _____	C 05/28/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/24/21, through 5/28/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1	2 000		

these orders and identify the date when they will be completed.

The following complaints were found to be UNSUBSTANTIATED:

H5384025C (MN67784)
H5384026C (MN72739)
H5384027C (MN68330)
H5384029C (MN72732)

The following complaint was found to be UNSUBSTANTIATED:
H5384028C (MN72774), however, a related licensing order was issued at (S0565).

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by:	2 285		7/20/21

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2 285	Continued From page 3 Based on interview and document review, the facility failed to complete annual performance evaluations for 3 of 5 nursing assistants (NA-C, NA-F, NA-G)who had been employed by the facility for over one year. This had the potential to affect all 37 residents who resided in the facility. Findings include: An undated employee list provided by the facility indicated the following: NA-C's hire date was 2/17/20. No annual performance evaluation had been completed in 2020. NA-F's hire date was 8/25/17. No annual performance evaluation had been completed in 2020. NA-G's hire date was 3/31/20. No annual performance evaluation had been completed in 2020. On 5/27/21, at 3:37 p.m. the director of nursing (DON) was interviewed. The DON stated he had not completed performance evaluations for the the staff listed. The DON verified performance evaluations should be completed annually. The facility policy titled Performance Appraisals, last approved 4/29/21, indicated all employees will receive a performance appraisal on an annual basis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), human resources director, administrator, or designee could develop, review, and/or revise policies and procedures related to performance reviews. The DON or designee could educate all appropriate staff on the policies and procedures.	2 285	Corrected	

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2 285	Continued From page 4 The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan to include risk factors and interventions following a fracture for 1 of 1 resident (R21) reviewed for injuries of unknown origin. Findings include: R21's diagnoses included age related osteoporosis, chronic obstructive pulmonary disease (COPD), left femur fracture, heart failure, dementia, and right knee fracture. R21's quarterly Minimum Data Set (MDS) dated 4/6/21, indicated R21 was dependent on staff with transfers, required extensive assist with bed mobility, dressing, toileting, personal hygiene, and had lower extremity impairment. R21's care plan initiated 1/14/20, indicated R21	2 565	Corrected	7/20/21

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2 565	Continued From page 5	2 565		

had impaired mobility related to right cerebrovascular accident (CVA) (stroke) with high muscle tone and contracture's in knees. R21 had a new right knee fracture, and to keep left knee flexed at 90 degrees with padding with pillows. R21's care plan indicated R21 required assistance with bed mobility, directed staff to turn and reposition every two hours, did not ambulate, and required a Hoyer lift (an assistive device used to help with transfers). R21's care plan further indicated R21 had a healed pelvis and left knee fracture, and right knee fracture which required a knee brace for support. R21's care plan lacks risk factors which put R21 at risk for fractures and interventions to prevent further fractures.

R21's progress note dated 5/6/21, indicated R21 winced and cried out during cares and repositioning.

R21's progress note dated 5/7/21, indicated R21 reported her knees hurt.

R21's progress note dated 5/9/21, indicated R21 continued to complain of excessive pain in bilateral legs/knees with movement and positioning.

R21's Consulting Radiologist report of the right knee dated 5/10/21, indicated findings included a comminuted fracture (broken bone in more than two pieces) of the distal femoral meta diaphysis (above the right knee).

R21's physician note dated 5/12/21, indicated R 21 was found to have a right knee fracture and previously had a left knee fracture last year. R21 had no falls and was presumed the fracture was from low impact trauma, perhaps during repositioning and cares. R1 had profound

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2 565	Continued From page 6	2 565		

osteoporosis, was frail, and believed R21's current life expectancy was to be less than 6 months. The physician note further indicated based on R21's overall health, would treat the fracture as with her last two fractures with comfort based approach, increase scheduled narcotics, and consult physical therapy (PT) for a protective knee brace.

R21's Live Event dated 5/12/21, indicated R21 had been expressing severe pain during repositioning especially in knees starting on 5/7/21. An X-ray was ordered on 5/10/21, and the results were received 5/12/21. R21's physician ordered an increase in pain medications, and PT to assess for a brace to immobilize the right knee.

On 5/26/21, at 9:35 a.m. nursing assistant (NA)-A stated during morning cares on 5/10/21, R21 began to holler out in pain like she had never heard before. NA-A stated she had given R21 a bed bath the previous day and R21 did not complain of any pain. NA-A stated during morning report on 5/10/21, the previous shift reported R21 complained of in her leg and thought it may have been a result of not having her pillows in proper placement and R21's knees bumping against the bedrails. NA-A stated R21 was to have lambs wool around her bedrails for padding and protection, and the lambs wool was never put back on when R21 got her new bed. NA-A verified R21's care sheet did not indicate R21 was prone to fractures or interventions to prevent possible further fractures during cares and repositioning.

On 5/27/21, at 12:28 p.m. PT-A stated she assessed and treated R21 for a knee brace after a right knee fracture. PT-A stated R21's knees

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were contracted, had severe osteoporosis, and had a history of fractures without an traumatic event. PT-A further stated R21 was fragile, and there was no indication R21's right knee fracture was a result from a fall or injury.

On 05/27/21, at 3:23 p.m. RN-A stated R21 had osteoporosis, bones were fragile, and had a history of fractures from low impact. RN-A stated R21 had been complaining of knee pain, had an x-ray and results revealed R21 had a fracture above the right knee. RN-A stated R21's primary physician note indicated R21's fracture could have occurred during repositioning and cares due to her osteoporosis and fragility. R21 stated staff were not educated on R21's risk for fractures and or interventions to prevent further possible fractures from occurring. RN-A verified R21's care plan and care guide did not include R1's risk for fractures during cares or interventions to prevent further fractures while caring for R21.

On 5/27/21, at 4:58 p.m. the director of nursing (DON) stated R21 had fragile bones and had a history of fractures without signs of a traumatic event. The DON stated R21's care plan and care guide should include R21's risk for fractures, and direct staff to have more of a gentle approach during cares due to R21's condition.

A policy on care planning was requested, but not provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to comprehensive care planning.
The DON or designee could educate all appropriate staff on the policies and procedures.

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2 565	Continued From page 8 The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: 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 hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body). R4's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R4 was cognitively intact, required extensive assistance with transfers and toilet use. In addition R4's MDS indicated occasional incontinence with bladder and always	2 835	Corrected	7/8/21

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2 835	Continued From page 9 continent of bowel. R4's care area assessment (CAA) for assessment of activities of daily living functional/rehabilitation potential dated 12/8/20, indicated R4 required stand by assist of one with a two-wheeled walker. R4's CAA for urinary incontinence dated 12/8/20, indicated R4 had potential for functional incontinence due to weakness and assist of one to get to the bathroom, is also on diuretics for congestive heart failure. R4's care plan updated on 3/23/21, indicated R4 had impaired mobility related to weakness and an unsteady gait and required the assistance of one with a gait belt and two-wheeled walker for walking to the bathroom. R4's care plan further indicated R4 had altered elimination with the 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. On 5/24/21, at 6:55 p.m. R4 was interviewed. R4 stated she was aware of when she needed to use	2 835		

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2 835	Continued From page 10	2 835		

the bathroom to urinate, but sometimes after she would take her lasix (furosemide) pill the staff wouldn't come right away and she would end up soaking through the pad, underwear, and clothing. R4 stated this would occur every couple of days and it made her feel bad and embarrassed. In addition R4 stated at night she would wear regular underwear with no need for a pad.

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."

-at 1:34 p.m. registered nurse (RN)-B was interviewed. RN-B verified it would be a dignity issue if someone who is continent of bladder was incontinent because staff couldn't get there in time to assist them to the bathroom. RN-B verified residents who are on diuretics might need to be assisted to the bathroom on a schedule to avoid bladder accidents.

On 5/27/21, at 11:49 a.m. NA-E was interviewed. NA-E stated R4 was continent of urine unless staff were unable to answer her light right away. NA-E thought R4 had about three accidents a week because of this. NA-E stated it made R4 feel bad and she would apologize to staff after an incontinence accident.

-at 11:54 a.m. licensed practical nurse (LPN)-A was interviewed. LPN-A stated R4 would be incontinent of urine if staff did not answer her light promptly. LPN-A verified this embarrassed R4 when this occurred. LPN-A stated they had not tried any type of scheduled voiding after R4 receives lasix.

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2 835	Continued From page 11 -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 able to answer her call light. -at 1:05 p.m. the director of nursing (DON) was interviewed. The DON verified residents who are continent of bladder should not be having bladder accidents. The facility policy Assessment, Comprehensive Bowel and Bladder last approved 3/2/17, indicated the standard was to evaluate and identify individuals with reversible and irreversible causes of incontinence. The policy directed staff to review medications particularly those that might affect continence, need for type and frequency of physical assistance as necessary to assist the resident to access the toilet. In addition the policy indicated a schedule is maintained for regularity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to development of bowel and bladder programs to maintain continence . The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		

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2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a restorative program was implemented, reassessed, and revised to meet resident needs to maintain or improve range of motion (ROM) and functional mobility for 1 of 4 residents (R17) reviewed for restorative programs. Findings include: R17's annual Minimum Data Set (MDS) assessment dated 3/17/21, indicated R17 had a moderate cognitive impairment, had no rejection of care behaviors during the assessment period, required extensive assist of one staff for transfers and ambulation in her room, and did not walk in the hallway. R17's comprehensive assessment indicated R17 had a ROM deficit of upper and	2 890	Corrected	7/20/21

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2 890	Continued From page 13 lower extremities on one side of the body, and did not participate in a restorative program such as for ROM or ambulation during the assessment period. R17's Care Area Assessment (CAA) for Activities of Daily Living (ADL) Functional/Rehabilitation Potential indicated R17 had a history of bilateral total knee arthroplasties, rotator cuff surgeries and Parkinson's, and required assistance with mobility. R17's CAA indicated R17 had a restorative program that included using the NuStep Arms, level 3 for 10 to 20 minutes, walk with front-wheeled walker (FWW) in her room to dining room with contact guard assist of one with the wheelchair to follow, for 40-80 feet, as tolerated. R17's care plan initiated 4/26/18, indicated R17 had impaired mobility and directed staff for R17 to complete the NuStep (exercise machine that helps strengthen muscles around joints, build bone strength, increase ROM, reduce pain and stiffness) arms program for 10 to 20 minutes, a walking rehab program with her FWW to the dining room with contact guard assist of one for 40-80 feet, distance as tolerated. R17's physical therapy discharge summary dated 6/1/18, indicated R17 was able to ambulate with one contact guard assist and wheeled walker for 200 feet. R17's Care Guide sheet dated 4/8/21, indicated R17 had a nursing rehabilitation program and directed staff to have resident walk with the FWW from her room to the dining room with contact guard assist of one with the wheelchair to follow 40-80 feet, distance as tolerated, and had a NuStep program.	2 890		

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2 890	Continued From page 14 R17's physician progress note dated 4/21/21, indicated R17 was not ambulatory related to Parkinson's and significant 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 or syndrome). R17's H&P indicated R17 was very ambulatory due to Parkinson's and significant osteoarthritis. R17's physical therapy note dated 3/20/19, indicated R17 had been refusing to walk for the previous week due to severe leg and knee pain. R17 walked approximately 30 feet with therapy at that time. R17's progress note indicated the physician had been working on pain management for R17, and PT documented that there was nothing further PT could offer. R17's restorative walking documentation dated 1/2020 through 12/2020, indicated the following: 1/2020: R17 ambulated 5 days and refused 3 days out of 31 possible opportunities. 2/2020: R17 ambulated 6 days, and refused 6 days out of 29 possible opportunities. 3/2020: R17 ambulated 22 days, and refused 8 days out of 31 possible opportunities.	2 890		

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2 890	Continued From page 15 4/2020: R17 ambulated 7 days and refused 6 days out of 30 possible opportunities. 5/2020: R17 walked 10 days and refused one day out of 31 potential opportunities. 6/2020: R17 walked 6 days and refused none out of 30 potential opportunities. 7/2020: R17 walked 3 days and refused none out of 31 potential opportunities. 8/2020: R17 walked 2 days and refused 3 days out of 31 potential opportunities. 9/2020: R17 walked 2 days and refused 2 days out of 30 potential opportunities. 10/2020: R17 walked 3 days and refused 1 day out of 31 potential opportunities. 11/2020: R17 walked no days and refused none out of 30 potential opportunities. 12/2020: R17 walked no days and refused 2 days out of 31 potential opportunities. R17's restorative documentation for her NuStep program, indicated the following: 1/2020: R17 did the NuStep 5 days and refused 3 days out of 31 potential opportunities. 2/2020: R17 did the NuStep 1 day and refused 6 days out of 29 potential opportunities. 3/2020: R17 did the NuStep no days and refused 7 days out of 31 potential opportunities. 4/2020: R17 did the NuStep 3 days and refused 4 days out of 30 potential opportunities. 5/2020: R17 did the NuStep 4 days and refused 1 day out of 31 potential opportunities. 6/2020: R17 did the NuStep 3 days and refused none out of 30 potential opportunities. 7/2020: R17 did the NuStep 1 day and refused 1 day out of 31 potential opportunities. 8/2020: R17 did the NuStep 2 days and refused 1 day out of 31 potential opportunities. 9/2020: R17 did the NuStep 1 day and refused none out of 31 potential opportunities. 10/2020: R17 had no documented days of	2 890		

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participation or refusals out of 31 potential opportunities..
11/2020: R17 had no documented days of participation or refusals out of 30 potential opportunities..
12/2020: R17 refused the NuStep 2 days and had no documented refusals out of 31 potential opportunities.
R17's documentation had several "no's" without a reason for non-participation.

R17's medical record lacked restorative documentation for 1/2021 through 5/2021.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 2/15/21, indicated R17 had been ambulating less, and was using the stand-assist lift more frequently for trips to the bathroom.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 3/23/21, indicated R17 was rarely ambulating, and was using the stand-assist lift for trips to the bathroom per resident preference.

R17's care conference review progress note dated 4/7/21, indicated R17 was not walking. R17's progress note lacked documentation regarding R17's lack of participation and change in status regarding restorative programs as care planned.

R17's Rounds Review progress notes regarding nursing rehabilitation dated 4/19/21, indicated R17 was rarely ambulating, and was using the stand-assist lift for trips to the bathroom per resident preference.

R17's Rounds Review progress notes regarding

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2 890	Continued From page 17	2 890		

nursing rehabilitation dated 5/16/21, indicated R17 was rarely walking, and used the stand-assist lift for trips to the bathroom per her preference.

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.

On 5/25/21, at 9:32 a.m. R17 stated she had difficulty moving her left arm, and said it was from falling in the past. R17 stated she did not get any exercises and said staff walked with her side-by-side. R17 said she should walk more.

On 5/27/21, at 10:00 a.m. registered nurse (RN)-A stated R17 did not do her programs due to her knees being so bad, and tremors from Parkinson's. RN-A stated R17 tried to walk, but used the stand-assist lift, and thought she could maybe go back to therapy. RN-A stated R17 is dressed by staff and did not complain about her shoulder hurting her. RN-A stated they do not have a restorative aide at this time, so the nursing assistants have to do the restorative programs or ROM.

On 5/27/21, at 10:16 a.m. nursing assistant (NA)-B stated R17 had not walked for awhile, and was using the stand-assist lift more. NA-B stated if a resident was on a restorative program and was unable to participate, she would report it to the charge nurse.

On 5/27/21, at 10:20 a.m. R17 was sitting in her easy chair in her room and stated she could not walk alone; only when staff were there with her. R17 stated her arms were stiff and she was

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2 890	Continued From page 18 unable to reach her phone half the time. On 5/27/21, at 11:28 a.m. registered nurse (RN)-A stated R17 used to walk, but has had a 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, who would then document the resident's refusal. Physical therapy was to be asked to consult if a resident	2 890		

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2 890	Continued From page 19 consistently refused or there was a change in functional status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to assessments, re-evaluation and care plan revision for restorative programs. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was followed for 8 of 20 residents (R23, R19, R11, R13, R30, R15, R28, and R17) observed during meal service on the Woods unit. Findings include:	21000	Corrected	7/12/21

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21000	Continued From page 20 On 5/24/21, at 5:08 p.m. nursing assistant (NA)-C walked into the kitchen area on the Woods unit, and without washing or sanitizing hands, took silverware out of a drawer. - NA-C walked to a table to put cover-ups on two different residents, R23 and R19, then placed a cup in a food cart. - NA-C returned to the meal service cart with the clean trays, took a tray from the cart and set it down in front of R11, uncovered R11's food and opened up the crackers, removed the cover from the mug and moved the cup to the center, top of the tray. NA-C took some more cover ups and placed one on R11, and offered one to other residents sitting at tables in the dining room. -NA-C returned to the meal tray cart, removed a tray from the cart and handed it to another staff to deliver to R13. -NA-C took the meal tray cart down the 400 hallway, removed a tray from the cart and delivered it to R30, and set it on the tray table, put a cover-up on R30, moved the tray table in front of R30, removed covers and opened food packages, buttered R30's corn bread, lifted the milk glass and mugs by the top of the glass and mugs where R30 would drink from, and moved them on the tray for R30. NA-C exited R30's room, pulled the stop sign across the doorway and fastened it. -NA-C returned to the meal tray cart, removed a tray and brought it into R15's room, put a cover-up on R15, opened the corn bread, buttered it, opened crackers, moved a tissue box to the tray table, moved R15's mugs. -NA-C returned to the meal tray cart, removed a tray and entered R17's room after opening the stop sign. NA-C moved the items on R17's tray table, placed the meal tray on the tray table, put a bag in R17's refrigerator, assisted R17 to pick up	21000		

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21000	Continued From page 21	21000		

her feet, moved the tray table in front of her, and then 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, but lacked directives for when 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 educate all appropriate staff on the policies and procedures.
The DON or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21830	Continued From page 22	21830		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:	21830		7/7/21

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(1) examining the personal effects of the resident;
(2) examining the medical records of the resident in the possession of the facility;
(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and
(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.
(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or

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21830	Continued From page 24 designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on low blood sugars and notify the physician for 1 of 5 residents (R22) reviewed for unnecessary medications. In addition, the facility failed to ensure a resident representative was notified following a fall for 1 of 4 residents (R16) reviewed for accidents. Findings include: R22's quarterly Minimum Data Set (MDS) dated 4/7/21, indicated R22 was cognitively intact, diagnoses included diabetes and renal insufficiency, and received insulin daily. R22's care plan indicated R22 was clinically monitored for diabetes and was monitored for appropriate self-administration of insulin. R22's care plan lacked parameters for notification of R22's physician of out lying blood glucose. R22's physician orders printed 5/27/21, included: -insulin glargine (Lantus-long acting insulin) 23 units subcutaneously twice daily -insulin human lispro (Humalog-short acting insulin) 5 units subcutaneously three times daily with meals	21830	Corrected	

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R22's physician progress notes dated 4/5/21, indicated R22's diagnoses included diabetes, and R22's blood sugars were elevated with an increasing hemoglobin A1C (a blood test that measures your average blood sugar levels over the past 3 months). R22's physician planned to add insulin at meal time.

R22's physician progress notes dated 5/5/21, indicated R22 had some low blood glucose related to increased insulin at meal time as ordered the previous month, so insulin dosing had been decreased in response to R22's low blood sugars and had not had any further low blood glucose at the time of the physician's visit on 5/5/21. R22's physician progress notes further noted that R22 was working on decreasing her intake and was happy with some weight loss.

R22's Blood Glucose Record between 4/6/21, and 5/5/21, after R22's increase in insulin at meals, indicated R22's morning blood glucose before breakfast ranged from 62 milligrams (mg)/deciliter (dl) to 167 mg/dl, with 5 occurrences of blood glucose values in the 60's, 2 in the 70's, and 8 in the 80's.

R22's progress notes dated 4/28/21, at 10:00 p.m. indicated R22 was shaking, sweating, and had numbness in her left leg and foot, was crying and had severe itchiness. R22's blood glucose was 57 mg/dl, and she was given a snack. No follow up blood glucose was documented.

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

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21830	Continued From page 26 daily on 4/29/21, due to some low blood glucose results. R22's Blood Glucose Record between 5/6/21 and 5/27/21, following a decrease in insulin dosing, indicated R22's blood glucose and the nursing response to blood glucose below 90 mg/dl: -5/6/21, at 7:35 a.m. : 65 mg/dl; R22 drank her "powders" with pills per her request. No follow up blood glucose was recorded. -5/14/21, at 6:32 a.m.: 64 mg/dl; R22 received 180 milliliters (ml) orange juice, no follow up was recorded -5/15/21, at 7:04 a.m. 59 mg/dl; no action taken, no follow up recorded -5/16/21, at 6:34 a.m.: 55 mg/dl: no action taken, no follow up recorded -5/18/21, at 7:45 a.m.; 66 mg/dl; no action taken, no follow up recorded -5/19/21, at 8:00 a.m.; 79 mg/dl: no action taken, no follow up recorded -5/20/21, at 7:35 a.m.; 77 mg/dl; no action taken, no follow up recorded -5/21/21, no blood glucose recorded -5/23/21, at 5:51 a.m.; 80 mg/dl; had 60 ml orange juice to hold her over until breakfast, no follow up recorded -5/24/21, at 5:58 a.m.; 52 mg/dl; drank 240 ml orange juice; follow up blood glucose recorded at 7:12 a.m. was 92 mg/dl -5/25/21, at 5:48 a.m.; 68 mg/dl; drank 240 ml of orange juice; follow up blood glucose recorded at 6:58 a.m. was 116 mg/dl. R22's progress notes dated 5/24/21, indicated R22's blood glucose was 52 mg/dl, drank 240 ml of orange juice and stated she did not eat dinner the night before. R22's follow up blood glucose was 92 mg/dl, and R22 was sleeping.	21830		

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R22's progress note dated 5/25/21, indicated R22's blood glucose was 68 mg/dl, R22 drank 240 ml orange juice and was asymptomatic, and said she did not eat much for dinner the night before. R22 had a follow up blood glucose of 116 mg/dl.

R22's progress notes dated 5/26/21, indicated R22's blood glucose was 59 mg/dl and drank 240 ml of orange juice, ate a piece of toast with butter, and 240 ml of milk. R22 was asymptomatic and could not remember what she had eaten for supper the previous night.

R22's progress notes lacked indication R22's physician had been notified of R22's continued pattern of low blood glucose.

On 5/27/21, at 9:44 am. registered nurse (RN)-B stated R22's parameters were to call the physician for a blood glucose greater than 200 mg/dl, but lacked parameters to call the physician for low blood glucose results. RN-B verified R22's physician had not been notified of R22's low blood glucose since the physician decreased R22's insulin on 4/29/21, due to low blood glucose. RN-B stated they give R22 something to eat or drink with low blood glucose results. RN-B verified R22's medical record lacked documentation of interventions and follow-up blood glucose for most occurrences of low blood glucose. RN-B further verified the physician would be unable to make appropriate decisions regarding diabetes and insulin management if the physician is not notified of R22's low or high blood glucose.

On 5/27/21, at 11:09 a.m. RN-A stated the expectation was to do a follow-up and intervention for low blood glucose. RN-A verified

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R22 had several low blood glucose without follow-up blood glucose. RN-A stated she would expect a follow-up blood glucose within an hour of the low blood glucose result. RN-A verified R22 would be at risk for a continued drop in blood glucose. RN-A verified it would be beneficial to notify the physician for better management of diabetes and insulin, and stated it was time to notify R22's physician.

The facility policyHypoglycemia reviewed 5/22, directed follow up blood glucose within 15 minutes if a blood glucose is below 60 mg/dl twice and had symptoms of hypoglycemia, and if a blood glucose is above 85 mg/dl, staff was to provide a snack of a complex carbohydrate. The facility policy lacked guidance for blood glucose between 60 and 85 mg/dl. The facility further lacked guidance when to notify a physician of continued low blood glucose.

R16's diagnoses include dementia, macular degeneration, legal blindness, and osteoarthritis.

R16's quarterly Minimum data Set (MDS) dated 3/17/21, indicated R16 had severe cognitive impairment, was independent in bed mobility, and required supervision with transfers, and ambulation.

R16's care plan initiated 4/18/16, indicated R16 had impaired mobility, was at risk for falls, independent with walker, and required hourly rounds for safety while in her room.

R16's Fall Scene Investigation (FSI) dated 5/16/21, indicated R16 was found on the floor in her room and had no apparent injury. R16's FSI further indicated, R16's representative was not notified of R16's fall.

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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.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to notification of change to physician and/or resident representative.
The DON or designee could educate all appropriate staff on the policies and procedures.
The DON or designee could develop monitoring

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21830	Continued From page 30 systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING **04 - NORTH SHORE HEALTH** 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 55604**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cook County Northshore Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

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

Electronically Signed | 07/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as one building: Cook County Northshore Hospital C & NC, is a 1-story building with no basement. The 100 and 400 wings of the facility were constructed in 2016 and was determined to be of Type II(111) construction. In 2017 the 200 and 300 wings were constructed to the building that were determined to be of Type II(111) construction. The 100,200,300, & 400 wings were constructed to replace the original facility and the plans for these wings were approved on 04/30/2015, prior to the	K 000		

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K 000	Continued From page 2 2012 code adoption and are considered to be of existing construction. The building is attached to a hospital and is properly separated by a 2 hour fire rated separation. The building is separated into 2 smoke compartments by a 1 hour fire rated smoke barrier. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. The facility has a capacity of 37 beds and had a census of 37 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has not maintained the fire alarm system testing and	K 345	K345 Preparation, submission and implementation of this Plan of Correction	6/21/21

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K 345	Continued From page 3 maintenance documentation in accordance with NFPA 72 National Fire Alarm Code 2010 edition, section 14.3.1. This deficient practice could affect 37 of 37 residents. Findings include: On 05/27/2021, at 10:30 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices. This deficient condition was confirmed by a Maintenance Supervisor.	K 345	does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. The visual inspection of the fire alarm initiating devices is conducted monthly. For the month of June 2021, the visual inspection was conducted on June 21, 2021. The information was and is up to date and in its own book per the Fire Marshall recommendations in 2018. We will continue to perform the monthly inspections of the fire alarm initiating devices which exceeds the minimum semiannual inspection. This information will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		5/28/21

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K 363	Continued From page 4 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide one corridor door with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 10 of the 37 residents.	K 363	K363 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory	

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K 363	Continued From page 5 Findings include: On 05/27/2021, at 12:45 a.m., observations revealed that the door to resident room 106 had a 1/4 inch gap between the door and the frame and the door did not fit tightly in the frame. It was also found that the door did not have any approved door gasket between the door and the frame to limit the transfer of smoke. This deficient condition was confirmed by a Maintenance Supervisor.	K 363	requirements and constitutes the facility□s allegation of compliance. The repair to the resident room 106 door was performed on 05/28/21 at 09:12am the strike was replaced and the door now meets the 1/8 or less requirement. The smoke gasket was present at the time of repair and in good working order. All remaining corridor doors were also reviewed on 05/28/21 and were in compliance. The Maintenance Department Manager or his designee will conduct a door inspection during the first week of each quarter (January, April, July, and October). This requirement will also be added to the building Preventive Maintenance software to provide a reminder for completion and a location for documentation of completion. The summary of the door inspections will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	