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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OBP5

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) **COOK CO NORTHSHORE HOSP & C&NC**
(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 **11/10/2014** (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:
B. Not in Compliance with Program Requirements
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X
Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Christine Campbell, HFE NEII — 09/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 012/19/2014 (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.
03001
(L31)

30. REMARKS
Posted 01/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/02/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5384

On November 10, 2014, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on October 14, 2014. We presumed, based on their plan of correction, that facility had corrected these deficiencies as of September 30, 2014. Based on our visit, we havedetermined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on October 14, 2014, as of October 31, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 31, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 17, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

-Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 21, 2014, be rescinded. (42 CFR 488.417 (b))

Since the facility attainedsubstantial compliance on October 31, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b for the results of this visit.

Effective October 31, 2014, the facility is certified for 37 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245384

January 25, 2015

Ms. Kimber Wraalstad, Administrator Administrator
Cook County Northshore Hosp & C&NC
515 - 5th Avenue West
Grand Marais, Minnesota 55604

Dear Ms. Wraalstad:

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

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

Effective October 31, 2014 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Health Regulations
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 21, 2014

Ms. Kimber Wraalstad, Administrator
Cook County Northshore Hospital & C&NC
515 - 5th Avenue West
Grand Marais, Minnesota 55604

RE: Project Number S5384024

Dear Ms. Wraalstad:

On October 17, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 22, 2014. (42 CFR 488.422)

On October 17, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 21, 2014. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of October 17, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 21, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on August 21, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 14, 2014. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 10, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on October 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on

October 14, 2014, as of October 31, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 31, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 17, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 21, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 21, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 21, 2014, is to be rescinded.

In our letter of October 17, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 21, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 31, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245384	A. Building B. Wing	11/10/2014

Name of Facility	Street Address, City, State, Zip Code
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0441 Reg. # 483.65 LSC	10/31/2014	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	10/31/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PLH/mm	Date: 11/21/2014	Signature of Surveyor: 13922	Date: 11/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/21/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00080	A. Building B. Wing	11/10/2014

Name of Facility	Street Address, City, State, Zip Code
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20255 Reg. # MN Rule 4658.0070 LSC	Correction Completed 10/31/2014	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 10/31/2014	ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. 4 A-I LSC	Correction Completed 10/31/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PLH/mm	Date: 11/21/2014	Signature of Surveyor: 13922	Date: 11/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/21/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OBP5

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) **COOK CO NORTHSHORE HOSP & C&NC**
(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 **10/14/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Christine Campbell, HFE NEII — 10/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 11/20/2014 (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.
03001
(L31)

30. REMARKS
Posted 11/25/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/02/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5384

On October 14, 2014 a Post Certification Revisit was completed and determined the facility had not corrected all deficiencie issued pururant to the August 21, 2014 standard survey. One deficiency was reissued and one deficiency was identified. As a result of the revisit a resultyoverified correction of deficienciestandard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the survey, investigation of complaint number H5384011 was conducted and determined to be unsubstantiated.

As a result of the October 14, 2014 revisist, we imposed State Monitoring, effective October 22, 2014.

In addition we are reecommending the following action to the CMS Region V Office for iumposition:

- Mandatory Denial of Payment for New Medicare and Medicaid admissions, effectiveNovember 21, 2014

If Mandatory DPNA goes into effect, the facility would be subject to a two year looss of NATCEP, beginning November 21, 2014.

Refer to the CMS 2567 and CMS 2567 for health, along with the facility's plan of correction.Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 17, 2014

Ms. Kimber Wraalstad, Administrator
Cook County Northshore Hospital & C&NC
515 - 5th Avenue West
Grand Marais, Minnesota 55604

RE: Project Number S5384024

Dear Ms. Wraalstad:

On September 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On October 14, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 21, 2014. The deficiency not corrected is as follows:

F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

In addition, at the time of this revisit, we identified the following deficiency:

F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 22, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR

488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 21, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 21, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 21, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Cook Co Northshore Hosp & C&nc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective November 21, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of

law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Patricia Halverson, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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5384r14

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 _____	R 10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	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
{F 000}	INITIAL COMMENTS An onsite resurvey was completed by surveyors of this department, on October 14, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on August 21, 2014. During this visit the following regulations were determined to be not corrected.	{F 000}		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	{F 441}		10/31/14

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

Electronically Signed

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

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{F 441}	Continued From page 1 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide appropriate infection control precautions for 1 of 1 residents (R35) observed during a dressing change and for 1 of 1 residents (R2) reviewed with herpes-zoster (shingles). The facility did not implement tracking, trending and monitoring infection control systems. This had the potential to affect 24 of 24 residents in the facility. Findings include: R2 was started on acyclovir (anti-viral medication commonly used to treat herpes-zoster) for 5 days on 10/2/14, with no documented diagnoses. Progress notes from 10/2/14, indicated R2's left eye was red, itchy and she was unable to see clearly. R2 also had a small red circular rash above her right eye. R2 had also been started on Tobradex eye drops (an antibacterial-steroidal medication) to her left eye on 9/29/14, also with no documented diagnosis. On 10/7/14 the acyclovir was completed. On 10/9/14, the left eye concern was resolved and on 10/10/14, the Tobradex was discontinued. The Infection Control Coordinator (ICC) RN, interviewed on 10/14/14, at 12:42 p.m., stated	{F 441}	F441 The facility provided retraining for the Care Center LPN on proper hand washing, proper glove use for dressing changes with wound care. Retraining occurred on Monday, October 20, 2014. A detailed procedure was developed for Non-sterile Dressing Changes. This procedure was laminated and has been placed with the dressing supplies as a resource for review prior to the dressing changes. The Director of Nursing or her designee will monitor each RN and LPN on their adherence to proper hand washing, proper glove use for non-sterile dressing changes with wound care and proper application of topical medications, once a week for eight weeks beginning October 20, 2014; A competency checklist for the individual RN and LPN monitor has been developed. RNs and LPNs who fail the monitor once will receive retraining and coaching. Consistent failure of the monitor will result in further coaching and disciplinary action. The Director of Nursing or her designee will monitor each	

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{F 441}	Continued From page 2 she was unaware R2 was on the Tobradex or why it was ordered. She further stated the Nurse's Report of Infection form was not completed for the Tobradex. The Nurse's Report of Infection form was reviewed for R2's use of acyclovir with the ICC RN. The document identified the diagnosis of shingles and when asked where it came from the ICC RN did not know as she had not completed the form and had not completed a record review. The ICC RN verified she was unaware R2 was being treated for shingles and did not complete any monitoring to ensure appropriate infection control precautions had been implemented and utilized by staff. Interview with the director of nursing (DON) on 10/14/14 at 1:00 p.m. revealed she was unaware R2 was on either the Tobradex or acyclovir and was unsure why the medications had been ordered. The DON verified she had done no monitoring to ensure appropriate infection control protocols had been implemented and utilized. On 10/14/14 at 2:15 p.m. the DON provided a clinic visit note identifying R2's visit on 10/2/14 for the rash which was diagnosed as recurrent shingles and treated with acyclovir. The DON then verified she had done no audits on infection control precautions implemented and utilized with R2. She further stated that there had been no monitoring of other departments including housekeeping and laundry as that was something they didn't routinely do. Interview with the ICC RN on 10/14/14 at 12:40 p.m. revealed she had reviewed the previous tracking and trending system for infection control and identified missing information. She then revised the forms and policies and educated staff in September. She also identified residents with	{F 441}	RN, LPN and TMA on their adherence for proper cleaning of glucometer after obtaining resident blood sugar check monthly for three months beginning October 2014; then quarterly for a total of one year, ending September 2015. All monitoring results will be reported to the Continuous Quality Improvement/Peer Review Committee. Care Center Employees who are on vacation or Leave of Absence will be observed for the above monitors on their first shift returning to work. The facility has modified the Report of Infection form and associated policy and procedure. The Medication Orders policy and procedure has been modified to require corresponding diagnosis with every medication order. A memo will be sent to all Care Center Nurses regarding the change on the Medication Orders policy and procedure and the need for a diagnosis prior to processing the medication order. Completion date of October 24, 2014. The Care Center Charge Nurse or Care Center HUC will alert the Infection Control Coordinator (ICC) of Resident□s infection or an order for antibiotics by initiating the Report of Infection and giving it to the ICC on date of first action. The ICC will then review report of infection, obtain culture results, follow up/advise Care Center of potential need for further action such as precautions or isolation. The ICC will review and monitor all medications	

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{F 441}	Continued From page 3 the same recurring micro-organism in infections and planned to contact the pharmacist. The ICC RN admitted she had done no audits on the infection control systems within the facility. R35 was observed during a dressing changes on 10/13/14, at 2:44 p.m.. Licensed practical nurse (LPN)-D washed hands and removed R35's sock from the right foot. LPN-D removed the edges of the soiled dressing from R35's right heel, donned clean gloves, and set up the clean dressing supplies. LPN-D then removed the soiled dressing, placed it in the trash, removed the soiled gloves and donned clean gloves. LPN-D verified at that time he had not washed hands with glove changes. LPN-D then cleansed the pressure ulcer with normal saline and gauze, removed gloves and washed his hands, donned clean gloves and completed the dressing change. On interview upon completion of the dressing change, R35's physician progress notes dated 9/24/14, indicated a pressure ulcer right heel stage II with necrotic base, large surrounding dusky area, suspicious for more deep tissue necrosis. On 10/1/14, the physician's orders directed dressing change to right heel: apply Medihoney gel to area of eschar, use no sting barrier prep to protect periwound skin. Apply heel-shaped Meplex Border, and change every three days. On 10/14/14, at 9:52 a.m. the DON was interviewed and stated she would expect staff to wash their hands any time after removing a soiled dressing, and prior to donning clean gloves. The DON stated LPN-D had received training in dressing changes and hand hygiene; however, there were no audits to verify staff compliance with infection control procedures.	{F 441}	prescribed for nosocomial infections. This monitor will be reviewed monthly for three months starting October 2014, then quarterly for one year, ending September 30, 2015. All nosocomial infection data will be verified, evaluated and summarized into a quarterly report and presented to the Continuous Quality Improvement/Peer Review Committee quarterly.	

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{F 441}	Continued From page 4 The facility policy and procedure on Non-sterile Dressing Change undated directed staff to remove soiled dressing, place in trash bag, remove gloves, wash hands and apply new gloves.	{F 441}		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 520	F520	10/31/14

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F 520	Continued From page 5 facility failed to complete quality monitors and reviews to ensure correction of identified deficient practices. This had the potential to affect 24 of 24 residents in the facility. Findings include: During review of the quality assessment and assurance (QA) program on 10/14/14 at 2:15 p.m. the director of nursing (DON) stated the group meets quarterly and is led by the hospital DON and administrator. The DON stated the care center tried to meet monthly, but the last meeting was 8/12/14. She verified the deficient practices from the Minnesota Department of Health (MDH) survey exited 8/21/14, were not reviewed in QA regarding facility status for correction. The DON further stated the care center did not do any routine monitoring of cares or concerns. The DON reported they were scheduled to meet on 10/13/14, but with the arrival of MDH staff the meeting was rescheduled for 10/20/14. The DON indicated had the meeting occurred she would have reviewed the audits she had completed and verified there were no direct care audits completed.	F 520	The facility has a comprehensive quality assessment and assurance program that includes a Care Center Nursing Department Subcommittee, Continuous Quality Improvement/Peer Review Committee (organization wide Committee including all Departments), Medical Staff and Board of Directors. The Continuous Quality Improvement/Peer Review Committee meets monthly and the Care Center Nursing Department Subcommittee will meet monthly rather than Quarterly. The facility does complete routine monitoring of cares and concerns. The monitors for the Statement of Deficiencies F441 are as follows: The Director of Nursing or her designee will monitor each RN and LPN on their adherence to proper hand washing, proper glove use for non-sterile dressing changes with wound care and proper application of topical medications, once a week for eight weeks beginning October 20, 2014; A competency checklist for the individual RN and LPN monitor has been developed. RNs and LPNs who fail the monitor once will receive retraining and coaching. Consistent failure of the monitor will result in further coaching and disciplinary action. The Director of Nursing or her designee will monitor each RN, LPN and TMA on their adherence for proper cleaning of glucometer after obtaining resident blood sugar check monthly for three months beginning October 2014; then quarterly for a total of one year, ending September 2015. All	

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F 520	Continued From page 6	F 520	monitoring results will be reported to the Continuous Quality Improvement/Peer Review Committee. Care Center Employees who are on vacation or Leave of Absence will be observed for the above monitors on their first shift returning to work. The Care Center Charge Nurse or Care Center HUC will alert the Infection Control Coordinator (ICC) of Resident□s infection or an order for antibiotics by initiating the Report of Infection and giving it to the ICC on date of first action. The ICC will then review report of infection, obtain culture results, follow up/advise Care Center of potential need for further action such as precautions or isolation. The ICC will review and monitor all medications prescribed for nosocomial infections. This monitor will be reviewed monthly for three months starting October 2014, then quarterly for one year, ending September 30, 2015. All nosocomial infection data will be verified, evaluated and summarized into a quarterly report and presented to the Continuous Quality Improvement/Peer Review Committee quarterly. The Continuous Quality Improvement Coordinator will review and track the completion of all monitors being completed as a result of the Statement of Deficiencies. The tracking of the completion of the monitors are being audited concurrently.	

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{F 000}	INITIAL COMMENTS An onsite resurvey was completed by surveyors of this department, on October 14, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on August 21, 2014. During this visit the following regulations were determined to be not corrected.	{F 000}		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	{F 441}		

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{F 441}	Continued From page 1 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide appropriate infection control precautions for 1 of 1 residents (R35) observed during a dressing change and for 1 of 1 residents (R2) reviewed with herpes-zoster (shingles). The facility did not implement tracking, trending and monitoring infection control systems. This had the potential to affect 24 of 24 residents in the facility. Findings include: R2 was started on acyclovir (anti-viral medication commonly used to treat herpes-zoster) for 5 days on 10/2/14, with no documented diagnoses. Progress notes from 10/2/14, indicated R2's left eye was red, itchy and she was unable to see clearly. R2 also had a small red circular rash above her right eye. R2 had also been started on Tobradex eye drops (an antibacterial-steroidal medication) to her left eye on 9/29/14, also with no documented diagnosis. On 10/7/14 the acyclovir was completed. On 10/9/14, the left eye concern was resolved and on 10/10/14, the Tobradex was discontinued. The Infection Control Coordinator (ICC) RN, interviewed on 10/14/14, at 12:42 p.m., stated	{F 441}		

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{F 441}	Continued From page 2	{F 441}		

she was unaware R2 was on the Tobradex or why it was ordered. She further stated the Nurse's Report of Infection form was not completed for the Tobradex. The Nurse's Report of Infection form was reviewed for R2's use of acyclovir with the ICC RN. The document identified the diagnosis of shingles and when asked where it came from the ICC RN did not know as she had not completed the form and had not completed a record review. The ICC RN verified she was unaware R2 was being treated for shingles and did not complete any monitoring to ensure appropriate infection control precautions had been implemented and utilized by staff.

Interview with the director of nursing (DON) on 10/14/14 at 1:00 p.m. revealed she was unaware R2 was on either the Tobradex or acyclovir and was unsure why the medications had been ordered. The DON verified she had done no monitoring to ensure appropriate infection control protocols had been implemented and utilized. On 10/14/14 at 2:15 p.m. the DON provided a clinic visit note identifying R2's visit on 10/2/14 for the rash which was diagnosed as recurrent shingles and treated with acyclovir. The DON then verified she had done no audits on infection control precautions implemented and utilized with R2. She further stated that there had been no monitoring of other departments including housekeeping and laundry as that was something they didn't routinely do.

Interview with the ICC RN on 10/14/14 at 12:40 p.m. revealed she had reviewed the previous tracking and trending system for infection control and identified missing information. She then revised the forms and policies and educated staff in September. She also identified residents with

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{F 441}	Continued From page 3	{F 441}		

the same recurring micro-organism in infections and planned to contact the pharmacist. The ICC RN admitted she had done no audits on the infection control systems within the facility.
R35 was observed during a dressing changes on 10/13/14, at 2:44 p.m.. Licensed practical nurse (LPN)-D washed hands and removed R35's sock from the right foot. LPN-D removed the edges of the soiled dressing from R35's right heel, donned clean gloves, and set up the clean dressing supplies. LPN-D then removed the soiled dressing, placed it in the trash, removed the soiled gloves and donned clean gloves. LPN-D verified at that time he had not washed hands with glove changes. LPN-D then cleansed the pressure ulcer with normal saline and gauze, removed gloves and washed his hands, donned clean gloves and completed the dressing change. On interview upon completion of the dressing change,

R35's physician progress notes dated 9/24/14, indicated a pressure ulcer right heel stage II with necrotic base, large surrounding dusky area, suspicious for more deep tissue necrosis. On 10/1/14, the physician's orders directed dressing change to right heel: apply Medihoney gel to area of eschar, use no sting barrier prep to protect periwound skin. Apply heel-shaped Meplex Border, and change every three days.

On 10/14/14, at 9:52 a.m. the DON was interviewed and stated she would expect staff to wash their hands any time after removing a soiled dressing, and prior to donning clean gloves. The DON stated LPN-D had received training in dressing changes and hand hygiene; however, there were no audits to verify staff compliance with infection control procedures.

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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 441}	Continued From page 4 The facility policy and procedure on Non-sterile Dressing Change undated directed staff to remove soiled dressing, place in trash bag, remove gloves, wash hands and apply new gloves.	{F 441}		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 520		

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 _____	R 10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	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
F 520	Continued From page 5 facility failed to complete quality monitors and reviews to ensure correction of identified deficient practices. This had the potential to affect 24 of 24 residents in the facility. Findings include: During review of the quality assessment and assurance (QA) program on 10/14/14 at 2:15 p.m. the director of nursing (DON) stated the group meets quarterly and is led by the hospital DON and administrator. The DON stated the care center tried to meet monthly, but the last meeting was 8/12/14. She verified the deficient practices from the Minnesota Department of Health (MDH) survey exited 8/21/14, were not reviewed in QA regarding facility status for correction. The DON further stated the care center did not do any routine monitoring of cares or concerns. The DON reported they were scheduled to meet on 10/13/14, but with the arrival of MDH staff the meeting was rescheduled for 10/20/14. The DON indicated had the meeting occurred she would have reviewed the audits she had completed and verified there were no direct care audits completed.	F 520		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245384	A. Building B. Wing	10/14/2014

Name of Facility	Street Address, City, State, Zip Code
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/14/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/14/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/14/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** PLH/mm	**Date:** 10/17/2014	**Signature of Surveyor:** 13922	**Date:** 10/14/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/21/2014

_____ **Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OBP5

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) **COOK CO NORTHSHORE HOSP & C&NC**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 09/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/29/2014 (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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5384

On August 21, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the survey, investigation of complaint number H5384011 was conducted and determined to be unsubstantiated.

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 5, 2014

Ms. Kimber Wraalstad, Administrator
Cook County Northshore Hospital & C&NC
515 - 5th Avenue West
Grand Marais, MN 55604

RE: Project Number S5384024, H5384011

Dear Ms. Wraalstad:

On August 21, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 21, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5384011.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 21, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5384011 that was found to be unsubstantiated.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Patricia Halverson, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 30, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5384s14

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 _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census: 34 An investigation of complaint H5384011 was investigated and not substantiated with no deficiencies issued.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		9/30/14

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

Electronically Signed | 09/15/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/21/2014

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure timely notification of the resident's family occurred with the development of several pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's significant change Minimum Data Set (MDS) dated 7/14/14, indicated R1's diagnoses included osteoporosis and dementia. The MDS further indicated R1 had severe cognitive impairment, required extensive assistance with bed mobility and transfers and had 1 stage 3 and 2 unstageable pressure ulcers. R1's electronic Progress Notes dated 6/29/14, indicated a pressure ulcer was discovered on the medial aspect of the left heel under an air cast	F 157	Resident 1'□s son and daughter-in-law visited on September 8, 2014. The following was documented in the Nurse□s notes on that day: "FAMILY: Resident son and daughter-in-law visiting today. Resident Care Manager and Wound Care Nurse met with family and reviewed resident Plan of Care. Discussed pathological break in lower leg, air splint use and development of pressure ulcer. Son reported that resident's PCP had contacted them after Rounds to notify them of the wound. Son also stated, "Mom has always gotten really good care here." Son does not attend Care Conferences due to need to travel distance, and chooses not to attend via telephone conference because he states that he can't hear well enough. This	

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 157	Continued From page 2 used to treat a fracture. The pressure ulcer measured 2.5 cm by 1.5 cm by 1 cm in depth with pale gray slough in the wound bed. R1's Interdisciplinary Patient Progress Notes dated 6/29/14, indicated a physician was called to evaluate R1's left foot. The Progress Note described several pressure ulcers under R1's air cast to include: 1. medial malleolus with stage 3 ulcer, straw colored/copious exudate, estimated size 2.5 inches by 1.5 inches; 2. lateral malleolus with unstageable ulcer, pressure point had non-blanching purpura colored area, non tender to palpation; and 3. edge of the left foot at the distal 5th metatarsal, bluish, non-blanching, non-tender. The Progress Note concluded R1 developed pressure ulcers under the air cast. Review of R1's electronic Progress Notes dated from 6/29/14, through 8/14/14, lacked evidence of family notification regarding the pressure ulcers under the air cast. On 8/14/14, at approximately 2:30 p.m. registered nurse (RN)-A verified the lack of documented notification of R1's family regarding the pressure ulcers. On 8/14/14, at approximately 3:30 p.m. the director of nursing (DON) stated she was not aware R1's family was not notified when R1's pressure ulcer had been discovered. The DON further stated R1's family should have been notified and documentation of the notification in R1's medical record.	F 157	statement indicates the son was notified by resident□'s primary care physician by a letter mailed to them either after rounds on 7/28/14 or 8/18/14." The letters mailed to the legal representatives of the Residents by the Primary Care Providers will be copied and retained in the chart. The Care Center Charge Nurses will be directed to immediately inform the Resident; consult with the Resident□s physician; and if known, notify the Resident□s legal representative or an interested family member when there is an accident involving the resident which results in an injury and has the potential for requiring physician intervention; a significant change in the resident□s physical, mental, or psychosocial statue (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. This directive will be communicated to the Charge Nurses of the Care Center via a facility email memo by Friday, September 19, 2014. A policy will be developed by September 19, 2014, to address "Notification of Changes (Injury/Decline/Room, etc)". The new policy will be shared with Care Center Charge Nurses via facility email and reviewed at the Care Center Charge	

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F 157	Continued From page 3	F 157	nurse meeting on Monday, October 6, 2014. The Director of Nursing or her designee will monitor documentation in resident□s record for Notification of Changes. This will be done once a week starting on September 22, 2014 for four weeks. Monitoring will continue monthly for five months. The results of the monitoring plan will be reported to the QA committee.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident incontinent briefs were placed out of view for 3 of 4 residents (R13, R3, R1) reviewed for dignity. Findings include: R13's physician's order sheet, undated, identified diagnoses that included peripheral vascular disease and dementia. The quarterly Minimum Data Set (MDS) dated 7/14/14, indicated R13 had long and short term memory problems, and severely impaired daily decision making skills. The MDS further indicated R13 was totally incontinent of bowel and bladder, and required extensive assistance of one staff for toileting	F 241	Personal incontinent products will be removed from areas in the Residents□' rooms that can be seen by the public or the shelving units will have a covering placed over them to prevent the incontinent products from being seen. Incontinent products will be stored in the bathroom and those stored in the room will be stored out of public view. The policy "Maintenance of Resident Dignity" will be updated to state: "Resident incontinent briefs will be stored in their rooms concealing the presence of briefs from public view or in the bathroom". The updated policy will be shared with Care Center staff via facility email and reviewed	9/30/14

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F 241	Continued From page 4 needs. On 8/18/14, at 6:25 p.m. R13's room was observed to have a wall-mounted white corner cabinet in the sitting area. The cabinet contained adult incontinent briefs. The cabinet was observed throughout the survey from 8/18/14, through 8/21/14, with visible incontinent briefs. On 8/20/14, at 2:24 p.m. family member (FM)-A was interviewed, and stated R13 had been a very private person, and would be bothered by having visitors aware he/she was incontinent. FM-A stated R13 would not have wanted anyone to know this. On 8/21/14, at 9:33 a.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed, and both verified the cabinet in R13's room contained incontinent briefs. R1's significant change MDS dated 7/14/14, indicated R1's diagnoses included osteoporosis and dementia. The MDS further indicated R1 had severe cognitive impairment, required extensive assistance of two staff with toileting needs, and was always incontinent of bowel and bladder. On 8/19/14, at 12:55 p.m. R1's room was observed to have a wall-mounted white corner cabinet in the sitting area. The cabinet contained adult incontinent briefs. The cabinet was observed throughout the survey from 8/18/14, through 8/21/14, with visible incontinent briefs. On 8/20/14, at 2:20 p.m. family member (FM)-B was interviewed during a telephone call, and stated R1 was a very private person and would be appalled if any one was aware of their incontinence.	F 241	at the staff meetings on October 2 and 6, 2014. Completion date of September 30, 2014. The Director of Nursing or designee will monitor the resident rooms to verify that incontinent products are not visible to the public. The monitor will be completed twice a month for three months and then once a month for three months. The results of the monitor will be reported to the Quality Improvement/Peer Review Committee on a monthly basis.	

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F 241	Continued From page 5 On 8/21/14, at 9:25 a.m. nursing assistant (NA)-E stated the shelves had been in R1's room for maybe 2 to 3 years. NA-E further stated the incontinent briefs were put there for staff convenience. On 8/21/14, at 3:08 p.m. registered nurse (RN)-A stated incontinent products should be covered or placed out of sight. R3's annual Minimum Data Set (MDS) dated 6/10/14, indicated R3 had a severe cognitive deficit, required limited assistance of one staff for toileting and grooming, and had frequent urinary incontinence. The care plan dated 7/18/14, indicated R3 was to be reminded to toilet to reduce incontinence, as it seemed to be an embarrassment and agitation. The care card dated 7/22/14, also indicated incontinence seemed to be an embarrassment and agitation. During observation on 8/19/2014, at 1:59 p.m., there was an incontinent pad on R3's bathroom counter. On 8/20/14, at 7:23 incontinent pads were stacked on an open shelf behind the entry door in R3's first entry area. On 8/21/14, at 9:07 a.m. R3's entry door was about 3/4 of the way open. The incontinent pads were visible on the shelf behind the door from the hallway. There was also an incontinent pad on the bathroom counter top. During an interview on 8/21/14, at 1:55 p.m. nursing assistant (NA)-D stated the shelves were put up a long time ago and incontinent pads have	F 241		

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F 241	Continued From page 6 always been there. During an interview on 8/21/14, at 2:09 p.m. registered nurse (RN)-A nodded head in a gesture of agreement when it was noted R3's care plan indicated R3 seemed to be embarrassed and agitated with incontinence, and stated R3 was the only one using the bathroom at this time. The facility policy and procedure for dignity revised 10/13, directed no visible indicators visible to public view that relate to the resident's personal care. The policy and procedure further directed staff to remove any information of a personal nature as it relates to the resident, including incontinence pads on top of the resident's bed when not occupied by the resident.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care to for the care and services to prevent the development of pressure ulcers was provided for 1 of 4 residents (R1) reviewed for pressure ulcers. Findings include:	F 282	Plan of care changes directing the charge nurse to a change in an intervention are made on the plan of care. This change shows up on the nurse'□s intervention work list with the information showing up in the text box. Nurses receive updated care card information by placement of the new card care in the treatment kardex and on the report board for nurses. The	9/26/14

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F 282	Continued From page 7 R1's significant change Minimum Data Set (MDS) dated 7/14/14, indicated R1 had severe cognitive impairment, had existing pressure ulcers, and required extensive assistance with bed mobility, transfers and bathing. R1's care plan reviewed 6/9/14, indicated a risk for development of pressure ulcers. The care plan directed an air splint to the left foot/ankle, licensed staff only to remove the splint for cleansing and pressure checks. On 8/21/14, at 1:17 p.m. registered nurse (RN)-D stated R1's stage 3 pressure ulcer was discovered on 6/29/14, when staff noticed fluid leaking through R1's left lower leg air splint. RN-A and RN-D both stated they would expect the nurse performing the weekly skin assessment to observe R1's skin under the brace and check the bony prominences around the heel and ankle areas. On 8/21/14, at 2:34 p.m. licensed practical nurse (LPN)-C was interviewed via telephone. LPN-C stated she did not open up R1's air splint and view R1's heel or ankle during the weekly skin assessment on 6/28/14.	F 282	updated care cards are kept on the report board for one week. A splint intervention task has been developed and will appear on the nurse'□s work list. This task will be done once per day. The time of the documentation will be determined as to the best time to remove the splint depending on the resident□'s mobility and ease of removal/ checking of skin/ replacing of splint. Documentation of the time/day will be different for each resident based on what works best for the resident. This information will be communicated to the Charge Nurses via a facility email and reviewed at the Care Center Charge Nurse meeting on Monday, October 6, 2014. The policies on pressure ulcers and cast care will be reviewed and revised as appropriate by September 26, 2014. The reviewed/revised policies will be communicated to staff via a facility email and reviewed at the October staff meeting. The Director of Nursing or her designee will monitor documentation in resident□s record for pressure ulcers. This will be done once a week starting on September 22, 2014 for four weeks. Monitoring will continue monthly for five months. The results of the monitoring plan will be reported to the Quality Improvement/Peer Review Committee monthly.	
F 314	483.25(c) TREATMENT/SVCS TO	F 314		9/26/14

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F 314 SS=G	Continued From page 8 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate care to prevent the development of pressure ulcers for 1 of 4 residents (R1) reviewed for pressure ulcers. The lack of assessment and the development of a stage 3 pressure ulcer constituted actual harm for R1. Findings include: R1's significant change Minimum Data Set (MDS) dated 7/14/14, indicated diagnoses that included osteoporosis and dementia. The MDS further indicated R1 had severe cognitive impairment, required extensive assistance with bed mobility and transfers, and was totally dependent in bathing activities. The MDS also indicated R1 was at risk for pressure ulcers and had 1 stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) and 2 unstageable pressure ulcers. The MDS indicated skin and	F 314	Resident 1 had a slightly displaced bimalleolar fracture. An air splint was applied to protect the fracture and it was noted "good pain control when we are not manipulating the limb". The bruising of the leg was increasing in size and the Physician ordered the "air stirrup □ sport brace to the left ankle continuous" and told the LPN that the splint should be worn continuously to avoid further displacement or fracture of the osteoporotic bones. A pressure ulcer developed in an area that was unable to be visualized with the air cast in place. Resident 1□'s unstageable pressure ulcers were resolved on August 24, 2014. As of September 15, 2014, the stage 3 pressure ulcer on Resident 1□s medial malleolus is almost completely resolved. All areas of Resident 1□'s skin are evaluated during the weekly skin assessments. Weekly skin assessments are done by charge nurses after a	

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F 314	Continued From page 9 ulcer treatments that included pressure reducing devices for the bed and chair, nutrition/hydration interventions, ulcer care and application of dressings to the feet. R1's Interdisciplinary Patient Progress Notes dated 6/5/14, indicated R1 was seen in the clinic on 6/4/14, with left mid-shin bruising and lower extremity edema and no apparent trauma. The progress note further indicated R1 had a chronic malformation of the left foot with medial rotation and plantar flexion (toes pointed with rotation of the left foot to the center). The progress note indicated a slightly displaced bimalleolar fracture and was fitted with an air stirrup sport splint (a splint used to treat common sports injuries) to protect the fracture. Physician's orders dated 6/5/14, directed a continuous air stirrup-sport brace to R1's left ankle. R1's care plan dated as reviewed 6/9/14, identified risk factors for pressure ulcer development that included limitation in self mobility, inability to ambulate and urinary incontinence. The care plan indicated R1 had no current pressure-related lesions with protective interventions of the splint in place, check with nurse for positioning of splint, nurse only should remove to check for pressure, cleansing and skin care. The care plan did not address frequency of cleansing and skin care. The weekly skin checks were part of the usual monitoring of all residents for potential skin problems. R1's electronic progress notes dated 6/29/14, indicated a stage 3 pressure ulcer discovered under the air cast. The ulcer on the medial aspect of the heel measured 2.5 cm by 1.5 cm by 1 cm in depth, with pale gray slough in the wound bed.	F 314	resident□s bath. A monitor splint intervention has been developed and will appear on the nurse□'s work list when any other resident needs to use a splint to heal a fracture. This information will be communicated to the Charge Nurses via a facility email and reviewed at the Care Center Charge Nurse meeting on Monday, October 6, 2014. The policies on pressure ulcers and cast care will be reviewed and revised as appropriate by September 26, 2014. The reviewed/revised policies will be communicated to staff via a facility email by September 26, 2014 and reviewed at the October staff meeting. The Director of Nursing or her designee will monitor documentation in resident□'s record for pressure ulcers. This will be done once a week starting on September 22, 2014 for four weeks. Monitoring will continue monthly for five months. The results of the monitoring plan will be reported to the Quality Improvement/Peer Review Committee monthly.	

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R1's Weekly Skin Assessment dated 6/14/14, indicated the air cast was not removed to view the skin after a bed bath. The Weekly Skin Assessments dated 6/21/14, and 6/28/14, indicated R1 had no discolorations over bony prominences; however, did not after pressure had been reduced. The documentation did not indicate the air splint was removed to observe the skin condition under the splint.

R1's Interdisciplinary Patient Progress Notes dated 6/29/14, described several pressure ulcers under R1's air cast to include: 1. medial malleolus with stage 3 ulcer, straw colored/copious exudate, estimated size 2.5 inches by 1.5 inches; 2. lateral malleolus with unstageable ulcer, pressure point had non-blanching purpura colored area, non tender to palpation; and 3. edge of the left foot at the distal 5th metatarsal, bluish, non-blanching, non-tender. The progress note concluded the pressure ulcers developed under the air cast.

On 8/13/14, at 9:39 a.m. licensed practical nurse (LPN)-A was observed to provide ulcer care to R1's left heel pressure ulcer. R1 was laying in the bed with a knee-high, white sheepskin lined boot to the left lower leg. The boot was removed and the left lower leg and foot were observed to be turned in with noticeable foot drop. LPN-A cut away the old dressings and removed all of the old dressing material. The dressings did not have visible drainage. There was a stage 3 ulcer observed on the lower aspect of the left inner heel just below the inner ankle bone. The ulcer was shaped like a crescent moon, dry and tan in color. LPN-A applied a clean, dry gauze dressing, wrapped R1's left foot, heel, and ankle

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F 314	Continued From page 11 with Kerlix gauze, and secured the dressing with paper tape. LPN-A reapplied R1's white sheepskin boot to R1's left lower leg. On 8/21/14, at 1:17 p.m. registered nurse (RN)-D stated R1's stage 3 pressure ulcer was discovered on 6/29/14, when the nursing assistants caring for her that day noticed fluid was leaking through the air splint. RN-D confirmed R1's weekly skin assessments dated 6/21/14, and 6/28/14, indicated no evidence of pressure ulcers. RN-A and RN-D both stated they would expect observation of all areas of the body, especially bony prominences, with the weekly skin assessments. LPN-C was interviewed by phone on 8/21/14, at 2:34 p.m. stated she did not open the air splint to observe R1's heel and ankle during the weekly skin assessment on 6/28/14. LPN-C stated she had been instructed to leave the air splint in place. In addition, R1's Nutritional Assessment dated 7/16/14, indicated Ensure (high protein dietary supplement) one half cup twice daily would be administered to improve nutrition for healing ulcers. R1's Snack Fluids Intake forms for July and August, 2014, indicated R1 rarely consumed the supplement. During July 2014 R1 consumed the Ensure on 3 out of 30 opportunities. During August only 6 out of 34 opportunities. On 8/20/14, at 1:35 p.m. nursing assistant (NA)-F stated R1's supplements were provided at 10:00 a.m., 2:00 p.m., and at bed time. NA-F stated the amount taken was recorded for the dietary department to total. NA-F stated R1 refused the supplement earlier that day and sometimes would be asleep when the supplement was delivered.	F 314		

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F 314	Continued From page 12 On 8/21/14, at 9:40 a.m. the dietary manager (DM) stated she was aware R1 was not taking the supplement very often. On 8/21/14, at approximately 3:30 pm the registered dietician (RD) stated she was not aware R1 had a pressure ulcer or R1 was not consistently receiving the Ensure supplement.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		9/30/14

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F 329	Continued From page 13 Based on observation, interview and document review, the facility failed to ensure parameters for the use of multiple pain medications were in place for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R3's annual Minimum Data Set (MDS) dated 6/10/14, indicated dementia with severe cognitive impairment. R3 required limited assistance of one staff with personal hygiene and toilet use, and was independent with bed mobility, transfers, ambulation, and eating after set up. The MDS further indicated R3 had no pain but did have mood indicators and verbal behaviors. The signed physician orders dated 7/7/14, included acetaminophen 325-650 milligrams (mg) every 4-6 hrs as needed (PRN) for degenerative joint disease. The order did not include parameters for administration of acetaminophen 325 mg versus 650 mg.. Physician orders dated 7/27/14, included ibuprofen 600 mg every 4-6 hours PRN and Vicodin 5/325 one by mouth (po) every 4-6 hours PRN for pain. There was no criteria to determine when to give ibuprofen, Vicodin or acetaminophen. On 7/31/14, R3 received an order for hydrocodone-acetaminophen 5/325 mg one tab every 4 hours PRN for pain without parameters for use of any of the four pain medications ordered for PRN use. R3's PRN Pain Medication Sheet indicated the last dose of acetaminophen 650 mg was on 2/9/14, documented as effective for pain relief. On 7/27/14, began receiving hydrocodone/APAP (Lortab) 5/325 for back pain with additional doses	F 329	Physician orders for Resident 3 discontinued the following medications on August 28, 2014: Ibuprofen 600mg, Vicodin 5/325 and Hydrocodone-Acetaminophen. On September 15, 2014, Resident 3□s Physician stated: pain med order should read: may use additional Tylenol for pain management @ 650 mg po q4hrs PRN pain, limit 3000mg Tylenol total q 24 hrs. A fax was sent to Resident 3□s physician for clarification of the Tylenol order as this is covered in the Care Center□s standing orders if needed and to clarify the Lortab order to read Lortab 1-2 PRN, 1 tab for pain < 6/10, 2 tabs for pain > 6/10. Resident 3□s Primary Physician will be asked to address Resident□s pain in her next progress note. The consultant pharmacist was notified her documentation did not address the lack of parameters for PRN pain medications, the order for Ibuprofen in a patient with end stage renal failure and anemia with recent blood loss. All other Care Center residents currently receiving PRN medications will be reviewed to ensure parameters for their use are in place. Parameters for PRN medications will be developed with input from the Medical Staff and the Consulting Pharmacist. Any resident with new PRN medication orders will need specific parameters ordered for their use. A policy will be developed with input from the Medical Staff and the Consulting Pharmacist. The	

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	245384	A. BUILDING _____ B. WING _____	08/21/2014

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COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

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F 329	Continued From page 14 on 8/5/14, 8/6/14, and 8/14/14. R3 received apparent pain relief with hydrocodone. R3's care plan dated 8/18/14, indicated R3 possibly had pain that was contributing to agitation, and directed staff to ask, observe, and offer PRN pain medications when R3 was restless, wandering, or getting agitated. The physician progress notes dated 5/13/14, 6/24/14, and 7/7/14 did not address pain for R3. The monthly pharmacy consultant documentation from 2/19/14 through 8/20/14, did not address the lack of parameters for PRN pain medications. The nursing progress notes dated 7/29/14, indicated R3 had stools that tested positive for blood. The physician progress notes dated 7/7/14, indicated R3's hemoglobin has been between 8.5 and 9.5, which is low. A pharmacy consultant review on 8/20/14, did not address the lack of parameters for pain medications or the order for Ibuprofen in a patient with end stage renal failure and anemia with recent blood in the stool. Licensed practical nurse (LPN)-A, interviewed on 8/21/14, at 1:50 p.m., stated it was a good question when asked how she would know which PRN pain medication to give when R3 was having pain. LPN-A stated R3 was not always able to report pain and Lortab was administered based on R3's nonverbal cues. Pain medications were offered when R3 was more agitated. The dosage administered was based on the R3's level of apparently discomfort or agitation. During an interview on 8/21/14, at 2:12 p.m. registered nurse (RN)-A verified the lack of	F 329	new policy will be communicated via facility email to the Charge Nurses and the Medical Staff. The final policy will be reviewed at the October 2014 Nurse staff meeting and the October Medical Staff meeting. New pain medication orders will be monitored for specific parameters once a week for four weeks starting September 22, 2014, then monthly for three months. The results of the monitoring plan will be reported to the Quality Improvement/Peer Review Committee monthly.	

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F 329	Continued From page 15 parameters for use of PRN pain medications. RN-A stated nurses were encouraged to ask for parameters when medications were ordered. The consultant pharmacist was unavailable for an interview. The facility was unable to provide policies and procedures related to parameters for PRN medications.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		8/25/14

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F 356	Continued From page 16 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to post the nurse staff posting to include the actual hours worked for both licensed and unlicensed staff. This had the potential to affect all 34 residents residing in the facility, visitors and anyone else who may have chosen to view the information. Findings include: During the initial tour of the facility on 8/18/14, at 3:09 p.m., the staff posting was observed on a bulletin board near the nurse's station. The staff posting lacked the actual hours worked by staff. The posting included census of 34, number of staff in each position on days, evenings, and nights. On 8/19/14, at approximately 9:10 a.m. the staff posting was observed in the same area and did not include actual hours worked by staff. The posting included the same information as the previous day. During an interview on 8/22/14, at 1:45 p.m. the director of nursing (DON) stated they have not included the actual hours on the nurse staff posting. The DON was unaware the posting needed to include this information. She stated the unit coordinator was the one who posts the nurse staff posting daily.	F 356	The form for the posting of Nurse Staffing Information includes the total hours worked for both licensed and unlicensed staff. The shift times were designated by day, evening and nights and to not include the identification of the hours of each shift. The form was modified include the specific times of each shift. Completion date of August 25, 2014. The Director of Nursing will review all the posting reports from the previous month to verify that the posted Nurse Staffing Information includes the specific shift times. The results of this review will be reported to Quality Improvement/Peer Review Committee quarterly for six months.	

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F 356	Continued From page 17 A policy and procedure was not provided for the nurse staff posting.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to ensure parameters for the use of multiple pain medications were in place for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R3's annual Minimum Data Set (MDS) dated 6/10/14, indicated dementia with severe cognitive impairment. The MDS further indicated R3 had no pain but did have mood indicators and verbal behaviors. The signed physician orders dated 7/7/14, included acetaminophen 325-650 milligrams (mg) every 4-6 hrs as needed (PRN) for degenerative joint disease. The order did not include	F 428	Physician orders for Resident 3 discontinued the following medications on August 28, 2014: Ibuprofen 600mg, Vicodin 5/325 and Hydrocodone-Acetaminophen. On September 15, 2014, Resident 3□s Physician stated: pain med order should read: may use additional Tylenol for pain management @ 650 mg po q4hrs PRN pain, limit 3000mg Tylenol total q 24 hrs. A fax was sent to Resident 3□s physician for clarification of the Tylenol order as this is covered in the Care Center□s standing orders if needed and to clarify the Lortab order to read Lortab 1-2 PRN, 1 tab for pain < 6/10, 2 tabs for pain > 6/10. Resident 3□s Primary Physician will be asked to address Resident□s pain in her	9/30/14

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F 428	Continued From page 18 parameters for administration of acetaminophen 325 mg versus 650 mg.. Physician orders dated 7/27/14, included ibuprofen 600 mg every 4-6 hours PRN and Vicodin 5/325 one by mouth (po) every 4-6 hours PRN for pain. There was no criteria to determine when to give ibuprofen, Vicodin or acetaminophen. On 7/31/14, R3 received an order for hydrocodone-acetaminophen 5/325 mg one tab every 4 hours PRN for pain. There were no parameters for use of any of the four pain medications ordered for PRN use. R3's PRN Pain Medication Sheet indicated the last dose of acetaminophen 650 mg was on 2/9/14, documented as effective for pain relief. On 7/27/14, began receiving hydrocodone/APAP (Lortab) 5/325 for back pain with additional doses on 8/5/14, 8/6/14, and 8/14/14. R3 received apparent pain relief with hydrocodone. R3's care plan dated 8/18/14, indicated R3 possibly had pain that was contributing to agitation, and directed staff to ask, observe, and offer PRN pain medications when R3 was restless, wandering or getting agitated. The physician progress notes dated 5/13/14, 6/24/14, and 7/7/14 did not address pain for R3. The monthly pharmacy consultant documentation from 2/19/14 through 8/20/14, did not address the lack of parameters for PRN pain medications. The nursing progress notes dated 7/29/14, indicated R3 had stools that tested positive for blood. The physician progress notes dated 7/7/14, indicated R3's hemoglobin has been between 8.5 and 9.5, which is low. A pharmacy consultant review on 8/20/14, did not address the	F 428	next progress note. The consultant pharmacist was notified her documentation did not address the lack of parameters for PRN pain medications, the order for Ibuprofen in a patient with end stage renal failure and anemia with recent blood loss. All other Care Center residents currently receiving PRN medications will be reviewed to ensure parameters for their use are in place. Parameters for PRN medications will be developed with input from the Medical Staff and the Consulting Pharmacist. Any resident with new PRN medication orders will need specific parameters ordered for their use. A policy will be developed with input from the Medical Staff and the Consulting Pharmacist. The new policy will be communicated via facility email to the Charge Nurses and the Medical Staff. The final policy will be reviewed at the October 2014 Nurse staff meeting and the October Medical Staff meeting. New pain medication orders will be monitored for specific parameters once a week for four weeks starting September 22, 2014, then monthly for three months. The results of the monitoring plan will be reported to the Quality Improvement/Peer Review Committee monthly.	

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F 428	Continued From page 19 lack of parameters for pain medications or the order for Ibuprofen in a patient with end stage renal failure and anemia with recent blood in the stool. During an interview on 8/21/14, at 2:12 p.m. registered nurse (RN)-A verified the lack of parameters for use of PRN pain medications. The consultant pharmacist was unavailable for an interview. The undated facility policy and procedure for consulting pharmacist indicated the goal was to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy to the extent possible. The policy and procedure lacked direction for review for contraindicated medications and for ensuring parameters for use of PRN medications.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		9/30/14

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F 431	Continued From page 20 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were appropriately labeled with resident names and opened dates for 3 of 3 residents (R30, R36, R32) receiving insulin flex pens; medication labels were not legible in 1 of 2 medication carts affecting R24; and medication refrigerator temperatures were not maintained within the proper temperatures for viability in 1 of 1 medication refrigerators in which 4 resident's medications were located (R32, R30, R7, R38). Findings include: On 8/20/14, at 12:21 p.m. the medication refrigerator located in the medication storage room was observed with licensed practical nurse	F 431	The facility is now using a refrigerator temperature log and recording temperatures twice a day for the medication refrigerator. The parameters to follow for refrigerator temperatures are 36 □ 46 degrees Fahrenheit. The insulin pens are now labeled with Resident name, opened date and discard 28 days after opened date. In order to maintain the legibility of labels for medications not ordered from our providing pharmacy, the label will be covered with clear packaging tape. The clear packing tape will be applied upon receipt of these medications.	

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F 431	Continued From page 21 (LPN)-A. The temperature was 37 degrees F [Fahrenheit] according to the digital thermometer mounted on the outside of the refrigerator door. The refrigerator contained several resident medications which included: R32's Lantus insulin pens dispensed 6/18/14, and Novolog insulin pens dispensed 12/18/13, R30's Lantus insulin pens dispensed 7/31/14, and Lantus insulin vial dispensed 7/28/14; R38's Lantus vial dispensed 8/19/14; R7's Tubersol vial dispensed 8/1/14; R36's Latanoprost eye drops dispensed 11/29/13; and R28's Enbrel syringes for injection dispensed 8/1/14. LPN-A stated she was not sure of the correct range of temperatures in a medication refrigerator. LPN-A located a clip board with a monthly calendar where nightly medication refrigerator temperatures were recorded. The calendar for June 2014 indicated 6 of 30 days with temperature readings below 36 degrees F. The July 2014 calendar indicated 4 of 29 days with temperatures below 36 degrees F. In August, 2014, the temperature was below 36 degrees on 3 of 20 days. The manufacturer's guidance for Latanoprost [Xalatan] eye drops revised 8/2011, indicated the medication should be refrigerated at 36 to 46 degrees F.; and Enbrel should be kept at 36 to 46 degrees F and not be allowed to freeze. During observation of the medications carts, on 8/20/14, at 12:30 p.m. with LPN-A, the 200 room hall cart was observed to contain 3 opened insulin flex pens. One of the Lantus flex pens was labeled in black magic marker with a resident's nick-name written on it; another Lantus flex pen was labeled with a first name only; and a third flex pen containing Novolog insulin was labeled with the same first name and a last name initial, and no opened date.	F 431	A Medication Storage Policy will be developed in conjunction with the Consulting Pharmacist by September 30, 2014. The Director of Nursing or her designee will monitor refrigerator temperatures weekly for four weeks and once a month for six months. The results of the monitoring plan will be reported to the Quality Improvement/Peer Review Committee monthly.	

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F 431	Continued From page 22 On 8/20/14, at approximately 12:45 p.m. LPN-A stated the insulin flex pen labeled with a nick-name belonged to R32. LPN-A further stated the other two flex pens, both with the same resident first name on them belonged to residents who were still residing in the facility and the name labeling was confusing. LPN-A verified the Novolog flex pen lacked an opened date and confirmed all insulin flex pens and vials should be labeled with an opened date as the insulin would be good for 28 days after opening. LPN-A also verified the black magic marker was not reliable to stay and be legible on the flex pens. R32's Physician Order Sheet dated 8/21/14, indicated R32's diagnoses included diabetes type 2 and directed Lantus insulin 15 units sq [subcutaneous] daily at bed time. R30's Physician Order Sheet dated 8/21/14, indicated R30's diagnoses included diabetes type 2 and Lantus insulin 48 units sq at bed time and Novolog insulin 10 units sq before each meal. R36's Physician's Orders and Diagnosis list were requested but not provided. On 8/20/14, at 1:09 p.m. the 100 room hall cart was observed with registered nurse (RN)-B. There was a prescription medication bottle with a faded label attached. The manufacturer's medication label included the medication name and dosage; but the pharmacy label was faded to the point of being illegible. RN-B stated the medication belonged to R24 and came from a mail order pharmacy. RN-B stated the label always faded away within a month's time. R24's Physician Order Sheet dated 8/20/14, indicated R24's diagnoses included persistent mental	F 431		

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F 431	Continued From page 23 disorder and directed Klonipin (antianxiety medication) 0.5 mg oral at bed time. On 8/21/14, at 2:51 p.m. the director of nursing (DON) stated residents' medication labels should match the medication administration record (MAR). The DON further stated that insulin pens should be labeled with an opened date and the name of the resident. The DON stated the medication refrigerator temperatures were monitored each night, and the temperature log was monitored monthly by the consultant pharmacist. The DON confirmed the low temperatures below 36 degrees F from 6/2014, 7/2014, and 8/2014. The DON reported the digital thermometer would alarm when the temperature dropped below 34.4 degrees F., and the staff had been instructed to turn the refrigerator temperature up. The DON confirmed she was not aware of the appropriate refrigerator temperature to assure medication viability. A Medication Storage Policy was requested but not provided. The facility's Medication Administration, General Considerations policy revised 6/2008, indicated newly opened vials of medication would be labeled with the date the vial was opened and labeled with the expiration date. On 8/26/14, at 11:10 a.m. the consultant pharmacist (CP) was contacted for a phone interview. The CP stated she helped the facility to set up the digital thermometer for monitoring of the medication refrigerator temperatures. The CP further stated she had provided the facility information regarding proper temperature maintenance, such as insulin and the Tubersol	F 431		

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F 431	Continued From page 24 needing to be stored between 36 degrees F and 46 degrees F. The CP also stated she does not perform regular monitoring of the refrigerator temperatures on the monthly visits to the facility. The CP confirmed she does go through the medication carts monthly for expired medications, labeling, etc. The CP stated she was not aware of the faded label for R24's Klonipin and would expect the facility to find a way to prevent the fading out of the label contents. The CP confirmed she would expect the pharmacy labels to be readable, with resident name and with the dispensed date of the medication clearly visible. The CP stated she was not aware the nursing staff were taking insulin flex pens out of the refrigerator and storing the opened flex pens in the medication carts for resident use. The CP confirmed all flex pens should have a resident label, clearly readable, and contain an opened date.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		9/30/14

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COOK CO NORTHSHORE HOSP & C&NC	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
F 441	Continued From page 25 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow infection control standards during dressing changes for 2 of 3 residents (R1, R14) observed for wound care; during blood glucose monitoring procedures for 1 of 1 residents (R34) observed for blood glucose monitoring. In addition, the facility failed to implement an infection control surveillance program to identify, document and monitor resident infections. This had the potential to affect all 34 residents residing in the facility. Findings include: R14 was observed on 8/21/14, at 10:00 a.m.	F 441	The facility will provide training for all Care Center RN and LPN□s on proper hand washing, proper glove use for dressing changes with wound care, proper application of topical medications, and proper cleaning of glucometer after obtaining resident blood sugar check. Said training will be Mandatory and will occur on Monday, September 29, 2014 at 7:30 am and 12:30 pm The Director of Nursing or her designee will monitor each RN and LPN on their adherence to the above procedure monthly for three months beginning	

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F 441	Continued From page 26 during wound care for a pressure ulcer. dressing change. The Physician Order Sheet signed 8/6/14, indicated R14 diagnoses included type two diabetes, below the knee amputation, venous insufficiency and peripheral vascular disease. The significant change Minimum Data Set (MDS) dated 7/22/14, indicated R14 had no cognitive impairment. R14 required extensive assistance with bed mobility and transfers. The MDS further indicated R14 had one stage three pressure ulcer (a ulcer caused from pressure to an area with full thickness tissue loss) and received the application of a nonsterile dressing with or without topical medications to an area other than the foot. The Physician Order signed 8/6/14, directed change sacral ulcer dressing to Silvadene cream (an antibacterial cream) once daily until granulation was exposed then change back to Medi-honey (a wound gel used for its antibacterial and debriding properties) every one to there days. Cover with a Mepilex Border (an adhesive foam dressing) dressing and change every three days and as needed. On 8/21/14, at 10:00 a.m. registered nurse (RN)-B was observed to provide ulcer care to R14's sacral ulcer. The RN sanitized her hands with the hand sanitizer on the wall in R14's room, moved R14's wheelchair and two tables, pulled the shade and set up the supplies. The RN then donned gloves, removed pillows from behind R14's back, moved the over bed table and positioned R14 onto the left side. The RN then removed the dressing from the ulcer, removed her gloves and sanitized her hands. The RN then	F 441	October 2014; then quarterly for a total of one year, ending September 2015. All monitoring results will be reported to the Quality Improvement/Peer Review Committee. The facility will update current Policy and Procedure for equipment sanitizing to include directions for sanitizing glucometers immediately after each use. Completion date of September 30, 2014. The facility will update the policy and procedure for nosocomial infections to include direction for identifying and addressing current trends to prevent cross-contamination or spread of infections. This process will include a pathway for the Infection Control Coordinator (ICC) to obtain notice of Care Center Resident infections in real time. The Care Center Charge Nurse or Care Center HUC will alert the ICC of Resident□s infection by initiating the Report of Infection and giving to the ICC on date of first action. The ICC will then review report of infection, obtain culture results, follow up/advise Care Center of potential need for further action such as precautions or isolation. The ICC will review and monitor all medications prescribed for nosocomial infections. This monitor will be reviewed monthly for three months starting October 2014, then quarterly for one year, ending September 30, 2015. All nosocomial infection data will be verified, evaluated and summarized into a	

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F 441	Continued From page 27 cleansed the ulcer with saline and a gauze dressing and with the same gloved hands dipped her finger into a medication cup which contained Silvadene cream and applied the Silvadene cream with her index finger to R14's ulcer. The RN applied the Mepilex Border dressing, assisted R14 to sit back up, removed the gloves and sanitized her hands. The RN gathered the trash and exited the room. On 8/21/14, at 10:22 a.m., RN-B stated that was the way she did the dressing change. The RN stated after cleaning the wound she applies the cream with her finger and does not change her gloves, wash or sanitize her hands or use anything else to apply the cream. On 8/21/14, at 2:30 p.m. RN-C who was responsible for infection control at the facility stated the RN should have changer her gloves after cleaning the wound. The RN should not have applied the cream with her finger and should have used some type of an applicator to apply the cream to the wound. The facility's Topical Medications Administration policy effective 2/06, indicated topical medications were to be administered safely and appropriately to aid residents to overcome lesions. The policy directed staff to use a tongue blade or cotton swab apply a thin layer of cream or ointment to the affected area. Proper glove use and hand hygiene standards were not maintained during R1's pressure ulcer dressing change. R1's significant change Minimum Data Set (MDS) dated 7/14/14, indicated R1's diagnoses included	F 441	quarterly report and presented to the Quality Improvement/Peer Review Committee quarterly. The ICC will update the current Infection Control policy and procedure to reflect said changes to identify current trends to prevent cross contamination or spread of infections. The update of p/p and implementation of said actions will occur on or before September 30, 2014. A copy of this update will be provided to all Care Center staff.	

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F 441	Continued From page 28	F 441		

osteoporosis and dementia. The MDS further indicated R1 had severe cognitive impairment and required extensive assistance with bed mobility and transfers. The MDS also indicated R1 had 1 stage 3 pressure ulcer and 2 unstageable pressure ulcers, with skin and ulcer treatments in place which included ulcer care and application of dressings to the feet.

R1's Physician's Orders dated 8/4/14, directed ulcer care to R1's left medial malleolus wound: clean every 3 days, remove slough, apply medi-honey gel to wound bed, cover with Telfa and wrap with Kerlix. R1's Physician's Orders further directed to apply Eucerin cream daily to lateral malleolar and 5th toe.

On 8/13/14, at 9:39 a.m. licensed practical nurse (LPN)-A was observed to provide ulcer care to R1's left heel pressure ulcer. R1 was observed laying in the bed and had a knee-high, white sheepskin lined boot applied to R1's left lower leg. LPN-A loosened the Velcro straps on the white boot and removed it from R1's left lower leg. R1's left lower leg and foot were observed to be turned in and R1's foot had noticeable foot drop. LPN-A was observed to apply disposable gloves and use scissors to cut away the old dressings on R1's left lower leg and foot. LPN-A removed the old gauze dressings and Telfa pad. R1's left foot ulcer dressings were observed to have no visible drainage. R1's stage 3 left foot ulcer was observed on the lower aspect of R1's left inner heel, below R1's inner ankle bone, was shaped like a crescent moon, dry, and tan in color. With the same gloves on, LPN-A applied a clean Telfa dressing to R1's left heel ulcer, wrapped R1's left foot, heel, and ankle with Kerlix gauze wrap, and secured the Kerlix with paper

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tape. LPN-A reapplied R1's white sheepskin boot to R1's left lower leg. LPN-A removed the used gloves and sanitized her hands in R1's bathroom before leaving the room.

On 8/20/14< at 10:00 a.m. LPN-A stated she would normally not change gloves during dressing change unless the wound had a lot of drainage and the gloves were visibly soiled. LPN-A further confirmed R1's old Telfa dressing did not contain visible drainage, therefore LPN-A stated she did not remove the gloves and wash her hands, before applying new gloves and dressing R1's ulcer with a new Telfa and Kerlix gauze. LPN-A verified she forgot to apply the Eucerin cream to R1's left foot when she had removed the old dressing.

On 8/21/14, at 2:50 p.m. registered nurse (RN)-A confirmed nurses should be changing disposable gloves and washing or sanitizing their hands when going between dirty and clean dressings during a dressing change procedure.

The facility's Handwashing policy reviewed 1/2010, indicated staff were required to wash their hands before and after performing any procedure and after removing gloves.

Based on observation, interview and document review, the facility failed to implement a comprehensive infection control program that maintained consistent tracking and trending of infections to identify, document and monitor resident infections. In addition, the facility failed to ensure cleaning of a used glucometer (machine used to check blood sugars) prior to placing it on a food service area and on a

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F 441	Continued From page 30 medication cart to prevent cross-contamination for 1 of 1 residents (R43) observed for glucometer checks. The facility also failed to ensure proper hand hygiene and/or glove changing was implemented during dressing changes for 2 of 3 residents (R1, R14) observed for wound care. Finding include: During an observation on 8/20/14, at 11:40 a.m. the licensed practical nurse (LPN)-A completed a blood sugar check on R34, who had a diagnosis of diabetes, with the glucometer, removed her gloves and left the room while carrying the glucometer. LPN-A went to the closest sink to wash her hands, which was in the dining room food service area, and placed the glucometer on the sink area. She washed her hands, picked up the glucometer, and went to the medication room and set the glucometer on the medication cart. LPN-A documented the results of the blood sugar check on the Medication Administration Record (MAR), picked up the glucometer, wiped it with a bactericidal wipe, and placed the glucometer on the charger. LPN-A verified she set the glucometer down on the sink in the food service area during the time of food service, and also set the glucometer on the medication cart prior to cleaning the glucometer. She verified she should not have set it down and should have cleaned it right away. During an interview with the infection control coordinator (ICC), on 8/21/14, at 10:03 a.m. the ICP verified the glucometer should have been washed before setting it down. The facility policy and procedure for equipment	F 441		

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F 441	Continued From page 31 sanitizing dated 3/10, directed nursing to sanitize equipment, including glucometers, prior to being returned to designated storage areas after each use with sani wipes provided by the facility and allow to air dry. The facility lacked direction for sanitizing immediately after each use. On 8/21/14 at 10:03 a.m., infection tracking and trending logs for the facility were reviewed during an interview with the ICC. The completed logs for March, April, and May of 2014, were provided for review and lacked culture results for 4 of 5 infections cultured in March and 4 of 5 infections cultured in May. 0 of the 18 infections recorded during those three months included documentation of outcome. The ICC stated she gets a monthly infection report with the number of infections from the care center and gets forms that included the resident and room number, date, symptoms, type of infection, antibiotics used, culture, and results if there was one performed. The ICC stated she is able to get the culture results from the lab herself, and verified the log did not always include the organism and the care center is not consistent with reporting culture results. The ICC stated the care center is to give her notice if they have a lot of residents with the same type of organism. The ICC did not identify how current issues with infections would be identified and managed, when asked. The undated facility policy and procedure for nosocomial (infections acquired in the facility) under the infection control manual and exposure plan, directed potentially contagious infections are reported to the ICC, culture reports are collected from the resident's chart and logged on the a report of infection control data sheet. It further directed nursing to complete a report of	F 441		

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F 441	Continued From page 32 infection and nosocomial infection report and submit them to the ICC. The data is to be verified, evaluated and summarized into a quarterly report and presented to the Quality Assurance Committee and the Infection Control Committee. The policy and procedure lacks direction for identifying and addressing current trends to prevent cross-contamination or spread of infections.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure walls, doors, resident equipment and furnishings were maintained and repaired for 17 of 41 residents residing in rooms 101, 102, 106, 202, 203, 204, 206, 207, 208, 210, 301, 308). In addition, the laundry dryer vents in 2 of 2 dryers contained significant lint build up. This had the potential to affect all 34 residents who resided in the facility. Findings include: During an environmental tour of the facility with the maintenance supervisor (MS) on 8/21/14, at 10:00 a.m. the following residents rooms were observed: Room 101: scratched lower third of the wooden	F 465	The scratches, nicks and chips of the doors, door frames, walls, counters and floors in rooms 101, 102, 106, 202, 203, 204, 206, 207, 208, 210 and 308 are in the process of being repaired. The repairs will be completed by September 30, 2014. Completion date of September 30, 2014. In discussions with Nursing Administration, the practice of removing the flush handles on the toilets has been discontinued. Room 102 toilet flush handle and lids have been replaced. Housekeeping staff will submit work tickets to the Maintenance Department to address maintenance concerns. The	9/30/14

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F 465	Continued From page 33 bathroom door, sheet rock paper on the wall next to the bathroom mirror was torn and marred, and the tiled floor underneath the toilet was dirty with a rust-colored substance. Room 102: marred bathroom wall near the mirror, toilet bars loose, and toilet tank missing the cover with 2 rolls of unopened toilet tissue resting on the toilet tank inner parts. Room 106: scraped up lower third of wooden bathroom door and marred bedroom doorway. Room 202: window shade hanging sideways in right-sided window in bed room, cracked floor tiles around closets, and dented and marred wall near closet door. Room 203: sticky white substance on wall near toilet up high and counter top with large chip of Formica missing. Room 204: sticky white substance on wall near toilet up high and cracked and melted personal lamp shade on lamp at the bedside. Room 206: sticky white substance on wall near toilet up high and scraped up wooden bathroom door. Room 207: marred and scraped up wooden bathroom door. Room 208: sticky white substance on wall near toilet up high. Room 210: chipped bathroom sink counter top and sticky white substance on wall next to toilet high up.	F 465	Director of Maintenance will attend Nursing Unit meetings to review the process of completing work requisitions for maintenance concerns. The Director of Maintenance or his designee will monitor the all door and frames, wall surfaces, windows and window treatments and floors for good repair once a month for the next six months. The information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis. The personal wheelchair from room 301 has been removed. Future concerns with Resident□s personal items will be address with the resident and documentation placed in the chart regarding the Resident□s preference. The cleaning schedule for the large dryer lint traps were changed from being cleaned daily to twice daily; one at mid day and once on the evening shift.	

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F 465	Continued From page 34 Room 301: right arm rest of the resident's personal wheelchair covered in paper tape. Room 308: scraped and gouged wall under the bedroom light switch and scraped and gouged corner of wall near the bathroom. On 8/21/14, at approximately 10:30 a.m. the MS confirmed the findings and stated he does not have a schedule for maintenance of resident rooms or common areas. The MS further stated he relies on staff to put in a work order for repairs of resident rooms, including doorways, walls, counter tops, and room furnishings. The MS further stated the toilet tank cover was taken off of the toilet in Room 102 and the handle removed to prevent the resident from flushing the toilet. The CP also stated the toilet paper should not be stored on the back of the open toilet tank. The CP confirmed the window shade in Room 202 needed to be fixed to hang straight. The CP also confirmed the lamp shade in Room 204 would need to be replaced. The CP stated the wheelchair in Room 301 was a personal wheelchair and the resident had applied the paper tape to the right arm rest for personal comfort. The CP confirmed the resident could benefit from a physical therapy consult about the condition of the wheelchair and would refer the situation to the physical therapy department. On 8/21/14, at approximately 10:35 a.m. during a tour of the facility's laundry services, the 2 large dryer vents were observed to contain approximately 3/4 inch of white, lint build up on the vents' screens with several large clumps of lint noted underneath in the bottom of the dryers. The housekeeping supervisor (HS) confirmed the	F 465		

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F 465	Continued From page 35 dryer lint on the screens and in the bottom of the 2 dryers and stated the vents were cleaned daily, at the end of the day. The HS further stated laundry is done twice daily, once during the day and then again on the evening shift. The HS stated with the amount of laundry done, the lint traps should be cleaned more than once daily.	F 465		

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

F5384022

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cook County Northshore Hospital C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Cook County Northshore Hospital C & NC, is a 1-story building with no basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1999 additions were constructed to the building that was determined to be of Type V(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has a hospital attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 37 beds and had a census of 32 at the time of the survey. It is the determination of this Life Safety Code	K 000		

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

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	**515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted

September 5, 2014

Ms. Kimber Wraalstad, Administrator
Cook County Northshore Hospital & C&NC
515 - 5th Avenue West
Grand Marais, Minnesota 55604

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5384024, H5384011

Dear Ms. Wraalstad:

The above facility was surveyed on August 18, 2014 through August 21, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5384011. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Patricia Halverson at (218) 302-6151 or email at: patricia.halverson@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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