DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		ID: OBP5 Facility ID: 00080
1. MEDICARE/MEDICAID PROVIDER N (L1) 245384 2.STATE VENDOR OR MEDICAID NO. (L2) 365745100	0.	3. NAME AND AD (L3) COOK CO N (L4) 515 - 5TH AV (L5) GRAND MA	ORTHSHORE H 'ENUE WEST		&NC (L6) 55604	1. Ini 3. Tei 5. Val	E OF ACTION: 7(L8) tial 2. Recertification rmination 4. CHOW lidation 6. Complaint -Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLI	8. Fu	Il Survey After Complaint
6. DATE OF SURVEY 11/10/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL	YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 37 (L37) (L38) 16. STATE SURVEY AGENCY REMARK See Attached Remarks	37 (L18) 37 (L17) 19 SNF (L39) S (IF APPLICABLE S	X Requirement ICF (L42)	Rece with Program quirements Pased On: Acceptable POC ents and/or Applied V IID (L43)	Vaivers:	And/Or Approved Waiver 2. Technical Persc 3. 24 Hour RN 4. 7-Day RN (Rur 5. Life Safety Coo * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1)	nnel6 7 al SNF)8 le9 (L12)	Requirements: . Scope of Services Limit . Medical Director . Patient Room Size 9. Beds/Room (L15)
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGEN	ICY APPROVAL	Date:
Christine Campbell, I			09/17/2014	(L19)	Enforcement	Specialist	012/19/2014 (L20)
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible		20. COM	D BY HCFA RE		21. 1. Statement o 2. Ownership/ 3. Both of the .	f Financial Solvency (Control Interest Disclo	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTI <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimin	00	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involuntary Termi 04-Other Reason for Withdra		OTHER 07-Provider Status Change 00-Active
			(L45)				
28. TERMINATION DATE:	29 (L28)	0. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS Posted 01/12/20	15 Co.	
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (10/02/2014	OF APPROVAL DAT	те (L33)	DETERMINATION A	PPROVAL	

CCN: 24-5384

C&T REMARKS - CMS 1539 FORM

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 attained substantial 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 Department of Health • Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer



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

Cook Co Northshore Hospital & C&NC November 21 2014 Page 2

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 Meeth

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245384	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/10/2014
Name	of Facility		Street Address, City, State, Zip Code	
CC	OK 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)	ltem		Y5)	Date
		(Correction					Correction					Correction
ID Prefix	E0441		Completed 10/31/2014		ID Prefix	E0520		Completed 10/31/2014		ID Prefix			Completed
			10/31/2014					10/31/2014					
Reg. # LSC	483.65				Reg. #	483.75(o)(1)				Reg. # LSC			
		(Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix								-					
Reg. # LSC					Reg. # LSC					Reg. #			
					200								
		(Correction					Correction					Correction
		(Completed					Completed					Completed
ID Prefix								-					
Reg. #					Reg. #					Reg. #			
					LSC								
		C	Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC _			
		C	Correction					Correction					Correction
		(Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC _			
Reviewed By	Review	ed B	у	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	v PLH	I/m	m	11	/21/20	4		1392	22			11/	10/2014
Reviewed By	Review	ed B	у	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:						-	Uncorrected I			•		
	8/21/2014					Unco	rrecte	d Deficiencies	(CMS	-2567) Sent to	o the Facility?	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00080	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/10/2014
Name	of Facility		Street Address, City, State, Zip Code	
CC	OK 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)	ltem	(Y5	i)	Date	(Y4)	ltem		Y5) I	Date
ID Prefix	20255	(Correction Completed 10/31/2014		ID Prefix	21375	0	Correction Completed 0/31/2014		ID Prefix	21390		Correction Completed 10/31/2014
Reg. # LSC	MN Rule 4658.0070				Reg. # LSC	MN Rule 4658.0800 Subp	. 1			Reg. # LSC	MN Rule 4658.0	800 Subp	. 4 A- I
ID Prefix Reg. # LSC			Correction Completed		Reg. #		(Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. #		(Correction Completed		ID Prefix Reg. #			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			-		te: 1 / 2 1 / 2 0	Signature of Surv	ey		2			Date:	0/2014
State Agency Reviewed By CMS RO					<u>1/21/20</u> te:	14 Signature of Surv	/ey	<u>1392</u> or:	.2			11/1 Date:	0/2014
	Survey Completed on: 8/21/2014	(5/	20)	-							a Summary of to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

						D: OBP5 Facility ID: 00080
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245384 2.STATE VENDOR OR MEDICAID NO. (L2) 365745100).	 NAME AND AD (L3) COOK CO N (L4) 515 - 5TH AV (L5) GRAND MA 	ORTHSHORE H /ENUE WEST		(L6) 55604 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA 8. Full Survey After C	9. Other omplaint
 6. DATE OF SURVEY 8. ACCREDITATION STATUS 0 Unaccredited 1 TJC 2 AOA 3 Other 	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF FISCAL YEAR ENDING 15 ASC 16 HOSPICE 16 HOSPICE 12/31	DATE: (L35)
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	37 (L18)37 (L17)	Compliance X_1. A B. Not in Com	nce With equirements		And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Serv. 3. 24 Hour RN 7. Medical Direct. 4. 7-Day RN (Rural SNF) 8. Patient Room 5. Life Safety Code 9. Beds/Room * Code: B (L12)	etor
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY MEETS	
18 SNF 18/19 SNF 37	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1): (L15)	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK See Attached Remarks	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL	Date:
Christine Campbell, H			10/23/2014	(L19)	Enforcement Specialist	11/20/2014 (L20)
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible 		20. COM	IPLIANCE WITH C		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCF 3. Both of the Above :	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987	23. LTC AGREEMI BEGINNING		24. LTC AGREEME ENDING DATE		<u>VOLUNTARY</u> <u>00</u> <u>INVOLUN</u>	(L30) <u>TARY</u> leet Health/Safety
(L24)	(L41)		(L25)			leet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of		(L44)		03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)	Posted 11/25/2014 Co.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ΓE		
	(L32)	10/02/2014		(L33)	DETERMINATION APPROVAL	

C&T REMARKS - CMS 1539 FORM

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.

STATE AGENCY REMARKS

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.



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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

5384r14

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 10/23/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245384	B. WING			R / 14/2014
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
COOKC	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	TS	{F 00	00}		
{F 441} SS=F	of this department, determine complian issued during a rec August 21, 2014. regulations were de	was completed by surveyors on October 14, 2014, to nce with Federal deficiencies certification survey exited on During this visit the following etermined to be not corrected. N CONTROL, PREVENT	{F 44	\$1}		10/31/14
	Infection Control P safe, sanitary and	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.				
	Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied	stablish an Infection Control ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective				
	determines that a prevent the spread isolate the residen (2) The facility mus communicable dis from direct contact direct contact will t (3) The facility mus hands after each of	tion Control Program resident needs isolation to d of infection, the facility must				·
LABORATOF		IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	<u></u>	(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.

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIP			
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;	F	PLETED
		245384	B. WING			` 14/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12131
соок с	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
{F 441}	Continued From pa professional practi	-	{F 441	}		
		andle, store, process and as to prevent the spread of				
	by: Based on observa review the facility of infection control pr (R35) observed du 1 of 1 residents (R (shingles). The fac trending and moni This had the poter in the facility. Findings include: R2 was started on commonly used to on 10/2/14, with no Progress notes fro eye was red, itchy clearly. R2 also ha above her right ey Tobradex eye drop medication) to her no documented di acyclovir was com			F441 The facility provided retraining for Care Center LPN on proper han washing, proper glove use for dr changes with wound care. Retra occurred on Monday, October 21 A detailed procedure was develor Non-sterile Dressing Changes. procedure was laminated and ha placed with the dressing supplie resource for review prior to the of changes. The Director of Nursing or her d will monitor each RN and LPN of adherence to proper hand wash proper glove use for non-sterile changes with wound care and p application of topical medication week for eight weeks beginning 20, 2014; A competency check individual RN and LPN monitor developed. RNs and LPNs who monitor once will receive retrain coaching. Consistent failure of monitor will result in further coard disciplinary action. The Director	d essing aining 0, 2014. oped for This as been s as a dressing esignee n their ing, dressing roper is, once a October clist for the has been o fail the ing and the ching and	

Facility ID: 00080

If continuation sheet Page 2 of 8

					E CONSTRUCTION	(X3) DATE	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•			COMF	PLETED
		245384	B. WING			F 10/1	< 4/2014
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
соок с	O NORTHSHORE HO	SP & C&NC			15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 441}	it was ordered. She Report of Infection the Tobradex. The form was reviewed the ICC RN. The di diagnosis of shingle came from the ICC not completed the record review. The unaware R2 was b did not complete an appropriate infection been implemented Interview with the of 10/14/14 at 1:00 p. R2 was on either the was unsure why th ordered. The DON monitoring to ensu protocols had been 10/14/14 at 2:15 p. visit note identifying rash which was dia and treated with ac she had done no a precautions impler She further stated monitoring of other housekeeping and they didn't routinely	R2 was on the Tobradex or why e further stated the Nurse's form was not completed for Nurse's Report of Infection for R2's use of acyclovir with ocument identified the es and when asked where it RN did not know as she had form and had not completed a ICC RN verified she was eing treated for shingles and ny monitoring to ensure on control precautions had and utilized by staff. director of nursing (DON) on m. revealed she was unaware ne Tobradex or acyclovir and e medications had been verified she had done no re appropriate infection control n implemented and utilized. On m. the DON provided a clinic g R2's visit on 10/2/14 for the agnosed as recurrent shingles cyclovir. The DON then verified udits on infection control nented and utilized with R2. that there had been no r departments including laundry as that was something	{F 44	¥1}	 RN, LPN and TMA on their adhere proper cleaning of glucometer after obtaining resident blood sugar chemonthly for three months beginnin October 2014; then quarterly for a one year, ending September 2015 monitoring results will be reported Continuous Quality Improvement/Review Committee. Care Center Employees who are of vacation or Leave of Absence will observed for the above monitors of first shift returning to work. The facility has modified the Repo Infection form and associated polic procedure. The Medication Order and procedure has been modified require corresponding diagnosis we every medication order. A memorisent to all Care Center Nurses regist the change on the Medication Order policy and procedure and the need diagnosis prior to processing the medication order. Completion dat October 24, 2014. The Care Center Charge Nurse of Center HUC will alert the Infection for antibiotics by initiat Report of Infection and giving it to on date of first action. The ICC will 	r ck g total of All to the Peer on be on their rt of cy and s policy to vith will be parding ers d for a e of Care Control nfection ing the the ICC	
	p.m. revealed she tracking and trend and identified miss revised the forms	had reviewed the previous ing system for infection control sing information. She then and policies and educated staff also identified residents with			review report of infection, obtain c results, follow up/advise Care Cer potential need for further action su precautions or isolation. The ICC review and monitor all medication	ulture nter of uch as will	

Event ID: OBP512

Facility ID: 00080

If continuation sheet Page 3 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED	
		245384				F	२ 1 4/2014	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
соок с	O NORTHSHORE HO	SP & C&NC			15 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
{F 441}	the same recurring and planned to corr RN admitted she h infection control sy R35 was observed 10/13/14, at 2:44 p (LPN)-D washed h from the right foot. the soiled dressing clean gloves, and s supplies. LPN-D th dressing, placed it soiled gloves and c verified at that time with glove changes pressure ulcer with removed gloves and c On interview upon change, R35's physician pro- indicated a pressur necrotic base, larg suspicious for mor 10/1/14, the physic change to right here of eschar, use no s periwound skin. Ap Border, and chang On 10/14/14, at 9:5 interviewed and sta wash their hands a dressing, and prior DON stated LPN-E dressing changes	age 3 micro-organism in infections ntact the pharmacist. The ICC ad done no audits on the stems within the facility. during a dressing changes on .m. Licensed practical nurse ands and removed R35's sock LPN-D removed the edges of from R35's right heel, donned set up the clean dressing en removed the soiled in the trash, removed the donned clean gloves. LPN-D e he had not washed hands s. LPN-D then cleansed the normal saline and gauze, nd washed his hands, donned completed the dressing change. completion of the dressing ogress notes dated 9/24/14, re ulcer right heel stage II with e surrounding dusky area, e deep tissue necrosis. On cian's orders directed dressing el: apply Medihoney gel to area sting barrier prep to protect oply heel-shaped Meplex ie every three days. 52 a.m. the DON was ated she would expect staff to any time after removing a soiled to donning clean gloves. The D had received training in and hand hygiene; however, its to verify staff compliance	{F 4	41}	prescribed for nosocomial infection monitor will be reviewed monthly for months starting October 2014, the quarterly for one year, ending Sep 30, 2015. All nosocomial infection data will be verified, evaluated and summarized quarterly report and presented to the Continuous Quality Improvement/I Review Committee quarterly.	or three n tember e d into a he		

Facility ID: 00080

If continuation sheet Page 4 of 8

		AND HUMAN SERVICES			PRINTED: 10/23/2014 FORM APPROVED
STATEMENT	SFOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245384	B. WING		R 10/14/2014
NAME OF F	PROVIDER OR SUPPLIER	· · · ·		STREET ADDRESS, CITY, STATE, ZIP COI	
COOKC	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
{F 441}	Continued From pa	age 4	{F 441	}	
F 520 SS=F	Dressing Change u remove soiled dres		F 52	0	10/31/14
	assurance commit nursing services; a	ntain a quality assessment and tee consisting of the director of physician designated by the t 3 other members of the			
	committee meets a issues with respec and assurance act develops and imple	ment and assurance at least quarterly to identify t to which quality assessment ivities are necessary; and ements appropriate plans of entified quality deficiencies.			
	disclosure of the re except insofar as s	cretary may not require ecords of such committee such disclosure is related to the h committee with the is section.			
		ts by the committee to identify deficiencies will not be used as ns.			
	by:	NT is not met as evidenced w and document review the		F520	
L		a Obaciata Event ID: OPP5	<u> </u>	Epoility ID: 00080	Continuation sheet Page 5 of

Event ID: OBP512

Facility ID: 00080

If continuation sheet Page 5 of 8

	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MUT	ייסוד	E CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		245384	B. WING			R 10/1	4/2014
AME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	O NORTHSHORE HO	OSP & C&NC			15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 520	Continued From pa	age 5	F 5	20			
	facility failed to correviews to ensure of practices. This had residents in the face Findings include: During review of the assurance (QA) programmets quart DON and administ center tried to meet was 8/12/14. She was 8/12/14. She was from the Minnesota survey exited 8/21, regarding facility structure monitoring DON reported they 10/13/14, but with meeting was reschindicated had the rehave reviewed the survey exited was 10/13/14, but with meeting was reschindicated had the rehave reviewed the survey exited was the survey for the survey exited the survey for the survey exited the survey for the survey	nplete quality monitors and correction of identified deficient the potential to affect 24 of 24			The facility has a comprehensive q assessment and assurance progra includes a Care Center Nursing Department Subcommittee, Contin Quality Improvement/Peer Review Committee (organization wide Com- including all Departments), Medica and Board of Directors. The Cont Quality Improvement/Peer Review Committee meets monthly and the Center Nursing Department Subcommittee will meet monthly ra than Quarterly. The facility does co- routine monitoring of cares and con- The monitors for the Statement of Deficiencies F441 are as follows: The Director of Nursing or her desi will monitor each RN and LPN on t adherence to proper hand washing proper glove use for non-sterile dre changes with wound care and prop application of topical medications, week for eight weeks beginning Oc 20, 2014; A competency checklist individual RN and LPN monitor has developed. RNs and LPNs who fa monitor once will receive retraining coaching. Consistent failure of the monitor will result in further coachi disciplinary action. The Director of Nursing or her designee will monitor RN, LPN and TMA on their adhere proper cleaning of glucometer afte obtaining resident blood sugar che monthly for three months beginnin	m that uous mittee I Staff inuous Care ther omplete ncerns. gnee heir l, essing oer once a ctober t for the s been il the and f or each nce for r ck	

Event ID: OBP512 Facility ID: 00080

If continuation sheet Page 6 of 8

		AND HUMAN SERVICES				PRINTED: FORM OMB NO.	APPROVEI
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED R 10/14/2014	
		245384	B. WING				
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CO		
соок с	O NORTHSHORE HO	OSP & C&NC			15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	Continued From pa	age 6	F	520	monitoring results will be report Continuous Quality Improvem Review Committee. Care Center Employees who vacation or Leave of Absence observed for the above monit first shift returning to work. The Care Center Charge Nur Center HUC will alert the Infe Coordinator (ICC) of Resider or an order for antibiotics by it Report of Infection and giving on date of first action. The IC review report of infection, obt results, follow up/advise Care potential need for further acti precautions or isolation. The review and monitor all medica prescribed for nosocomial inf monitor will be reviewed mon months starting October 2014 quarterly for one year, ending 30, 2015. All nosocomial infection data verified, evaluated and summ quarterly report and presenter Continuous Quality Improven Review Committee quarterly. The Continuous Quality Impr Coordinator will review and the completion of all monitors be completed as a result of the Deficiencies. The tracking of completion of the monitors a audited concurrently.	are on e will be fors on their rese or Care ection Control at s infection nitiating the g it to the ICC C will then ain culture e Center of on such as ICC will ations fections. This thly for three 4, then g September will be harized into a ed to the nent/Peer ovement rack the ing Statement of f the	

Event ID: OBP512

Facility ID: 00080

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES			PRINTED: 10/23/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245384	B. WING		— R 10/14/2014
NAME OF I	PROVIDER OR SUPPLIER	I	1	STREET ADDRESS, CITY, S	TATE, ZIP CODE
соок с	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN	
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				LAN OF CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)
				· · · · · · · · · · · · · · · · · · ·	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: OBF	•512	Facility ID: 00080	If continuation sheet Page 8 c

MENT OF HEALTH AN	D HUMAN SERVICES			FOF	RMAPPROVED	
S FOR MEDICARE & I	MEDICAID SERVICES			OMB N	IO. 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED		
	245384	B. WING		1	R 0/14/2014	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E		
NORTHSHORE HOSP &	C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO					
INITIAL COMMENTS		{F 000)}			
of this department, on determine compliance issued during a recent August 21, 2014. Dur regulations were dete 483.65 INFECTION C SPREAD, LINENS The facility must estal Infection Control Prog safe, sanitary and corr to help prevent the de of disease and infection (a) Infection Control F The facility must estal Program under which (1) Investigates, contr in the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infe (b) Preventing Spread (1) When the Infection determines that a resi prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact wit direct contact will tran	 a October 14, 2014, to a with Federal deficiencies b with Federal deficiencies c ONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions. d of Infection n Control Program ident needs isolation to infection, the facility must rohibit employees with a se or infected skin lesions th residents or their food, if ismit the disease.	{F 44				
	S FOR MEDICARE & I S FOR MEDICARE & I S DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER NORTHSHORE HOSP & SUMMARY STA (EACH DEFICIENCI REGULATORY OR L INITIAL COMMENTS An onsite resurvey w of this department, or determine compliance issued during a recert August 21, 2014. Du regulations were deter 483.65 INFECTION C SPREAD, LINENS The facility must estal Infection Control Prog safe, sanitary and cort to help prevent the de of disease and infection (a) Infection Control F The facility must estal Program under which (1) Investigates, contri in the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infe (b) Preventing Spread (1) When the Infection determines that a resis prevent the spread of isolate the resident. (2) The facility must re- hands after each direction (3) The facility must re- hands after each direction (4) The facility must re- hands after each direction (5) The facility must re- hands after each direction (5) The facility must re- (5) The facility must re- (6) The facility must re- (7) The facility must	CORRECTION IDENTIFICATION NUMBER: 245384 ROVIDER OR SUPPLIER NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING 245384 B. WING	S FOR MEDICARE & MEDICAID SERVICES DF DEFIDENCIES (X1) PROVIDERSUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER A BUILDING 245384 B WING NORTHSHORE HOSP & CANC STREET ADDRESS, CITV, STATE, ZIP COD SIS - STH AVENUE WEST GRAND MARAIS, MN 55004 WORTHSHORE HOSP & CANC STREET ADDRESS, CITV, STATE, ZIP COD SIS - STH AVENUE WEST GRAND MARAIS, MN 55004 WORTHSHORE HOSP & CANC STREET ADDRESS, CITV, STATE, ZIP COD SIS - STH AVENUE WEST GRAND MARAIS, MN 55004 WORTHSHORE HOSP & CANC STREET ADDRESS, CITV, STATE, ZIP COD SIS - STH AVENUE WEST GRAND MARAIS, MN 55004 WORTHSHORE HOSP & CANC STREET ADDRESS, CITV, STATE, ZIP COD SIS - STH AVENUE WEST GRAND MARAIS, MN 55004 INITIAL COMMENTS PREFX INITIAL COMMENTS {F 000} 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 wisit the following regulations were determined to be not corrected. 433.65 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	S FOR MEDICARE & MEDICAID SERVICES OMB N 0 P DEFICIENCIES (X) PROVIDERSUPPLIERCIA (X) MULTIPLE CONSTRUCTION (X) OCCUPATION 1 245384 B. WING (X) ROWDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE 515 - 5TH ACENUE WEST ROWDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (B) WING (C) OCCUPATION (C) CODENTERING WORMANDON) INTITAL COMMENTS (F 000) PRETX (FCOOS=CETIVE ACTION SHOLD BY TULL RECOLDENTIFICATION MUST BE PRECEDED BY TULL RECOLDENTIFICATION SHORMANDON) PROVIDERS MAN OF CORRECTION (FACI CORRECTIVE ACTION SHOLD BY TAG INITIAL COMMENTS (F 000) PRETX PRETX An onsite resurvey was completed by surveyors of this department, on October 14, 2014, to determine compliance with Federal deficiencies issued during a recorrification survey exited on August 21, 2014. During this visit he following regulations were determined to be not corrected. (F 441) STREED, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and confortable environment and to help prevent the development and transmission of disease and infection. (F 441) (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 incidcions fr	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 10/17/2014

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.

		ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 10/17/2014 DRM APPROVED NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245384	B. WING			R 10/14/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
	NORTHSHORE HOSP &	C C & N C		515 - 5TH AVENUE WEST			
				GRAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 441}	Continued From page	e 1	{F 44	1}			
	professional practice.						
		lle, store, process and to prevent the spread of					
	by: Based on observatio review the facility did infection control prec. (R35) observed durin 1 of 1 residents (R2) (shingles). The facility trending and monitori This had the potentia in the facility. Findings include: R2 was started on ac commonly used to the	is not met as evidenced n, interview and document not provide appropriate autions for 1 of 1 residents g a dressing change and for reviewed with herpes-zoster y did not implement tracking, ing infection control systems. I to affect 24 of 24 residents evelovir (anti-viral medication eat herpes-zoster) for 5 days					
	Progress notes from eye was red, itchy an clearly. R2 also had a above her right eye. I Tobradex eye drops (medication) to her lef no documented diagr acyclovir was comple concern was resolved Tobradex was discon	ted. On 10/9/14, the left eye d and on 10/10/14, the					
		/14, at 12:42 p.m., stated					

Facility ID: 00080

If continuation sheet Page 2 of 6

	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 10/17/201 FORM APPROVE MB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTR	(X3) DATE SURVEY COMPLETED		
		245384	B. WING _				R 10/14/2014
NAME OF PROVIDER OR SUPPLIER				STREET AD	DDRESS, CITY, STATE, ZIP CO	DDE	
соок со	NORTHSHORE HOSP 8	C&NC			AVENUE WEST MARAIS, MN 55604		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE	
{F 441}	it was ordered. She find Report of Infection for the Tobradex. The Nut form was reviewed for the ICC RN. The doce diagnosis of shingles came from the ICC R not completed the for record review. The ICC unaware R2 was beind did not complete any appropriate infection been implemented ar Interview with the direct 10/14/14 at 1:00 p.m. R2 was on either the was unsure why the rordered. The DON ver monitoring to ensure protocols had been in 10/14/14 at 2:15 p.m. visit note identifying F rash which was diagr and treated with acycl she had done no aud precautions implemented the form the tracking and trending and identified missing revised the forms and the forms and trending and identified missing revised the forms and the forms	was on the Tobradex or why urther stated the Nurse's rm was not completed for urse's Report of Infection or R2's use of acyclovir with ument identified the and when asked where it N did not know as she had m and had not completed a CC RN verified she was ng treated for shingles and monitoring to ensure control precautions had nd utilized by staff. ector of nursing (DON) on revealed she was unaware Tobradex or acyclovir and medications had been erified she had done no appropriate infection control mplemented and utilized. On the DON provided a clinic R2's visit on 10/2/14 for the nosed as recurrent shingles clovir. The DON then verified its on infection control nted and utilized with R2. at there had been no epartments including undry as that was something	{F 44	41}			

Facility ID: 00080

If continuation sheet Page 3 of 6

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · · ·	PLETED
					R	
245384		B. WING		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	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
{F 441}	1.5	e 3 nicro-organism in infections	{F 441]	}		
	RN admitted she had infection control syste R35 was observed du 10/13/14, at 2:44 p.m (LPN)-D washed han from the right foot. LF the soiled dressing fr clean gloves, and set supplies. LPN-D ther dressing, placed it in soiled gloves and do verified at that time h with glove changes. I pressure ulcer with n removed gloves and clean gloves and con	act the pharmacist. The ICC I done no audits on the ems within the facility. uring a dressing changes on m. Licensed practical nurse ds and removed R35's sock PN-D removed the edges of om R35's right heel, donned t up the clean dressing n removed the soiled the trash, removed the nned clean gloves. LPN-D e had not washed hands LPN-D then cleansed the ormal saline and gauze, washed his hands, donned npleted the dressing change. ompletion of the dressing				
	indicated a pressure necrotic base, large s suspicious for more of 10/1/14, the physicial change to right heel: of eschar, use no stir periwound skin. Appl Border, and change of On 10/14/14, at 9:52	a.m. the DON was				
	interviewed and state wash their hands any dressing, and prior to DON stated LPN-D h dressing changes an	ed she would expect staff to y time after removing a soiled o donning clean gloves. The ad received training in d hand hygiene; however, to verify staff compliance				

Facility ID: 00080

If continuation sheet Page 4 of 6

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/17/2 FORM APPROV OMB NO. 0938-03		
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245384	B. WING		R 10/14/2014		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
	NORTHSHORE HOSP &	C & N C		515 - 5TH AVENUE WEST			
000000	NORTHSHORE HOSP &	Canc		GRAND MARAIS, MN 55604			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETI			
{F 441}	Continued From page	e 4	{F 44	1}			
F 520 SS=F	Dressing Change und remove soiled dressing		F 52	20			
	assurance committee nursing services; a pl facility; and at least 3 facility's staff. The quality assessme	in a quality assessment and e consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify					
	and assurance activit develops and implem	o which quality assessment ies are necessary; and ients appropriate plans of tified quality deficiencies.					
		ords of such committee th disclosure is related to the ommittee with the					
		by the committee to identify aficiencies will not be used as					
	by:	is not met as evidenced and document review the					

If continuation sheet Page 5 of 6

PRINTED: 10/17/2014

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 10/17/2014 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED R	
		245384	B. WING					≺ 14/2014
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		-
соок со	NORTHSHORE HOSP &	C&NC		-	15 - 5TH AVENUE WEST RAND MARAIS, MN 55	604		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 520	reviews to ensure cor practices. This had the residents in the facilit Findings include: During review of the construction group meets quarterly DON and administratic center tried to meet in was 8/12/14. She ver from the Minnesota D survey exited 8/21/14 regarding facility statu further stated the care routine monitoring of DON reported they w 10/13/14, but with the meeting was resched indicated had the meeting	lete quality monitors and rection of identified deficient ie potential to affect 24 of 24 y. quality assessment and ram on 10/14/14 at 2:15 ursing (DON) stated the y and is led by the hospital or. The DON stated the care nonthly, but the last meeting ified the deficient practices bepartment of Health (MDH) were not reviewed in QA us for correction. The DON e center did not do any cares or concerns. The ere scheduled to meet on e arrival of MDH staff the uled for 10/20/14. The DON eting occurred she would dits she had completed and	F	520				

Facility ID: 00080

If continuation sheet Page 6 of 6

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245384	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0157		10/14/2014		ID Prefix			10/14/2014		ID Prefix			10/14/2014
•	483.10(b)(11)				•	483.15(a)				•	483.20(k)(3)(ii)		_
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0314		10/14/2014		ID Prefix	F0329		10/14/2014		ID Prefix	F0356		10/14/2014
Reg. #	483.25(c)				Reg. #	483.25(I)				Reg. #	483.30(e)		
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	F0428		Completed 10/14/2014		ID Prefix	F0431		Completed 10/14/2014		ID Prefix	F0465		Completed 10/14/2014
Reg. #	483.60(c)				Reg. # LSC	483.60(b), (d), (e)				Keg. # LSC	483.70(h)		_
									+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
			o "										.
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
				-					+				
Reviewed By	/ Review	ed E	Зу	Da	ite:	Signature of	Surve	yor:				Date:	
State Agenc	, PLH	I/n	nm	10)/17/20	14	1392	22				10/	14/2014
Reviewed By	/ Review	ed E	Зу	Da	ite:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of													
	Lincorrected Deficiencies (CMS-2567) Sent to the Eacility?					NO							

DEPARTMENT OF H	IEALTH AND HUMA	N SERVICES	CENTERS FOR MEI	DICARE & MEDICAID SERVICES			
		ARE/MEDICAID CERTIFICATION TO BE COMPLETED BY THE S		ID: OBP5 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 HO (L4) 515 - 5TH AVENUE WEST (L5) GRAND MARAIS, MN	SP & C&NC (L6) 55604	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
5. EFFECTIVE DATE CHAI	NGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ES	<u>02</u> (L7) SRD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
 DATE OF SURVEY ACCREDITATION STAT 0 Unaccredited 2 AOA 	08/21/2014 (L34) US: (L10) 1 TJC 3 Other	02 SNF/NF/Dual06 PRTF10 NI03 SNF/NF/Distinct07 X-Ray11 IC04 SNF08 OPT/SP12 RI	F/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 12/31			
 11. LTC PERIOD OF CERTIN From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	FICATION 37 (L18) 37 (L17)	 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program 	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director			
13. Total Certified Deus	57 (217)	Requirements and/or Applied Wai	vers: * Code: B *	(L12)			
14. LTC CERTIFIED BED B	REAKDOWN		15. FACILITY MEETS				
18 SNF 18	/19 SNF 19 SNF 37	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37)	(L38) (L39)	(L42) (L43)					
16. STATE SURVEY AGEN See Attached Remarks	CY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATION DATE):					
17. SURVEYOR SIGNATU	RE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:			
Kathie Killoran	, HFE NEII	09/17/2014 (L1	Enforcemen	Enforcement Specialist 09/29/2014			
	PART II - TO BE	COMPLETED BY HCFA REGIO					
19. DETERMINATION OF 1 _X1. Facility is El2. Facility is not	igible to Participate	20. COMPLIANCE WITH CIVII RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION	: (L30)			
OF PARTICIPATION 01/01/1987	BEGINNINC	DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure 0	0 INVOLUNTARY 05-Fail to Meet Health/Safety			
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimburs				
25. LTC EXTENSION DAT		VE SANCTIONS a of Admissions:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	07-Provider Status Change			
(I 27)	(L44) spension Date:		00-Active			
		(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/CARRIER NO.	30. REMARKS				
		03001					
	(L28)	(L3	1)				
31. RO RECEIPT OF CMS-1	539 32	. DETERMINATION OF APPROVAL DATE					
	(L32)	(L3)	3) DETERMINATION APP	ROVAL			

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.



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;

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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.

Cook County Northshore Hospital & C&NC September 5, 2014 Page 3

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.

Cook County Northshore Hospital & C&NC September 5, 2014 Page 4

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

Cook County Northshore Hospital & C&NC September 5, 2014 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Cook County Northshore Hospital & C&NC September 5, 2014 Page 6

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

Sincerely,

Mark Weath

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

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIP	LE CONSTRUCTION		0. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		CON	MPLETED
		245384	B. WING		08	/21/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	E	
OOK C	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN `55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 000	INITIAL COMMEN	TS	F 000			
	as your allegation of Department's acce enrolled in ePOC, at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.				
	on-site revisit of yo validate that subst	acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with				
F 157	investigated and n deficiencies issued 483.10(b)(11) NO	TIFY OF CHANGES	F 15	7		9/30/14
SS=D	A facility must imm consult with the re- known, notify the re- or an interested fa accident involving injury and has the intervention; a sig physical, mental, of deterioration in he status in either life clinical complication significantly (i.e., a existing form of tro	ediately inform the resident; sident's physician; and if resident's legal representative mily member when there is an the resident which results in potential for requiring physician hificant change in the resident's or psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ons); a need to alter treatment a need to discontinue an eatment due to adverse to commence a new form of				
						(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.

		AND HUMAN SERVICES				FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY
		245384	B. WING		·	08/2	1/2014
	PROVIDER OR SUPPLIER	SP & C&NC	I	51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	Continued From patreatment); or a dethe resident from the system of the resident from the system of the facility must at and, if known, the or interested family change in room or specified in system of specified in system of specified in system of the system of the system of the address and part of the address and part of the system of	age 1 cision to transfer or discharge he facility as specified in lso promptly notify the resident resident's legal representative y member when there is a roommate assignment as 15(e)(2); or a change in ler Federal or State law or cified in paragraph (b)(1) of ecord and periodically update hone number of the resident's re or interested family member. ENT is not met as evidenced w, and document review, the sure timely notification of the ccurred with the development e ulcers for 1 of 3 residents pressure ulcers.		157	Resident 1'□s son and daughte visited on September 8, 2014. T following was documented in th notes on that day: "FAMILY: Re and daughter-in-law visiting tod Resident Care Manager and W Nurse met with family and revie resident Plan of Care. Discusse pathological break in lower leg, use and development of pressu Son reported that resident's PC contacted them after Rounds to them of the wound. Son also st "Mom has always gotten really here." Son does not attend Car	The e Nurse sident son ay. ound Care wed air splint are ulcer. P had o notify ated, good care e	
	indicated a press	ogress Notes dated 6/29/14, ure ulcer was discovered on the the left heel under an air cast			Conferences due to need to tra distance, and chooses not to a telephone conference because that he can't hear well enough.	tend via he states This	et Page 2 of

Facility

____ 36 ıy

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245384	B. WING		08/2	1/2014
VAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
соок с	O NORTHSHORE HO	SP & C&NC	1	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	COMPLETIC
F 157	Continued From pa	age 2	F 157	7		
,		ture. The pressure ulcer		statement indicates the son v	vas notified	
		by 1.5 cm by 1 cm in depth with		by resident⊡'s primary care p		
	pale gray slough in			letter mailed to them either a		
				on 7/28/14 or 8/18/14." The le		
		ry Patient Progress Notes		to the legal representatives o Residents by the Primary Ca		
		cated a physician was called to oot. The Progress Note		will be copied and retained in		
		pressure ulcers under R1's air				
		medial malleolus with stage 3	1	The Care Center Charge Nu		
		d/copious exudate, estimated		directed to immediately inform Resident; consult with the Re	m tne sident⊡s	
		1.5 inches; 2. lateral malleolus llcer, pressure point had		physician; and if known, notif	the	
		pura colored area, non tender		Resident⊡s legal representa		
		edge of the left foot at the		interested family member wh		
	distal 5th metatars	al, bluish, non-blanching,		an accident involving the res		
	non-tender. The F	Progress Note concluded R1		results in an injury and has the		-
	developed pressur	re ulcers under the air cast.		for requiring physician interve significant change in the resi		
	Review of R1's ele	ectronic Progress Notes dated		physical, mental, or psychos		
		ugh 8/14/14, lacked evidence of		(i.e., a deterioration in health	, mental, or	
		regarding the pressure ulcers		psychosocial status in either	life	
	under the air cast.			threatening conditions or clir		
				complications); a need to alt		
		proximately 2:30 p.m. registered ied the lack of documented		significantly (i.e., a need to d existing form of treatment du		
		family regarding the pressure		consequences, or to comme		
	ulcers.			form of treatment); or a deci	sion to	
				transfer or discharge the res	ident from the	
		proximately 3:30 p.m. the		facility. This directive will be	o Nuroco of	
	director of nursing	(DON) stated she was not was not notified when R1's		communicated to the Charge the Care Center via a facility		
	pressure ulcer had	d been discovered. The DON		by Friday, September 19, 20		
		s family should have been		A matter with the atternation of the	Contomber	
		mentation of the notification in		A policy will be developed by 19, 2014, to address "Notific		
	R1's medical reco	iu.		Changes (Injury/Decline/Rod		
				new policy will be shared with		r
				Charge Nurses via facility er	mail and	1
				reviewed at the Care Center		

,

		& MEDICAID SERVICES				<u>1B NO. (</u> (X3) DATE	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (LETED
		245384	B. WING			08/2	1/2014
AME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OOK C	O NORTHSHORE HO	SP & C&NC			5 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 157	Continued From pa	age 3	F 1	57	nurse meeting on Monday, October 2014.	⁻ 6,	
				241	The Director of Nursing or her design will monitor documentation in reside record for Notification of Changes. will be done once a week starting of September 22, 2014 for four weeks Monitoring will continue monthly for months. The results of the monitoring will be reported to the QA committee	ent⊡s This n s. five ng plan	9/30/14
F 241 SS=D	INDIVIDUALITY The facility must p manner and in an enhances each res	Y AND RESPECT OF romote care for residents in a environment that maintains or sident's dignity and respect in his or her individuality.		_ 1			
· · · · · · · · · · · · · · · · · · ·	by: Based on observa review, the facility incontinent briefs 4 residents (R13, Findings include: R13's physician's diagnoses that inc disease and deme Data Set (MDS) d long and short ten severely impaired The MDS further i incontinent of bow	ENT is not met as evidenced ation, interview and document failed to ensure resident were placed out of view for 3 of R3, R1) reviewed for dignity. order sheet, undated, identified cluded peripheral vascular entia. The quarterly Minimum ated 7/14/14, indicated R13 had m memory problems, and daily decision making skills. ndicated R13 was totally rel and bladder, and required nce of one staff for toileting			Personal incontinent products will removed from areas in the Resider rooms that can be seen by the pub the shelving units will have a cover placed over them to prevent the incontinent products from being se Incontinent products will be stored bathroom and those stored in the r will be stored out of public view. T policy "Maintenance of Resident D will be updated to state: "Resident incontinent briefs will be stored in the rooms concealing the presence of from public view or in the bathroon updated policy will be shared with Center staff via facility email and re	nts⊡' olic or ing een. in the room he ignity" their briefs n". The Care	

Facility ID: 00080

If continuation sheet Page 4 of 36

		& MEDICAID SERVICES				(X3) DATE	0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED	
		245384	B. WING _			08/21/2014		
AME OF I	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE			
соок с	O NORTHSHORE HO	SP & C&NC			5 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 241	needs.		F 2	41	at the staff meetings on October 2 2014. Completion date of Septem			
	observed to have a cabinet in the sittin adult incontinent bit observed througho through 8/21/14, w On 8/20/14, at 2:24 was interviewed, at private person, and visitors aware he/s stated R13 would n know this. On 8/21/14, at 9:33 (DON) and registe interviewed, and b room contained interviewed, and b room contai	5 p.m. R13's room was a wall-mounted white corner g area. The cabinet contained riefs. The cabinet was but the survey from 8/18/14, ith visible incontinent briefs. 4 p.m. family member (FM)-A nd stated R13 had been a very d would be bothered by having the was incontinent. FM-A not have wanted anyone to 3 a.m. the director of nursing red nurse (RN)-A were oth verified the cabinet in R13's continent briefs. ange MDS dated 7/14/14, gnoses included osteoporosis e MDS further indicated R1 had npairment, required extensive staff with toileting needs, and inent of bowel and bladder. 55 p.m. R1's room was a wall-mounted white corner ng area. The cabinet contained oriefs. The cabinet was			2014. The Director of Nursing or designer monitor the resident rooms to veri- incontinent products are not visible public. The monitor will be comple- twice a month for three months ar once a month for three months. The results of the monitor will be repor- the Quality Improvement/Peer Re- Committee on a monthly basis.	ty that to the ted d then ne ted to		
	through 8/21/14, v On 8/20/14, at 2:2 was interviewed d stated R1 was a v	out the survey from 8/18/14, vith visible incontinent briefs. 0 p.m. family member (FM)-B uring a telephone call, and ery private person and would one was aware of their						

Event ID: OBP511

Facility ID: 00080

If continuation sheet Page 5 of 36

		AND HUMAN SERVICES			·		APPROVED 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE	
AND FLAN O	CORRECTION	245384	B. WING			08/21	
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	00/2	
	O NORTHSHORE HC				5TH AVENUE WEST ND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	Continued From pa	age 5	F 24	41			
	stated the shelves maybe 2 to 3 years	5 a.m. nursing assistant (NA)-E had been in R1's room for s. NA-E further stated the were put there for staff					
	On 8/21/14, at 3:0 stated incontinent placed out of sight	8 p.m. registered nurse (RN)-A products should be covered or t.					
	6/10/14, indicated deficit, required lin	num Data Set (MDS) dated R3 had a severe cognitive nited assistance of one staff for ming, and had frequent urinary				ŗ	
	be reminded to to seemed to be an The care card dat	ed 7/18/14, indicated R3 was to ilet to reduce incontinence, as it embarrassment and agitation. red 7/22/14, also indicated med to be an embarrassment					
	there was an inco counter. On 8/20/	on on 8/19/2014, at 1:59 p.m., ontinent pad on R3's bathroom 14, at 7:23 incontinent pads an open shelf behind the entry entry area.					
	about 3/4 of the w were visible on th	07 a.m. R3's entry door was vay open. The incontinent pads le shelf behind the door from the vas also an incontinent pad on unter top.	e				
	nursing assistant put up a long time	ew on 8/21/14, at 1:55 p.m. (NA)-D stated the shelves were e ago and incontinent pads have	e				
FORMOME	2567(02-99) Previous Versio	ons Obsolete Event ID: OBF	P511	Facili	ty ID: 00080 If co	ntinuation she	et Page 6 of 3

		AND HUMAN SERVICES			OMB NO. (PPROVED
STATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	
		245384	B. WING _		08/2	1/2014
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD	E	
соок со	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 241	registered nurse (F gesture of agreem	v on 8/21/14, at 2:09 p.m. RN)-A nodded head in a ent when it was noted R3's	F 24	11		
	care plan indicated embarrassed and stated R3 was the this time.	agitated with incontinence, and only one using the bathroom at				
F 282 SS=D	revised 10/13, dire visible to public vie personal care. Th directed staff to re personal nature as including incontine resident's bed whe 483.20(k)(3)(ii) SE	and procedure for dignity ected no visible indicators ew that relate to the resident's e policy and procedure further move any information of a s it relates to the resident, ence pads on top of the en not occupied by the resident. ERVICES BY QUALIFIED CARE PLAN	F 2	82		9/26/14
	must be provided	ided or arranged by the facility by qualified persons in each resident's written plan of				
	by: Based on observ review, the facility to for the care and development of p	ENT is not met as evidenced ation, interview, and document failed to follow the plan of care d services to prevent the ressure ulcers was provided for R1) reviewed for pressure		Plan of care changes directinurse to a change in an intermade on the plan of care. T shows up on the nurse'⊡s in work list with the information in the text box. Nurses received care card information by placen new card care in the treatment on the report board for nurse	vention are his change tervention showing up ve updated cement of the ent kardex and	

Event ID: OBP511

Facility ID: 00080

If continuation sheet Page 7 of 36

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		SURVEY PLETED
		245384	B. WING		08/2	21/2014
	ROVIDER OR SUPPLIER	SP & C&NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	GRAND MARAIS, MN 55604 PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	dated 7/14/14, indi- impairment, had ex- required extensive transfers and bathi R1's care plan revi- for development of plan directed an ai- licensed staff only cleansing and press On 8/21/14, at 1:1 stated R1's stage discovered on 6/29 leaking through R2 RN-A and RN-D b- the nurse perform to observe R1's sk the bony prominer areas. On 8/21/14, at 2:3 (LPN)-C was inter stated she did not	ange Minimum Data Set (MDS) cated R1 had severe cognitive kisting pressure ulcers, and assistance with bed mobility, ing. ewed 6/9/14, indicated a risk f pressure ulcers. The care r splint to the left foot/ankle, to remove the splint for ssure checks. 7 p.m. registered nurse (RN)-D 3 pressure ulcer was 9/14, when staff noticed fluid 1's left lower leg air splint. oth stated they would expect ing the weekly skin assessment kin under the brace and check nees around the heel and ankle 4 p.m. licensed practical nurse viewed via telephone. LPN-C open up R1's air splint and ankle during the weekly skin	F 28	 updated care cards are board for one week. A splint intervention tast developed and will appendent of the best time to remove depending on the residered ease of removal/ check replacing of splint. Doct time/day will be differer based on what works b resident. This informatic communicated to the C facility email and review Center Charge Nurse r Monday, October 6, 20 The policies on pressu care will be reviewed a appropriate by Septem reviewed/revised polici communicated to staff and reviewed at the Octometing. The Director of Nursing will monitor documentaries and reviewed at the Octometing. The Director of Nursing will monitor documentaries and reviewed to the Octometing. 	k has been ear on the task will be done of the letermined as to e the splint ent□'s mobility and ing of skin/ umentation of the the for each resident est for the on will be Charge Nurses via a wed at the Care neeting on 14. re ulcers and cast nd revised as ber 26, 2014. The es will be via a facility email ctober staff g or her designee ation in resident □s pers. This will be rting on September is. Monitoring will ve months. The ng plan will be	
F 314	483.25(c) TREAT	MENT/SVCS TO	F	Review Committee mo	ontniy.	9/26/14

	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				(X3) DATE	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		245384	B. WING			08/2	1/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
COOK C	O NORTHSHORE HO	SP & C&NC			15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 SS=G	PREVENT/HEAL P Based on the comp resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores rec services to promot prevent new sores This REQUIREME by: Based on observa review, the facility care to prevent the ulcers for 1 of 4 re pressure ulcers. T development of a constituted actual Findings include: R1's significant ch dated 7/14/14, ind	PRESSURE SORES orehensive assessment of a or must ensure that a resident lity without pressure sores pressure sores unless the condition demonstrates that able; and a resident having reives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced ation, interview, and document failed to provide appropriate e development of pressure sidents (R1) reviewed for The lack of assessment and the stage 3 pressure ulcer harm for R1.		314	Resident 1 had a slightly displace bimalleolar fracture. An air splint v applied to protect the fracture and noted "good pain control when we manipulating the limb". The bruisir leg was increasing in size and the Physician ordered the "air stirrup to brace to the left ankle continuous" told the LPN that the splint should continuously to avoid further displa or fracture of the osteoporotic bon pressure ulcer developed in an are	was it was are not ng of the sport and be worn acement es. A ea that	
	indicated R1 had s required extensive and transfers, and bathing activities. was at risk for pre (Full thickness tiss be visible but bond exposed. Slough r obscure the depth undermining or tu	dementia. The MDS further severe cognitive impairment, assistance with bed mobility was totally dependent in The MDS also indicated R1 essure ulcers and had 1 stage 3 sue loss. Subcutaneous fat may e, tendon or muscle is not may be present but does not of tissue loss. May include nneling) and 2 unstageable The MDS indicated skin and			 was unable to be visualized with the cast in place. Resident 1□'s unstageable pressure ulcers were resolved on August 24 As of September 15, 2014, the state pressure ulcer on Resident 1□s mealleolus is almost completely rest. All areas of Resident 1□'s skin are evaluated during the weekly skin assessments. Weekly skin assess are done by charge nurses after a state to the state of the state	ure 4, 2014. age 3 nedial solved. e sments	

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

PRINTED: 09/17/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DATE	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMF	PLETED
		245384	B. WING			08/2	1/2014
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
соок с	O NORTHSHORE HO	SP & C&NC	ĺ		5 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 314	ulcer treatments th devices for the bec interventions, ulcer dressings to the fe R1's Interdisciplina dated 6/5/14, indic on 6/4/14, with left extremity edema a progress note furth malformation of the and plantar flexion the left foot to the o indicated a slightly and was fitted with splint used to treat protect the fracture 6/5/14, directed a brace to R1's left a R1's care plan dat identified risk facto development that is mobility, inability to incontinence. The current pressure-r interventions of the nurse for positionii remove to check f care. The care pla cleansing and skir were part of the us for potential skin p R1's electronic pro- indicated a stage	at included pressure reducing and chair, nutrition/hydration care and application of et. any Patient Progress Notes ated R1 was seen in the clinic mid-shin bruising and lower nd no apparent trauma. The ner indicated R1 had a chronic e left foot with medial rotation (toes pointed with rotation of center). The progress note displaced bimalleolar fracture an air stirrup sport splint (a common sports injuries) to e. Physician's orders dated continuous air stirrup-sport ankle. ed as reviewed 6/9/14, ors for pressure ulcer included limitation in self o ambulate and urinary e care plan indicated R1 had no elated lesions with protective e splint in place, check with ng of splint, nurse only should or pressure, cleansing and skin in did not address frequency of n care. The weekly skin checks sual monitoring of all residents		314	resident □s bath. A monitor splint intervention has k developed and will appear on the nurse □'s work list when any other needs to use a splint to heal a fra This information will be communion the Charge Nurses via a facility e reviewed at the Care Center Char Nurse meeting on Monday, Octob 2014. The policies on pressure uf cast care will be reviewed and rev appropriate by September 26, 20 reviewed/revised policies will be communicated to staff via a facility by September 26, 2014 and reviet the October staff meeting. The Director of Nursing or her de will monitor documentation in res record for pressure ulcers. This v done once a week starting on Se 22, 2014 for four weeks. Monitori continue monthly for five months. results of the monitoring plan will reported to the Quality Improvem Review Committee monthly.	resident cture. cated to mail and rge per 6, cers and vised as 14. The wed at signee ident □'s vill be ptember ng will The be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00080

If continuation sheet Page 10 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES					PPROVED 0938-0391
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245384	B. WING			08/2	1/2014
NAMEC	OF PROVIDER OR SUPPLIER	· ·			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок	CO NORTHSHORE HO	SP & C&NC			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) II PREFI TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 3'	4 Continued From pa	age 10	F	314			
	indicated the air cat the skin after a bed Assessments date indicated R1 had n prominences; how had been reduced indicate the air spli skin condition unde R1's Interdisciplina dated 6/29/14, des under R1's air cas with stage 3 ulcer, exudate, estimated 2. lateral malleolus pressure point had colored area, non edge of the left foo bluish, non-blanch note concluded the under the air cast. On 8/13/14, at 9:3 (LPN)-A was obse R1's left heel pres the bed with a kne boot to the left low and the left lower be turned in with r away the old dress dressing material. visible drainage. T observed on the la heel just below the was shaped like a color. LPN-A app	Assessment dated 6/14/14, ist was not removed to view d bath. The Weekly Skin d 6/21/14, and 6/28/14, io discolorations over bony ever, did not after pressure. The documentation did not int was removed to observe the er the splint. ary Patient Progress Notes scribed several pressure ulcers t to include: 1. medial malleolus straw colored/copious d size 2.5 inches by 1.5 inches; s with unstageable ulcer, d non-blanching purpura tender to palpation; and 3. of at the distal 5th metatarsal, ing, non-tender. The progress e pressure ulcers developed 9 a.m. licensed practical nurse erved to provide ulcer care to sure ulcer. R1 was laying in ee-high, white sheepskin lined ver leg. The boot was removed leg and foot were observed to noticeable foot drop. LPN-A cut sings and removed all of the old The dressings did not have "here was a stage 3 ulcer ower aspect of the left inner e inner ankle bone. The ulcer a crescent moon, dry and tan in lied a clean, dry gauze d R1's left foot, heel, and ankle					

Facility ID: 00080

		AND HUMAN SERVICES				APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245384	B. WING _		08	/21/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	_
соок с	O NORTHSHORE HO	DSP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 556	04	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	(X5) COMPLETION DATE
F 314	with Kerlix gauze, a paper tape. LPN-A sheepskin boot to On 8/21/14, at 1:17 stated R1's stage 3 discovered on 6/29 assistants caring fr was leaking throug confirmed R1's we 6/21/14, and 6/28/ pressure ulcers. F they would expect body, especially bo weekly skin asses LPN-C was intervi 2:34 p.m. stated s observe R1's heel skin assessment of had been instructed place. In addition, R1's N 7/16/14, indicated supplement) one f administered to im ulcers. R1's Snact and August, 2014 the supplement. D the Ensure on 3 o August only 6 out 8/20/14, at 1:35 p stated R1's supple a.m., 2:00 p.m., a amount taken was	and secured the dressing with A reapplied R1's white R1's left lower leg. 7 p.m. registered nurse (RN)- 3 pressure ulcer was 9/14, when the nursing for her that day noticed fluid gh the air splint. RN-D beekly skin assessments dated 14, indicated no evidence of RN-A and RN-D both stated observation of all areas of the ony prominences, with the	D e t to e e d d d			
	supplement earlie be asleep when the	er that day and sometimes wo he supplement was delivered	ould		16	not Page 12 of 2
FORM CMS-	2567(02-99) Previous Versio	ons Obsolete Event ID: O	BP511	Facility ID: 00080	If continuation she	cerrage 12010

		AND HUMAN SERVICES				FORM	09/17/2014 APPROVED
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245384	B. WING			08/	21/2014
	PROVIDER OR SUPPLIER	SP & C&NC		51 5 ·	EET ADDRESS, CITY, STATE, ZIP CODE - 5TH AVENUE WEST AND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314 F 329 SS=D	On 8/21/14, at 9:40 (DM) stated she was supplement very of approximately 3:30 (RD) stated she was pressure ulcer or F receiving the Ensu 483.25(I) DRUG R UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u adverse conseque should be reduced combinations of th Based on a compr resident, the facilit who have not used given these drugs therapy is necessa as diagnosed and record; and reside drugs receive grad behavioral intervet contraindicated, in drugs.	a.m. the dietary manager as aware R1 was not taking the ften. On 8/21/14, at pm the registered dietician as not aware R1 had a R1 was not consistently re supplement. EGIMEN IS FREE FROM DRUGS ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of nces which indicate the dose or discontinued; or any e reasons above. The ensive assessment of a y must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical nts who use antipsychotic dual dose reductions, and ntions, unless clinically an effort to discontinue these ENT is not met as evidenced	F	314 329 Facil	ity ID: 00080	tinuation shee	9/30/14

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED	
		245384	B. WING		08/21/2014		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
соок с	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 329	Based on observa review, the facility f the use of multiple for 1 of 5 residents unnecessary media Findings include: R3's annual Minim 6/10/14, indicated impairment. R3 rec staff with personal was independent w ambulation, and ea further indicated R mood indicators an The signed physic included acetamin every 4-6 hrs as n joint disease. The parameters for ad 325 mg versus 65 7/27/14, included in hours PRN and Vi every 4-6 hours P criteria to determin Vicodin or acetamin received an order hydrocodone-acet every 4 hours PRI for use of any of the ordered for PRN use R3's PRN Pain Me last dose of aceta 2/9/14, document On 7/27/14, bega	tion, interview and document failed to ensure parameters for pain medications were in place (R3) reviewed for cations. um Data Set (MDS) dated dementia with severe cognitive quired limited assistance of one hygiene and toilet use, and with bed mobility, transfers, ating after set up. The MDS 3 had no pain but did have nd verbal behaviors. ian orders dated 7/7/14, ophen 325-650 milligrams (mg) eeded (PRN) for degenerative e order did not include ministration of acetaminophen 0 mg. Physician orders dated ibuprofen 600 mg every 4-6 codin 5/325 one by mouth (po) RN for pain. There was no ne when to give ibuprofen, inophen. On 7/31/14, R3 for caminophen 5/325 mg one tab N for pain without parameters he four pain medications		 Physician orders for Resid discontinued the following August 28, 2014: Ibuprofe Vicodin 5/325 and Hydrocodone-Acetaminop September 15, 2014, Res Physician stated: pain me read: may use additional management @ 650 mg p pain, limit 3000mg Tyleno fax was sent to Resident 3 for clarification of the Tyle is covered in the Care Ce orders if needed and to cl order to read Lortab 1-2 F pain < 6/10, 2 tabs for pai Resident 3□s Primary Ph asked to address Resider next progress note. The c pharmacist was notified h documentation did not ad parameters for PRN pain order for Ibuprofen in a pa stage renal failure and an blood loss. All other Care Center res receiving PRN medication reviewed to ensure parar use are in place. Parame medications will be devel from the Medical Staff an Pharmacist. Any resident with new PF orders will need specific ordered for their use. A p developed with input from Staff and the Consulting 	medications on in 600mg, when. On ident 3⊡s d order should Tylenol for pain to q4hrs PRN I total q 24 hrs. A 3⊡s physician nol order as this nter⊡s standing arify the Lortab PRN, 1 tab for in > 6/10. ysician will be nt⊡s pain in her consultant idents currently medications, the atient with recent idents currently ns will be neters for their eters for PRN oped with input id the Consulting RN medication parameters iolicy will be n the Medical		

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245384	B. WING			08/2	1/2014	
COOK C		TEMENT OF DEFICIENCIES	ID PREFI)	518 GF	REET ADDRESS, CITY, STATE, ZIP CODE 5 - 5TH AVENUE WEST RAND MARAIS, MN 55604 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETIO	
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DATE	
F 329	on 8/5/14, 8/6/14, apparent pain relief R3's care plan date possibly had pain t agitation, and direct offer PRN pain me restless, wandering The physician prog 6/24/14, and 7/7/14 The monthly pharm from 2/19/14 throu lack of parameters The nursing progres indicated R3 had s blood. The physic 7/7/14, indicated R between 8.5 and 9 consultant review lack of parameters order for Ibuprofer renal failure and a stool. Licensed practical 8/21/14, at 1:50 p. question when ast PRN pain medicat pain. LPN-A state report pain and LC on R3's nonverbal offered when R3 v administered was apparently discorr	and 8/14/14. R3 received f with hydrocodone. ed 8/18/14, indicated R3 hat was contributing to oted staff to ask, observe, and dications when R3 was g, or getting agitated. gress notes dated 5/13/14, 4 did not address pain for R3. nacy consultant documentation gh 8/20/14, did not address the 5 for PRN pain medications. ess notes dated 7/29/14, stools that tested positive for ian progress notes dated R3's hemoglobin has been 0.5, which is low. A pharmacy on 8/20/14, did not address the s for pain medications or the n in a patient with end stage nemia with recent blood in the 1 nurse (LPN)-A, interviewed on im, stated it was a good ked how she would know which tion to give when R3 was having ed R3 was not always able to ortab was administered based I cues. Pain medications were was more agitated. The dosage based on the R3's level of	F3	29	new policy will be communicated w facility email to the Charge Nurses the Medical Staff. The final policy reviewed at the October 2014 Nur meeting and the October Medical meeting. New pain medication orders will be monitored for specific parameters week for four weeks starting Sept 22, 2014, then monthly for three in The results of the monitoring plan reported to the Quality Improveme Review Committee monthly.	and will be se staff Staff e once a ember nonths. will be		

		AND HUMAN SERVICES				APPROVED . 0938-0391
	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIPL	ECONSTRUCTION	(X3) DAT	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				NPLETED
		245384	B. WING		08	/21/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP	CODE	
COOK CO	O NORTHSHORE HO	SP & C&NC	1	15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	parameters for use RN-A stated nurse	age 15 of PRN pain medications. s were encouraged to ask for medications were ordered.	F 329			
	interview.	armacist was unavailable for an				
F 356 SS=C	procedures related medications. 483.30(e) POSTEI	able to provide policies and I to parameters for PRN O NURSE STAFFING	F 356			8/25/14
	a daily basis: o Facility name. o The current date o The total numbe by the following ca unlicensed nursing resident care per s - Registered n - Licensed pra	r and the actual hours worked ategories of licensed and g staff directly responsible for shift: urses. ctical nurses or licensed (as defined under State law). se aides.				
	specified above o of each shift. Dat o Clear and reada o In a prominent p residents and visi	place readily accessible to				
	make nurse staffi	ng data available to the public st not to exceed the community				

		AND HUMAN SERVICES			FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245384	B. WING_		08/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
COOKC	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 5560	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
F 356	Continued From pa	age 16	F 3	56		
	staffing data for a r	aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.				
	by: Based on observa review the facility is posting to include the both licensed and is potential to affect a facility, visitors and chosen to view the Findings include: During the initial to 3:09 p.m., the staff bulletin board near posting lacked the The posting include staff in each position nights. On 8/19/14, at app posting was obser not include actual posting included the previous day. During an interview director of nursing included the actual posting. The DON needed to include	bur of the facility on 8/18/14, at f posting was observed on a t the nurse's station. The staff actual hours worked by staff. ed census of 34, number of on on days, evenings, and proximately 9:10 a.m. the staff ved in the same area and did hours worked by staff. The ne same information as the w on 8/22/14, at 1:45 p.m. the (DON) stated they have not al hours on the nurse staff was unaware the posting this information. She stated or was the one who posts the		The form for the postii Information includes the worked for both license staff. The shift times we day, evening and night the identification of the The form was modified specific times of each date of August 25, 201 The Director of Nursin posting reports from the to verify that the poster Information includes the times. The results of reported to Quality Imp Review Committee quar- months.	te total hours ed and unlicensed vere designated by ts and to not include a hours of each shift d include the shift. Completion 4. g will review all the ne previous month d Nurse Staffing ne specific shift this review will be provement/Peer	

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MEU			. 0938-039 E SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:				IPLETED		
		245384	B. WING		08	/21/2014		
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
соок с	O NORTHSHORE HO	SP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 356	Continued From pa	age 17	F3	356				
	A policy and proced nurse staff posting.	dure was not provided for the						
F 428 SS=D		EGIMEN REVIEW, REPORT	F 4	128		9/30/14		
		of each resident must be nce a month by a licensed			· · · · · · · · · · · · · · · · · · ·			
	the attending physi	ust report any irregularities to ician, and the director of reports must be acted upon.						
		NT is not mat as avidenced						
	by: Based on observa review, the consult parameters for the medications were i	NT is not met as evidenced tion, interview and document ant pharmacist failed to ensure use of multiple pain n place for 1 of 5 residents unnecessary medications.			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			
	Findings include:				Physician stated: pain med order should read: may use additional Tylenol for pain			
	6/10/14, indicated impairment. The M	um Data Set (MDS) dated dementia with severe cognitive ADS further indicated R3 had /e mood indicators and verbal			management @ 650 mg po q4hrs PRN pain, limit 3000mg Tylenol total q 24 hrs. <i>i</i> 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	;		
	included acetamine every 4-6 hrs as ne	an orders dated 7/7/14, ophen 325-650 milligrams (mg) eeded (PRN) for degenerative order did not include			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			

Event ID: OBP511

Facility ID: 00080

If continuation sheet Page 18 of 36

		AND HUMAN SERVICES				09/17/201 APPROVE
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DATE	
		245384	B. WING		08/2	21/2014
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI	P CODE	
соок с	O NORTHSHORE HO	OSP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 428	parameters for adr 325 mg versus 650 7/27/14, included i hours PRN and Via every 4-6 hours PF criteria to determin Vicodin or acetami received an order hydrocodone-aceta every 4 hours PRN parameters for use medications order R3's PRN Pain Me last dose of acetam 2/9/14, documente On 7/27/14, began (Lortab) 5/325 for on 8/5/14, 8/6/14, apparent pain relie R3's care plan dat possibly had pain agitation, and dire offer PRN pain me restless, wanderin The physician pro 6/24/14, and 7/7/1 The monthly phan from 2/19/14 throu lack of parameters The nursing progr indicated R3 had blood. The physic 7/7/14, indicated F	ministration of acetaminophen 0 mg Physician orders dated buprofen 600 mg every 4-6 codin 5/325 one by mouth (po) RN for pain. There was no ne when to give ibuprofen, inophen. On 7/31/14, R3 for aminophen 5/325 mg one tab N for pain. There were no e of any of the four pain		 next progress note. The opharmacist was notified h documentation did not ac parameters for PRN pain order for Ibuprofen in a p stage renal failure and ar blood loss. All other Care Center ress receiving PRN medicatio reviewed to ensure parar use are in place. Parame medications will be devel from the Medical Staff an Pharmacist. Any resident with new PF orders will need specific ordered for their use. A p developed with input from Staff and the Consulting new policy will be commu- facility email to the Charg the Medical Staff. The fi reviewed at the October meeting and the October meeting. New pain medication orce monitored for specific pa- week for four weeks star 22, 2014, then monthly fi The results of the monitor reported to the Quality Ir Review Committee monitor 	her ddress the lack of medications, the atient with end hemia with recent ddents currently ns will be meters for their eters for PRN loped with input nd the Consulting RN medication parameters policy will be n the Medical Pharmacist. The unicated via ge Nurses and nal policy will be 2014 Nurse staff r Medical Staff ders will be arameters once a ting September or three months. pring plan will be nprovement/Peer	

Facility ID: 00080

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION		E SURVEY PLETED
		245384	B. WING		08/	21/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST		
COOKC	O NORTHSHORE HO	SP & C&NC		GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428 F 431 SS=E	order for Ibuprofen renal failure and an stool. During an interview registered nurse (F parameters for use The consultant pha interview. The undated facility consulting pharma maintain the reside functioning and pre consequences rela- the extent possible lacked direction for medications and for of PRN medication 483.60(b), (d), (e) LABEL/STORE DF The facility must e a licensed pharma of records of recei controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accorda professional princi appropriate acces	for pain medications or the in a patient with end stage memia with recent blood in the on 8/21/14, at 2:12 p.m. (N)-A verified the lack of of PRN pain medications. Armacist was unavailable for an y policy and procedure for cist indicated the goal was to ent's highest practicable level of event or minimize adverse ited to medication therapy to a. The policy and procedure review for contraindicated or ensuring parameters for use ns.	F 4			9/30/14

Facility ID: 00080

If continuation sheet Page 20 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: FORM A OMB NO.	PPROVED			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		E CONSTRUCTION (X3) DATE COMP	SURVEY			
		245384	B. WING	i	08/2	1/2014			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
COOKC	O NORTHSHORE HO	SP & C&NC			5 - 5TH AVENUE WEST RAND MARAIS, MN 55604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 431	Continued From pa applicable.	age 20	F	431					
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.							
	permanently affixe controlled drugs lis Comprehensive Di Control Act of 1976 abuse, except whe package drug distr	rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to en the facility uses single unit ibution systems in which the ninimal and a missing dose car d.	1						
	by: Based on observa review, the facility were appropriately and opened dates R32) receiving ins labels were not le affecting R24; and temperatures were proper temperatur medication refrige medications were Findings include: On 8/20/14, at 12 refrigerator locate	ENT is not met as evidenced ation, interview, and document failed to ensure medications a labeled with resident names for 3 of 3 residents (R30, R36, ulin flex pens; medication gible in 1 of 2 medication carts medication refrigerator e not maintained within the res for viability in 1 of 1 rators in which 4 resident's located (R32, R30, R7, R38).			 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				

Facility ID: 00080

If continuation sheet Page 21 of 36

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

PRINTED: 09/17/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		245384	B. WING			08/2	21/2014	
NAME OF I	PROVIDER OR SUPPLIER	· ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
соок с	O NORTHSHORE HO	SP & C&NC			15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	[Fahrenheit] accord mounted on the our The refrigerator com medications which pens dispensed 6/7 pens dispensed 12 pens dispensed 7/2 dispensed 7/28/14; 8/19/14; R7's Tube R36's Latanoprost and R28's Enbrel s 8/1/14. LPN-A stat correct range of ter refrigerator. LPN-A monthly calendar w refrigerator temper calendar for June 2 with temperature re The July 2014 cale with temperatures 2014, the temperature 3 of 20 days. The r Latanoprost [Xalata indicated the media 36 to 46 degrees F 36 to 46 degrees F 36 to 46 degrees F During observation 8/20/14, at 12:30 p hall cart was obser flex pens. One of labeled in black ma nick-name written was labeled with a pen containing Nor	age 21 erature was 37 degrees F ling to the digital thermometer tside of the refrigerator door. Intained several resident included: R32's Lantus insulin (18/14, and Novolog insulin /18/13, R30's Lantus insulin /18/13, R30's Lantus insulin /18/14, and Lantus insulin vial R38's Lantus vial dispensed rsol vial dispensed 8/1/14; eye drops dispensed 11/29/13; yringes for injection dispensed ed she was not sure of the mperatures in a medication A located a clip board with a where nightly medication atures were recorded. The 2014 indicated 6 of 30 days eadings below 36 degrees F. endar indicated 4 of 29 days below 36 degrees F. In August, ture was below 36 degrees on manufacturer's guidance for an] eye drops revised 8/2011, cation should be refrigerated at 5.; and Enbrel should be kept at 5 and not be allowed to freeze. In of the medications carts, on 0.m. with LPN-A, the 200 room rved to contain 3 opened insulin the Lantus flex pens was agic marker with a resident's on it; another Lantus flex pen first name only; and a third flex volog insulin was labeled with the and a last name initial, and		¥31	A Medication Storage Policy will be developed in conjunction with the Consulting Pharmacist by Septem 2014. The Director of Nursing or her des will monitor refrigerator temperatu weekly for four weeks and once a for six months. The results of the monitoring plan will be reported to Quality Improvement/Peer Review Committee monthly.	ber 30, ignee res month the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OBP511

Facility ID: 00080

If continuation sheet Page 22 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 09/17/2014 1 APPROVED). 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245384	B. WING	≩		08	/21/2014		
NAME OF	PROVIDER OR SUPPLIER		L		STREET ADDRESS, CITY, STATE, ZIP C	CODE			
соок с	O NORTHSHORE HO	SP & C&NC			515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 431	On 8/20/14, at app stated the insulin fl nick-name belonge stated the other tw resident first name who were still resid labeling was confu Novolog flex pen la confirmed all insuli labeled with an op be good for 28 day verified the black r to stay and be legi R32's Physician O indicated R32's dia 2 and directed Lar [subcutaneous] da R30's Physician O indicated R30's dia 2 and Lantus insu Novolog insulin 10 R36's Physician's requested but not On 8/20/14, at 1:0 was observed with There was a prese faded label attach medication label in and dosage; but t the point of being mail order pharma always faded awa Physician Order S	roximately 12:45 p.m. LPN-A ex pen labeled with a ed to R32. LPN-A further o flex pens, both with the same on them belonged to residents ling in the facility and the name sing. LPN-A verified the acked an opened date and n flex pens and vials should be ened date as the insulin would rs after opening. LPN-A also magic marker was not reliable ble on the flex pens. rder Sheet dated 8/21/14, agnoses included diabetes type tus insulin 15 units sq ily at bed time. rder Sheet dated 8/21/14, agnoses included diabetes type in 48 units sq at bed time and units sq before each meal. Orders and Diagnosis list were		43	31				

Facility ID: 00080

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/17/2014 FORM APPROVED OMB NO. 0938-0391

					×	<u> </u>	0000 0001	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245384	B. WING		· · · · · · · · · · · · · · · · · · ·	08/2	21/2014	
	PROVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	medication) 0.5 mg On 8/21/14, at 2:51 (DON) stated resid match the medicati (MAR). The DON should be labeled w name of the reside medication refriger monitored each nig was monitored mor pharmacist. The D temperatures below 7/2014, and 8/2014 digital thermomete temperature dropp the staff had been refrigerator temper she was not aware temperature to ass A Medication Stora not provided. The facility's Medic Considerations pol newly opened vials labeled with the da labeled with the ex On 8/26/14, at 11.1 pharmacist (CP) w interview. The CP to set up the digita the medication refricced of CP further stated of information regard	ed Klonipin (antianxiety g oral at bed time. I p.m. the director of nursing ents' medication labels should ion administration record further stated that insulin pens with an opened date and the nt. The DON stated the rator temperatures were ght, and the temperature log nthly by the consultant DON confirmed the low w 36 degrees F from 6/2014, 4. The DON reported the r would alarm when the ed below 34.4 degrees F., and instructed to turn the rature up. The DON confirmed e of the appropriate refrigerator sure medication viability. age Policy was requested but cation Administration, General licy revised 6/2008, indicated s of medication would be ate the vial was opened and		431				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00080

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	. ,		CONSTRUCTION		E SURVEY IPLETED
		245384	B. WING			08/	21/2014
				515	EET ADDRESS, CITY, STATE, ZIP CODE - 5TH AVENUE WEST		
COOK C	O NORTHSHORE HO			GR	AND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431 F 441 SS=F	46 degrees F. The perform regular me temperatures on the The CP confirmed medication carts in labeling, etc. The of the faded label expect the facility fading out of the lac confirmed she work to be readable, with dispensed date of The CP stated she staff were taking in refrigerator and st the medication ca confirmed all flex label, clearly read- date. 483.65 INFECTION SPREAD, LINENS The facility must en- infection Control I safe, sanitary and to help prevent the of disease and inter- (a) Infection Control The facility must en- program under we (1) Investigates, of in the facility; (2) Decides what should be applied	ed between 36 degrees F and CP also stated she does not onitoring of the refrigerator ne monthly visits to the facility. she does go through the nonthly for expired medications, CP stated she was not aware for R24's Klonipin and would to find a way to prevent the abel contents. The CP uld expect the pharmacy labels th resident name and with the the medication clearly visible. was not aware the nursing nsulin flex pens out of the oring the opened flex pens in rts for resident use. The CP pens should have a resident able, and contain an opened PN CONTROL, PREVENT S establish and maintain an Program designed to provide a comfortable environment and e development and transmission fection. rol Program establish an Infection Control hich it - controls, and prevents infections procedures, such as isolation, d to an individual resident; and ecord of incidents and corrective	F	431			9/30/14

Facility ID: 00080

If continuation sheet Page 25 of 36

					FORM A	09/17/2014 PPROVED)938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
	245384	B. WING			08/2	1/2014
PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	SP & C&NC					
(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETION DATE
Continued From pa	age 25	F4	41			
determines that a prevent the spread isolate the residen (2) The facility must communicable dis from direct contact direct contact will the (3) The facility must hands after each of hand washing is in professional pract (c) Linens Personnel must has	resident needs isolation to a of infection, the facility must t. st prohibit employees with a ease or infected skin lesions t with residents or their food, if transmit the disease. st require staff to wash their direct resident contact for which idicated by accepted ice.					
by: Based on observ review, the facility standards during residents (R1, R1 during blood glucd of 1 residents (R3 monitoring. In add implement an infe program to identifi resident infection all 34 residents	ation, interview, and document failed to follow infection control dressing changes for 2 of 3 4) observed for wound care; ose monitoring procedures for 1 34) observed for blood glucose dition, the facility failed to ection control surveillance fy, document and monitor s. This had the potential to affect esiding in the facility.			Care Center RN and LPN□s on hand washing, proper glove use dressing changes with wound ca proper application of topical med and proper cleaning of glucomet obtaining resident blood sugar c Said training will be Mandatory a occur on Monday, September 25 7:30 am and 12:30 pm The Director of Nursing or her d will monitor each RN and LPN of adherence to the above procedu	proper for lications, er after heck. and will 9, 2014 at esignee n their ure	
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER O NORTHSHORE HO SUMMARY ST/ (EACH DEFICIENCI REGULATORY OR L Continued From pa (b) Preventing Spr (1) When the Infect determines that a transport the spread isolate the residen (2) The facility must hands after each or hand washing is in professional pract (c) Linens Personnel must hat transport linens so infection. This REQUIREME by: Based on observ review, the facility standards during residents (R1, R1 during blood gluco of 1 residents (R3 monitoring. In add implement an infe program to identifi resident infection all 34 residents ref Findings include:	F CORRECTION IDENTIFICATION NUMBER: 245384 PROVIDER OR SUPPLIER O NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245384 B. WING PROVIDER OR SUPPLIER 245384 B. WING O NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 25 F 4 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection stheir food, if direct contact will transmit the disease. F 4 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from 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. This had the potential to affect all 34 residents residing in the facility. Findings include: Findings include: <td>RS FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PROVIDER OR SUPPLIER 245384 D NORTHSHORE HOSP & C&NC SIT SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 25 F 441 (b) Preventing Spread of Infection IT (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 prohibit employees and transport linens so as to prevent the spread of infection control 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 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. This had the potential to affect all 34 residents residing in the facility. Findings include: Findings include:</td> <td>MENT OF HEALTH AND HUMAN SERVICES C SS FOR MEDICARE & MEDICAID SERVICES C PEPEIGENCES (X) PROVERSUPPLERCLIA IDENTIFICATION NUMBER: (X) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLER 245384 B. WING BO NORTHSHORE HOSP & C&NC STREET ADDRESS, CITY, STATE, ZIP CODE (St - STH AVENUE WEST GRAND MARAIS, MN 55604 SUMMARY STATEMENT OF DEFICIENCIES (BACH DEPRECY MUST BE PRECEDED BY PULL RECULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG Continued From page 25 F 4411 (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. F 4411 (c) The facility must prohibit employees with a continuicable disease or infected skin lesions from direct contact with transmit the disease. F (d) The facility must regulate staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The facility will provide training fi Care Center RN and LPNUS on hand washing, proper glove use drossing changes with 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 infection, the facility. The Enclore of Nursing or her divide will monitor each RN and LPNUS on hand washing, proper glove use droproper cleaning of glucomet obtaining resident blood gluc</td> <td>MENT OF HEALTH AND HUMAN SERVICES OMB NO.1 SS FOR MEDICARE & MEDICAID SERVICES OMB NO.1 CORRECTION INTERVICENSUPPLIERCULA IDENTIFICATION NUMBER: (X2; MULTIPLE CONSTRUCTION A BULLING (X2; MULTIPLE CONSTRUCTION A BULLING PROVIDER OR SUPPLIER 245384 B. WING 0812 O NORTHSHORE HOSP & C&NC STREET ADDRESS, CITY, STATE, ZIP GODE 515 - STH AVENUE WEST GRAND MARAIS, NN 55604 0812 REQUIDATORY OR LOS DENTFYING INFORMATION ID PROVIDERS FUNCE AND OF CORRECTION (EACH CORRECTIVE ACTION STOLDU BE (EACH CORRECTIVE ACTION STOLDU BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) ID PROVIDERS FUNCE AND OF CORRECTION (EACH CORRECTIVE ACTION STOLDU BE (EACH CORRECTIVE ACTION STOLDU BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) Continued From page 25 F 441 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident medes isolation to prevent the spread of Infection, the facility must isolate the resident. F 441 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. The facility will provide training for all Care Center RN and LPNUS on proper hand washing, proper glove use for dressing changes with wound care, proper application of topical medications, and proper cleaning of glucower and the facility. This REQUIREMENT is not met as evidenced by: implement an infection. This had the potential to affect all 34 residents residing in the facility. The facility will provid</td>	RS FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PROVIDER OR SUPPLIER 245384 D NORTHSHORE HOSP & C&NC SIT SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 25 F 441 (b) Preventing Spread of Infection IT (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 prohibit employees and transport linens so as to prevent the spread of infection control 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 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. This had the potential to affect all 34 residents residing in the facility. Findings include: Findings include:	MENT OF HEALTH AND HUMAN SERVICES C SS FOR MEDICARE & MEDICAID SERVICES C PEPEIGENCES (X) PROVERSUPPLERCLIA IDENTIFICATION NUMBER: (X) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLER 245384 B. WING BO NORTHSHORE HOSP & C&NC STREET ADDRESS, CITY, STATE, ZIP CODE (St - STH AVENUE WEST GRAND MARAIS, MN 55604 SUMMARY STATEMENT OF DEFICIENCIES (BACH DEPRECY MUST BE PRECEDED BY PULL RECULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG Continued From page 25 F 4411 (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. F 4411 (c) The facility must prohibit employees with a continuicable disease or infected skin lesions from direct contact with transmit the disease. F (d) The facility must regulate staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The facility will provide training fi Care Center RN and LPNUS on hand washing, proper glove use drossing changes with 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 infection, the facility. The Enclore of Nursing or her divide will monitor each RN and LPNUS on hand washing, proper glove use droproper cleaning of glucomet obtaining resident blood gluc	MENT OF HEALTH AND HUMAN SERVICES OMB NO.1 SS FOR MEDICARE & MEDICAID SERVICES OMB NO.1 CORRECTION INTERVICENSUPPLIERCULA IDENTIFICATION NUMBER: (X2; MULTIPLE CONSTRUCTION A BULLING (X2; MULTIPLE CONSTRUCTION A BULLING PROVIDER OR SUPPLIER 245384 B. WING 0812 O NORTHSHORE HOSP & C&NC STREET ADDRESS, CITY, STATE, ZIP GODE 515 - STH AVENUE WEST GRAND MARAIS, NN 55604 0812 REQUIDATORY OR LOS DENTFYING INFORMATION ID PROVIDERS FUNCE AND OF CORRECTION (EACH CORRECTIVE ACTION STOLDU BE (EACH CORRECTIVE ACTION STOLDU BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) ID PROVIDERS FUNCE AND OF CORRECTION (EACH CORRECTIVE ACTION STOLDU BE (EACH CORRECTIVE ACTION STOLDU BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) Continued From page 25 F 441 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident medes isolation to prevent the spread of Infection, the facility must isolate the resident. F 441 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. The facility will provide training for all Care Center RN and LPNUS on proper hand washing, proper glove use for dressing changes with wound care, proper application of topical medications, and proper cleaning of glucower and the facility. This REQUIREMENT is not met as evidenced by: implement an infection. This had the potential to affect all 34 residents residing in the facility. The facility will provid

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI			(3) DATE	<u>)938-039</u> survey
	F CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		245384	B. WING			08/2	1/2014
AME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
OOKC	O NORTHSHORE HO	SP & C&NC			5 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	COMPLÉTIO DATE
F 441	Continued From pa	age 26	F 4	41			
1 - 7 1 1	•	for a pressure ulcer. dressing			October 2014; then quarterly for a tot	tal of	
	change.				one year, ending September 2015. A	AII	
					monitoring results will be reported to	the	
		er Sheet signed 8/6/14,			Quality Improvement/Peer Review Committee.		
	diabates below the	noses included type two e knee amputation, venous			Committee.		
	insufficiency and p	eripheral vascular disease.			The facility will update current Policy	and	
					Procedure for equipment sanitizing to	:0	
		ange Minimum Data Set (MDS)			include directions for sanitizing	1100	
		cated R14 had no cognitive			glucometers immediately after each Completion date of September 30, 2		
	with bod mobility a	equired extensive assistance nd transfers. The MDS further					
		one stage three pressure ulcer			The facility will update the policy and		
		om pressure to an area with full			procedure for nosocomial infections	to	
	thickness tissue lo	ss) and received the			include direction for identifying and	ـ	
	application of a no	nsterile dressing with or without			addressing current trends to prevent cross-contamination or spread of	L	
	topical medication	s to an area other than the foot.			infections. This process will include a	а	
	The Physician Ord	ler signed 8/6/14, directed			pathway for the Infection Control		
	change sacral ulce	er dressing to Silvadene cream			Coordinator (ICC) to obtain notice of		
	(an antibacterial ci	ream) once daily until			Center Resident infections in real tin		
	granulation was ex	xposed then change back to			The Care Center Charge Nurse or C Center HUC will alert the ICC of	Jare	
	Medi-honey (a wol	und gel used for its antibacterial perties) every one to there days.			Resident⊡s infection by initiating the	е	
	Cover with a Meni	lex Border (an adhesive foam			Report of Infection and giving to the		
		and change every three days			on date of first action. The ICC will t	then	
	and as needed.				review report of infection, obtain cul		
					results, follow up/advise Care Center potential need for further action suc		
	On 8/21/14, at 10:	00 a.m. registered nurse ved to provide ulcer care to			precautions or isolation. The ICC wi		
	R14's sacral ulcer	The RN sanitized her hands			review and monitor all medications		
	with the hand san	itizer on the wall in R14's room,			prescribed for nosocomial infections		
		elchair and two tables, pulled			monitor will be reviewed monthly for	r three	
	the shade and set	t up the supplies. The RN then			months starting October 2014, then quarterly for one year, ending Septe		
	donned gloves, re	moved pillows from behind ad the over bed table and			30, 2015.	5111001	
	positioned R14 or	nto the left side. The RN then					
	removed the dres	sing from the ulcer, removed			All nosocomial infection data will be		
	her gloves and sa	nitized her hands. The RN then			verified, evaluated and summarized	d into a	

Facility ID: 00080

TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	0938-039		
D PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	a. Buildin	G	CON	PLETED		
		245384	B. WING _			21/2014		
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
OOK C	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
F 441	dressing and with the finger into a me Silvadene cream a cream with her inder RN applied the Me R14 to sit back up, sanitized her hands and exited the roor On 8/21/14, at 10:2 the way she did the stated after cleanin cream with her fing gloves, wash or sa anything else to ap On 8/21/14, at 2:30 responsible for infe stated the RN shot after cleaning the v have applied the c should have used apply the cream to The facility's Topic policy effective 2/0 were to be adminis to aid residents to directed staff to us swab apply a thin the affected area.	with saline and a gauze he same gloved hands dipped edication cup which contained nd applied the Silvadene ex finger to R14's ulcer. The pilex Border dressing, assisted removed the gloves and s. The RN gathered the trash m. 22 a.m., RN-B stated that was e dressing change. The RN ng the wound she applies the ger and does not change her unitize her hands or use oply the cream. 0 p.m. RN-C who was ection control at the facility uld have changer her gloves wound. The RN should not ream with her finger and some type of an applicator to the wound. al Medications Administration 16, indicated topical medications stered safely and appropriately overcome lesions. The policy is a tongue blade or cotton layer of cream or ointment to and hand hygiene standards	F 44		Review rrent Infection ire to reflect rrent trends to on or spread of /p and ions will occur 0, 2014. A copy			
	were not maintain dressing change.	ed during R1's pressure ulcer ange Minimum Data Set (MDS)						

Facility ID: 00080

If continuation sheet Page 28 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245384	B. WING	;		08/:	21/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
соок с	O NORTHSHORE HO	SP & C&NC			5 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 28	F	441			
	indicated R1 had s and required exten mobility and transfe R1 had 1 stage 3 p unstageable press treatments in place application of dress R1's Physician's O ulcer care to R1's clean every 3 days medi-honey gel to and wrap with Kerl further directed to lateral malleolar an On 8/13/14, at 9:3 (LPN)-A was obse R1's left heel pres laying in the bed a sheepskin lined bo leg. LPN-A looser white boot and rer leg. R1's left lowe be turned in and F drop. LPN-A was gloves and use so dressings on R1's removed the old g R1's left foot ulcer have no visible dra ulcer was observe left inner heel, bel shaped like a cress	rders dated 8/4/14, directed left medial malleolus wound: s, remove slough, apply wound bed, cover with Telfa lix. R1's Physician's Orders apply Eucerin cream daily to					
	wrapped R1's left	ng to R1's left heel ulcer, foot, heel, and ankle with Kerlix secured the Kerlix with paper	(

Facility ID: 00080

If continuation sheet Page 29 of 36

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES			ONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY APLETED
ID PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		245384	B. WING			08	/21/2014
AME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE - 5TH AVENUE WEST		
	O NORTHSHORE HO	SP & C&NC			AND MARAIS, MN 55604		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	tane I PN-A reap	plied R1's white sheepskin boot		441			
	to R1's left lower l gloves and sanitiz before leaving the	eg. LPN-A removed the used ed her hands in R1's bathroom proom.					
	would normally no dressing change drainage and the LPN-A further cor did not contain vis stated she did no her hands, before dressing R1's ulc gauze, LPN-A ve	2:00 a.m. LPN-A stated she of change gloves during unless the wound had a lot of gloves were visibly soiled. firmed R1's old Telfa dressing sible drainage, therefore LPN-A t remove the gloves and wash e applying new gloves and er with a new Telfa and Kerlix erified she forgot to apply the p R1's left foot when she had dressing.					
	confirmed nurses gloves and wash when going betw	50 p.m. registered nurse (RN)-A s should be changing disposable ing or sanitizing their hands reen dirty and clean dressings g change procedure.	A Ə				
	1/2010, indicated their hands befo	ndwashing policy reviewed d staff were required to wash re and after performing any after removing gloves.					
	review, the facili comprehensive maintained cons infections to ide resident infection to ensure clean (machine used	vation, interview and document ity failed to implement a infection control program that sistent tracking and trending of ntify, document and monitor ons. In addition, the facility failed ing of a used glucometer to check blood sugars) prior to ood service area and on a	1				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED 093 <u>8-0391</u>	
		& MEDICAID SERVICES			CONSTRUCTION	(X3) DAT	E SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	PLETED
		245384	B. WING			08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
соок с	O NORTHSHORE HO	SP & C&NC			5 - 5TH AVENUE WEST RAND MARAIS, MN 55604		1
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	for 1 of 1 residents glucometer checks ensure proper han changing was imp changes for 2 of 3 for wound care. Finding include: During an observa- the licensed practi- blood sugar check of diabetes, with ti- gloves and left the glucometer. LPN- wash her hands, w food service area, the sink area. Sh the glucometer, a and set the glucor LPN-A documenter check on the Mec (MAR), picked up bactericidal wipe, the charger. LPN glucometer down area during the fill the glucometer of cleaning the glucor not have set it do right away. During an intervie coordinator (ICC) ICP verified the g	prevent cross-contamination (R43) observed for The facility also failed to d hygiene and/or glove blemented during dressing residents (R1, R14) observed ation on 8/20/14, at 11:40 a.m. ical nurse (LPN)-A completed a c on R34, who had a diagnosis he glucometer, removed her a room while carrying the A went to the closest sink to which was in the dining room and placed the glucometer on the washed her hands, picked up nd went to the medication room meter on the medication cart. ed the results of the blood sugar lication Administration Record the glucometer, wiped it with a and placed the glucometer on I-A verified she set the on the sink in the food service me of food service, and also set in the medication cart prior to ometer. She verified she should wn and should have cleaned it ew with the infection control), on 8/21/14, at 10:03 a.m. the glucometer should have been etting it down.	ſ	441			
	I he facility policy	and procedure for equipment				tinuation she	et Page 31 of

Event ID: OBP511

Facility ID: 00080

6 If continu

		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 09/17/2014 FORM APPROVED OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		245384	B. WING			08/	/21/2014	
	PROVIDER OR SUPPLIER	SP & C&NC		515	EET ADDRESS, CITY, STATE, ZIP CODE - 5TH AVENUE WEST AND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	equipment, includii returned to design use with sani wipe allow to air dry. Th sanitizing immedia On 8/21/14 at 10:0 trending logs for th an interview with t March, April, and review and lacked infections cultured cultured in May. 0 during those three documentation of gets a monthly inf infections from the that included the r date, symptoms, used, culture, and performed. The I culture results fro the log did not alw the care center is culture results. T to give her notice with the same typ identify how curre be identified and The undated faci nosocomial (infe- under the infection plan, directed po are reported to th collected from the the a report of in	 10, directed nursing to sanitize ng glucometers, prior to being ated storage areas after each s provided by the facility and he facility lacked direction for tely after each use. 3 a.m., infection tracking and he facility were reviewed during he ICC. The completed logs for Vlay of 2014, were provided for culture results for 4 of 5 in March and 4 of 5 infections of the 18 infections recorded 		441			The Page 32	

Facility ID: 00080

If continuation sheet I ag

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A OMB NO.	PPROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION (X3) DATE COMP	SURVEY	
		245384	B. WING			1/2014	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST				
соок со	O NORTHSHORE HO	SP & C&NC		RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441 F 465 SS=E	submit them to the verified, evaluated quarterly report and Assurance Commi Committee. The p direction for identifit trends to prevent of of infections. 483.70(h) SAFE/FUNCTION E ENVIRON The facility must p sanitary, and comf residents, staff and This REQUIREME by: Based on observa- review, the facility resident equipmen maintained and re residing in rooms 206, 207, 208, 210 laundry dryer vent significant lint buil affect all 34 reside Findings include: During an environ the maintenance 10:00 a.m. the fol observed:	comial infection report and ICC. The data is to be and summarized into a d presented to the Quality ttee and the Infection Control olicy and procedure lacks ying and addressing current cross-contamination or spread AL/SANITARY/COMFORTABL rovide a safe, functional, fortable environment for		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		

Facility ID: 00080

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	
		245384	B. WING	·	08/21	/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				515 - 5TH AVENUE WEST		
соок с	O NORTHSHORE HO	ISP & C&NC		GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 465	to the bathroom m the tiled floor unde a rust-colored subs Room 102: marre mirror, toilet bars le the cover with 2 ro resting on the toile Room 106: scrape bathroom door and Room 202: windo right-sided window tiles around closet near closet door. Room 203: sticky toilet up high and lamp shade on lar Room 204: sticky toilet up high and lamp shade on lar Room 206: sticky toilet up high and door. Room 207: marre bathroom door. Room 208: sticky toilet up high. Room 210: chipp	eet rock paper on the wall next irror was torn and marred, and rneath the toilet was dirty with stance. d bathroom wall near the oose, and toilet tank missing Ils of unopened toilet tissue it tank inner parts. ed up lower third of wooden d marred bedroom doorway. w shade hanging sideways in v in bed room, cracked floor is, and dented and marred wall white substance on wall near counter top with large chip of	F 46	 Director of Maintenance will a Nursing Unit meetings to rev process of completing work r for maintenance concerns. The Director of Maintenance designee will monitor the all of frames, wall surfaces, windo window treatments and floor repair once a month for the r months. The information will to Quality Improvement/Peet Committee on a quarterly ba The personal wheelchair from has been removed. Future of Resident s personal items waddress with the resident and documentation placed in the regarding the Resident s process of the evening schedule for the lint traps were changed from cleaned daily to twice daily; day and once on the evening 	iew the requisitions or his door and ws and s for good next six I be reported r Review usis. m room 301 concerns with will be d chart reference. ne large dryer n being one at mid	

Facility ID: 00080

If continuation sheet Page 34 of 36

		AND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245384	B. WING		08/21/2014
NAME OF F	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ
соок с	O NORTHSHORE HO	SP & C&NC		515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
F 465	Continued From pa	age 34	F 46	55	
-	Room 301: right a personal wheelcha	rm rest of the resident's ir 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.				
	confirmed the findi have a schedule for rooms or common he relies on staff to of resident rooms, counter tops, and further stated the to of the toilet in Roo to prevent the resi The CP also states stored on the back CP confirmed the needed to be fixed confirmed the lam need to be replace wheelchair in Roo wheelchair and the paper tape to the comfort. The CP benefit from a phy condition of the with	proximately 10:30 a.m. the MS ings and stated he does not or maintenance of resident areas. The MS further stated o put in a work order for repairs including doorways, walls, room furnishings. The MS toilet tank cover was taken off m 102 and the handle removed dent from flushing the toilet. d the toilet paper should not be of the open toilet tank. The window shade in Room 202 d to hang straight. The CP also p shade in Room 204 would ed. The CP stated the m 301 was a personal e resident had applied the right arm rest for personal confirmed the resident could vsical therapy consult about the heelchair and would refer the ysical therapy department.			
	tour of the facility' dryer vents were approximately 3/4 the vents' screens lint noted underne	proximately 10:35 a.m. during a s laundry services, the 2 large observed to contain inch of white, lint build up on s with several large clumps of eath in the bottom of the dryers.			
FORM CMS-	The housekeepin 2567(02-99) Previous Versio	g supervisor (HS) confirmed the		Facility ID: 00080	ntinuation sheet Page 35 of 36

		AND HUMAN SERVICES	PRINTED: 09/17/2014 FORM APPROVED OMB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ſ	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245384	B. WING		08/	21/2014
	PROVIDER OR SUPPLIER	SP & C&NC		STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 465	dryer lint on the scr 2 dryers and stated at the end of the da laundry is done twic and then again on t stated with the amo	inge 35 eens and in the bottom of the the vents were cleaned daily, ay. The HS further stated be daily, once during the day the evening shift. The HS bunt of laundry done, the lint aned more than once daily.	F 4	· · · · · · · · · · · · · · · · · · ·		

Event ID: OBP511

Facility ID: 00080

If continuation sheet Page 36 of 36

	MENT OF HEALTH			F538	4027-	FORM	Printed: 08/27/2014 FORM APPROVED OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED						
245384			B. WING		08/25/2014						
					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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE				
K 000	INITIAL COMMENT	S		K 000							
	Minnesota Departm	Survey was conduct ent 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 F (NFPA) Standard 10 Chapter 19 Existing	Fire Protection Assoc 01, Life Safety Code Health Care.	ciation (LSC),								
	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 facility has a fire ala detection in the corr corridors that is mor department notificat detection in all resid areas have either he detection that are or accordance with the The facility has a ca	rm system with smo idors and spaces op nitored for automatic ion. It also has smol ent rooms. Other ha eat detection or smo h the fire alarm syste Minnesota State Fil pacity of 37 beds an	ke en to the fire zardous ke em in re Code.								
LABORATO	census of 32 at the It is the determination	on of this Life Safety		NATURE	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.

	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV		FORM APPROVED OMB NO. 0938-0391						
STATEMEN		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE 8 COMPL	URVEY			
		245384		B. WING		08/2	25/2014			
	ROVIDER OR SUPPLIER				STATE, ZIP CODE	•				
COOK CO NORTHSHORE HOSP & C&NC 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604										
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE			
K 000	Surveyor that the fir resident rooms is a unobstructed cover wardrobe closets ir (99) and CMS S&C	re sprinkler coverage adequate to provide o age to the exterior o n accordance with N	complete f the FPA 13	K 000	JEFICIENCY)					
				uri VANA						

If continuation sheet Page 2 of 2

Printed: 08/27/2014



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

Cook County Northshore Hospital & C&NC September 5, 2014 Page 2

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 Meeth

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 Cook County Northshore Hospital & C&NC September 5, 2014 Page 3