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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T14V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00080

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/15/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Terri Ament, Unit Supervisor 10/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 10/12/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/04/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245384

October 5, 2017

Ms. Kimber Wraalstad, Administrator
North Shore Health
515 5th Avenue West
Grand Marais, MN 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 September 12, 2017 the above facility is recommended for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 5, 2017

Ms. Kimber Wraalstad, Administrator
North Shore Health
515 5th Avenue West
Grand Marais, MN 55604

RE: Project Number S5384027

Dear Ms. Wraalstad:

On August 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. This survey found the most serious deficiencies 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 September 15, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 3, 2017, effective September 12, 2017 and therefore remedies outlined in our letter to you dated August 15, 2017, will not be imposed.

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.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: T14V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00080

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/03/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
This nursing home had a doing business as (dba) name change as reflected above. The previous dba Name was Cook County Northshore Hospital & C&NC.

17. SURVEYOR SIGNATURE Date :
Kimberly Settergen, HFE-NE II 09/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Certification Specialist 09/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 15, 2017

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

RE: Project Number S5384027

Dear Ms. Wraalstad:

On August 3, 2017, 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.

This survey found the most serious deficiencies in your facility 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 electronically delivered CMS-2567 whereby corrections are required.

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 12, 2017, 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 12, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 3, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/31/17, through 8/3/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 325		9/12/17

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

Electronically Signed | 08/22/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 1 (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were implemented and monitored and followed to prevent weight loss for 3 of 4 residents (R14, R2) reviewed for nutrition. Findings include: R14's Physician Order Sheet dated 7/19/17, indicated R14's diagnoses included adult failure to thrive, anemia, and heart failure. R14's quarterly Minimum Data Set (MDS) dated 4/28/17, indicated R14 had a severe cognitive impairment, and was independent with eating after set up. R14's MDS further indicated R14 had no swallowing problems, and no significant weight loss. R14's care plan dated 2/25/15, indicated R14 required a nutritional supplement, and the goal dated 6/11/13, was for R14 to maintain optimal nutritional status, eat greater than or equal to 3/4 of her food at least 75% of the time, and to drink supplements for stable weight. Interventions included to provide R14 with a regular diet, monitor intake from meals quarterly, and provide Ensure (a nutrition supplement) for p.m. snack. Nursing assistant (NA) interventions included to ensure adequate intake, follow up with snacks, provide supervision and encouragement with meals as needed, weigh monthly, and offer bedtime snack. R14 required minimal meal set	F 325	F325 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□'s allegation of compliance. On August 22, 2017, the Dietary Manager reviewed the records of Resident 2 and Resident 14 to assure they have a Physician order for nutritional supplements and is assuring a nutritional supplement is available to these residents as a p.m. snack. The Dietary Manager will monitor intake of nutritional supplements and weight loss by Resident 2 and Resident 14 twice a month and address intake concerns and weight loss at that time. By August 25, 2017, the Dietary Manager will review all resident records to assure that any resident receiving a nutritional supplement has a Physician order. It will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 2 up. R14's Physician Order Sheet dated 7/19//17, included orders for a regular diet., and dietary supplements. A Diet Requisition slip dated 3/16/17, indicated a diet order for Ensure to treat weight loss. R14's snack fluid record for 6/17, indicated R14 only received 240 cc of fluids (Ensure) in the p.m. on 6/8/17, and 240 cc of fluids (Ensure) on 7/8, 7/9, and 7/10/17. R14's intake of Ensure for the month of May, was requested but not provided. R14's Quarterly Dietary Conference Notes indicated R14's weight on 7/12/16, was 107 pounds, on 11/12/16, was 99.8 pounds, then slowly increased to 105.4 pounds on 5/6/17, then dropped to 100.3 by 7/10/17. R14's electronic record indicated R14's weight was 97.7 pounds on 7/23/17, and 97 pounds on 7/28/17. R14's percentage of food intake at meals was recorded for most meals on the Quarterly Dietary Conference Notes. R14's Nutritional Assessment dated 7/28/17, indicated R14's weights were 97.7 and 97 pounds, R14 had a 3% weight decrease from 6/10/17, to 7/23/17, and required supervision and encouragement during meals and follow up with a snack. R14's assessment further indicated R14 received 8 ounces of Boost (nutritional supplement) in the p.m. and regular floor nourishments at bedtime. R14's annual nutrition note dated 11/2/16, indicated there has been no change in nutritional interventions to the most recent nutrition note.	F 325	be verified a nutritional supplement is available to these residents at a resident preferred snack/mealtime. The Dietary Manager will monitor resident intake of nutritional supplement and weight loss twice a month for effectiveness of the nutritional supplement and modify the Care Plan as needed. The first monitor will begin by September 12, 2017. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year. The Care Center Director of Nursing and the Dietary Manager will implement an electronic charting system for documenting nutritional supplements intake by September 12, 2017. Education will be provided to the Care Center nursing staff on the rationale behind the need for nutritional supplements and on use of the electronic system on August 30, 2017. The Care Center Director of Nursing and the Dietary Manager will audit use of new electronic charting intervention for nutritional supplements. Audit will be monthly for 3 months, then quarterly for 9 months. This monitor will begin after September 12, 2017. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year. In addition, the Care Center Director of Nursing will continue to report quarterly on Quality Measure Percentage of Long Stay residents who lose too much weight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 325	Continued From page 3 R14's nutrition note indicated R14 had a 3% decrease in weight from 9/14/16, to 10/30/16, had a 6% weight decrease from 7/12/16, to 10/30/16, an 8% decrease from 4/16/16, to 10/30/16, and an 11% decrease from 10/26/15, to 10/30/16. R14's nutrition note lacked documentation of R14's intake of Ensure, and indicated current nutritional approaches would be continued. R14's quarterly nutrition note dated 1/26/17, indicated R14 had a 1% decrease in weight from 12/10/16, to 1/22/17, a 7% decrease from 10/10/16, to 1/22/17, and a 6% decrease from 7/12/16, to 1/22/17. R14's quarterly nutrition note lacked documentation of R14's intake of Ensure, and indicated current nutritional approaches would be continued. R14's quarterly nutrition note dated 4/27/17, indicated R14 required supervision and encouragement for food intake, and intake was monitored quarterly. R14's weight was stable from 4/9/17, to 4/26/17, increased by 4% from 1/22/17, to 4/26/17, and had a 3% decrease from 10/10/16, to 4/26/17. R14's quarterly nutrition note lacked documentation of R14's intake of Ensure and indicated R14's current nutritional approaches would be continued. R14's quarterly nutrition note dated 7/27/17, indicated R14 ate independently after minimal meal set up, and staff were to make sure she had adequate time to eat and to follow up with snacks if she did not eat well. R14's nutrition note indicated R14 was to receive 240 cc's of Ensure for a p.m. snack, and offered a snack from the p.m. snack cart that she usually accepted. R14 had a 3% weight decrease from 6/10/17, to 7/23/17, and a 6% weight decrease from 4/9/17,	F 325		

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	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 325	Continued From page 4	F 325		

to 7/23/17, and from 1/22/17, to 7/23/17, she had a 3% decrease. R14's quarterly nutrition note lacked documentation of R14's intake of Ensure, and indicated R14's current nutritional approaches would be continued.

On 8/2/17, at 8:43 a.m. R14 was observed being served hot cereal, toast, orange juice and milk. R14 ate independently, and finished the hot cereal and toast, and approximately 2/3 of the milk, then got up from the chair and walked down the hall.

On 8/1/17, at 9:25 a.m. dietary manager (DM) verified the nutritional supplement is not tracked routinely, and she did not make a regular note regarding the intake of supplements. The DM stated the nursing assistants (NAs) document snack intakes.

On 8/2/17, at 12:09 p.m. R14 was observed eating green beans, baked chicken and rice. At 12:15 p.m. R14 had eaten 1/4 of her meal and pushed her plate aside. R14 stood up at the table and was standing by her chair. Dietary aide (DA)-A took R14's plate from the table at that time. No encouragement or offers of alternative foods were made.

On 8/3/17, at 9:43 a.m. DM verified R14 had some weight loss, and had an order for Ensure in the p.m. DM verified she cannot be sure if R14 was getting the Ensure. DM stated she tries to follow up with staff to see if R14 is taking the Ensure, but has not documented it. DM stated staff have reported that R14 drinks the Ensure. DM stated she reviews intakes quarterly during the MDS assessment period (quarterly), and verified she should monitor more often when a

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	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 325	Continued From page 5 resident is nutritionally at risk. DM stated she felt R14's Ensure was helping, and that she is getting correct information from the NAs. DM stated she was not sure why R14's weight had dropped to 97 pounds in the past 2 weeks, and stated they probably need to increase the Ensure. DM stated staff usually encourage R14 to sit back down and cue her to eat, and verified that is what should have happened at lunch the previous day. DM verified she had not included supplement intake in her nutritional notes. DM further verified the type of supplement should be specified on the physician orders. On 8/3/17, at 12:09 p.m. DA-A verified she had taken R14's plate away at lunch the previous day, and stated if the the resident is still sitting, they leave the plate. DA-A stated she should have left R14's palte at the table. On 8/3/17, at 12:23 p.m. DM verified she had not been notified of R14's recent weight loss in July. On 8/3/17, at 12:25 p.m. director of nursing (DON)-A stated residents usually have a monthly weight taken, but some have weekly weights. DON-A stated when an NA gets a weight, and it is an anomaly, such as 5 pounds off from the previous weight, they get a re-weight. DON-A further stated when there is a weight loss, they tell the interdisciplinary team (IDT) and then the dietary manager would be notified. DON-A stated they need to do a better job of alerting nurses that a supplement was ordered and verified they need to do better at documenting intake of supplements. R2's Physician Order Sheet dated 6/2/17, identified diagnoses that included dementia.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 6 R2's 6/5/17, annual Minimum Data Set (MDS) dated 6/4/17, indicated R2 had severely impaired cognition, required set up with eating, and did not have any swallowing issues. The MDS further indicated R2's Body Mass Index (BMI, a measure of body fat on an individual) was 18.7% which was low on the normal scale of 18.5 to 24.9%. R2's care plan dated 8/2/17, indicated R2 needed her meals setup and her meat ground. The goal was for R2 to eat 75% of her meals 75% of the time. The care plan directed staff to provide Ensure (a nutritional supplement) daily and to provide it to her if she didn't eat a meal. R2's medical record lacked an order for the Ensure. According to an undated Quarterly Dietary Conference Notes form, R2 weighed: - 105 pounds on 8/9/16 -103 pounds on 8/30/16 -103 pounds on 9/2/16 -100 pounds on 10/11/16 -103 pounds on 11/30/16 -103 pounds on 12/6/16 -104 pounds on 1/3/17 -99 pounds on 2/9/17 -98 pounds on 3/3/17 -99 pounds on 4/4/17 -99 pounds on 5/10/17 -100 pounds on 6/5/17 -102 pounds on 7/11/17 On 8/2/17, from 7:24 a.m. until 9:12 a.m. R2 was observed in her room with the door shut, and the room dark. On 8/2/17, at 8:24 a.m. nursing assistant (NA)-A	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 325	Continued From page 7	F 325		

was observed passing breakfast room trays, but did not bring a breakfast tray to R2.

On 8/2/17, at 8:49 a.m. a breakfast tray was noted in the service area with R2's name on it.

On 8/2/17, at 8:52 a.m. licensed practical nurse (LPN)-A stated R2 had a variable wake time as she liked to sleep in; they save her breakfast tray for her.

On 8/1/17, at 9:12 a.m. R2 remained in her room sleeping.

On 8/2/17, at 11:31 a.m. R2 was observed sitting in the recliner in her room, with her feet up.

On 8/2/17, at 11:44 a.m. NA-A was observed delivering and setting up R2's lunch room tray on the overbed table and setting the table in front of R2. The meal consisted of mashed potatoes and gravy, a dessert cup, and a glass of milk.

On 8/2/17, at 11:58 a.m. R2 was observed to be eating her dessert independently.

On 8/2/17, at 12:16 p.m. R2 had pushed the overbed table away, and was again reclining in her chair. R2's dessert was eaten, but the mashed potatoes and gravy, and the milk were left untouched. At 12:33 p.m. R2 had not eaten any more of her lunch.

On 8/2/17, at 11:53 a.m. NA-B stated she was not R2's consistent NA, and the nurse was not R2's consistent nurse. NA-B stated R2 was "thrown off" because her consistent staff had the day off. NA-B stated R2 usually eats toast and oatmeal each day and eats it well; but R2 didn't eat her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 325	Continued From page 8	F 325		

breakfast today. NA-B stated she hoped R2 would eat her mashed potatoes, because she does like those, but R2 was having an off day.

On 8/2/17, at 2:32 p.m. the dietary manager (DM) stated it was care planned R2 would get an Ensure supplement with her afternoon snack. The DM confirmed the documentation showed R2 had received this supplement 3 times out of 31 opportunities in June, 2017, and 4 out of 31 opportunities in July, 2017. Documentation for May, 2017, was requested but not provided by the facility. The DM stated R2 may have received this supplement more frequently, but the facility did not have the documentation to support the provision or the consumption of supplements. The DM stated the facility system for providing and documenting supplement intakes was not working. The DM stated that currently any staff member may deliver supplements, but the NAs were responsible for documenting intake. The DM also stated the facility records mealtime consumption once a week every quarter. The mealtime fluid and food consumption were recorded separately; no specific staff role was responsible for this task, but anyone clearing tables could take responsibility. The DM stated R2 doesn't really like to eat, and has dementia related behaviors that affect her intake. The DM stated R2 has always been a small person, even when she lived in the community, and her admission weight was 125 pounds. The DM stated she thought the Ensure supplement was a physician's order, and she believed they were providing Ensure as a snack and as needed per the dietician's recommendation and care plan.

R2's 6/8/17, Nutritional Assessment indicated R2's usual weight was 120 and her current weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 325	Continued From page 9 was 101. A 6/20/17, dietician note indicated R2 was to be provided with Ensure if meal intake was poor and to also provide Ensure for afternoon snack. The note indicated R2 has had a decline in weight and to monitor intake and weights. A 6/21/17, physician note indicated R2's weight was down 10 pounds in the last year, and her oral intake was down at times related to her dementia. On 8/3/17, at 8:46 a.m. the DM confirmed there was no physician order for R2 to receive Ensure, and she was unsure why this had happened. The DM stated they usually start a supplement based on need, and then leave a note for the physician to write the order on their next rounds. The DM also confirmed that provision and consumption of R2's supplement cannot be determined by the documentation provided. Review of facility policies lack information related to provision of supplements, physician orders of supplements or documentation of supplement consumption.	F 325		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 334		9/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 334	Continued From page 10 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

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F 334	Continued From page 11 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate immunizations for pneumonia were provided for 3 of 5 residents (R9, R18, R36) reviewed for immunizations. Findings include: The Center for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccines include: one dose of pneumococcal conjugate vaccine (PCV13) is recommended for all adults aged 65 or older who have not previously received the vaccine. A dose of pneumococcal polysaccharide vaccine 23 (PPSV23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23. R9's undated Face Sheet indicated R9 was	F 334	F334 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□'s allegation of compliance. The Infection Control Coordinator has reviewed the Pneumococcal Immunizations status of Resident 9, Resident 18 and Resident 36. Resident 9 and Resident 36 require the Pneumococcal PCV 13 vaccination and Resident 18 requires the Pneumococcal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 12 admitted to the facility on 1/13/15. R9's vaccination record indicated R9 had received a pneumococcal vaccination (to aid in prevention of specific strains of pneumonia) on 7/19/06, after the age of 65. R9's medical record lacked documentation of which pneumococcal vaccine R9 had received. R9's medical record lacked documentation of the second pneumococcal vaccine, which indicated R9 had not received both pneumococcal vaccines. R18's undated Face Sheet indicated R18 was admitted to the facility on 2/3/15. R18's vaccination record dated 2/5/15, indicated R18 had received a pneumococcal vaccine on 9/8/06, after the age of 65. R18's medical record lacked documentation of which pneumococcal vaccine R18 had received. R18's medical record lacked documentation of the second pneumococcal vaccine, which indicated R18 had not received both pneumococcal vaccines. R36's undated Face Sheet indicated R36 was admitted to the facility on 4/11/17. R36's vaccination record dated 4/11/17, indicated R36 had received a PPSV23 (pneumococcal vaccine) on 8/1/06, after the age of 65. R36's vaccination record lacked documentation of a Prevnar 13 vaccination for pneumonia. On 8/2/17, at 1:06 p.m. the infection control preventionist, (ICP) verified R9, R18, and R36 had not received all the recommended pneumococcal vaccines. The ICP verified the facility had not followed up on the recommended immunizations, and that this was an area that	F 334	PPSV 23 vaccination. The Infection Control Coordinator has contacted the Primary care physicians for orders to administer the vaccine or documentation why the vaccine is contraindicated. The resident/family representative will be provided with the Vaccine information Sheet (VIS) regarding the vaccine and given the right to refuse vaccination. This will be documented on the Pneumococcal Vaccinations sheet. This will be completed by September 12, 2017. The Infection Control Coordinator completed an audit of all residents in the Care Center on August 21, 2017. This information will be used to identify the current Pneumococcal vaccination status, documentation of contraindication and resident refusal, if applicable. Physician orders will be received for residents needing vaccination. The resident/family representative will be provided with the Vaccine information Sheet (VIS) regarding the vaccine and given the right to refuse vaccination. This will be completed by September 12, 2017. The findings of the audit will be reviewed with the Infection Control Committee on September 20, 2017. The Infection Control Coordinator will revise the Influenza and Pneumococcal Immunizations policy to ensure it is up to date with the current CDC guidelines for the Pneumococcal PCV 13 and Pneumococcal PPSV 23 vaccinations. This will be completed by September 12, 2017. In addition, the Infection Control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING _____ B. WING _____	08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 13 required improvement. The ICP verified the facility policy and procedures did not address provision for both pneumococcal immunizations. The facility policy and procedure for Influenza and Pneumococcal Immunizations revised 6/1/16, lacked provision for both pneumococcal vaccines. The policy directed upon admission the resident's physician would evaluate the resident's pneumococcal immunization status and provide orders as needed, and immunization would be provided per the CDC guidelines.	F 334	Coordinator will work with the Clinical IT Specialist to develop improved documentation of immunizations received outside of the facility. The Infection Control Coordinator or her designee will complete a quarterly monitor of the status of newly admitted Resident'□s pneumococcal vaccination status including recommended CDC vaccinations and verification documentation of the provision of information/education to a resident or resident□s legal representative has been given prior to the administration of the immunization and the documentation of declinations. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year beginning in October 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	**515 - 5TH AVENUE WEST** **GRAND MARAIS, MN 55604**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cook County Northshore Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2017

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

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	245384	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as one building: 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 were determined to be of Type V(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has a hospital attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. It also has smoke detection in all resident rooms. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 37 beds and had a census of 31 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (10) and CMS S&C-05-38, A1. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		8/6/17

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K 341	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to 2 of several manual fire alarm pull stations in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code" sections 29.8.3.4. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affect 31 of 31 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 08/01/2017, observation revealed, that the manual fire alarm pull stations located at the 100 and 200 wings nurses stations were blocked from unobstructed access by a small paperwork file box that are placed directly in front of them. This deficient condition was verified by the Maintenance Supervisor.	K 341	K341 Items located in front of the fire alarm pull stations 100 and 200 staff work stations were moved by the Administrator on August 6, 2017. The importance keeping those areas free of obstructions have been sent in an email to Care Center employees on August 21, 2017. The importance of keeping this area clear will also be reviewed during the Care Center Nurses meeting and Nursing Assistants meeting in September 2017. During the quarterly fire drills conducted by the Maintenance Department Manager or his designee, the pull station accessibility will be reviewed. This information will be included on the fire drill report and forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		8/25/17

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K 353	Continued From page 4 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems 2010 edition, and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, 2011 edition. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 31 of 31 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 08/01/2017, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance staff it was	K 353	K353 A sprinkler flow test will be completed on August 25, 2017. The Maintenance Department Manager or his designee will conduct a sprinkler flow test during the first week of each quarter (January, April, July, and October). This requirement will also be added to the building Preventive Maintenance software to provide a reminder for completion and a location for documentation of completion.	

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K 353	Continued From page 5 revealed that at the time of the inspection the facility could not provide any documentation for 3 of 4 quarterly flow tests verifying that it has been completed. This deficient condition was verified by the Maintenance Supervisor.	K 353		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 4 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 31 of 31 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 712	K712 The Maintenance Department Manager will conduct a fire drill on August 25, 2017 and will verify the monitoring company received the signal. The fire alarm documentation will be modified to record verification the monitoring company has received the signal. This information will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	8/25/17

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K 712	Continued From page 6 On facility tour between 11:00 a.m. to 4:00 p.m. on 08/01/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not transmit a fire alarm signal to the alarm monitoring company for 2 of 12 fire drills This deficient condition was verified by a Maintenance Supervisor.	K 712		
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 31 of 31 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 08/01/2017, during the documentation review	K 901	K901 The Maintenance Department Manager and Maintenance Staff Members will complete a Facility Risk Assessment by September 12, 2017. This information will be forwarded to the Administrator and the Safety Committee. This requirement will also be added to the building Preventive Maintenance software to provide a reminder for annual completion and a location for documentation of completion.	9/12/17

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K 901	Continued From page 7 and an interview with the maintenance Supervisor it was revealed that the facility could not provide any risk assessment documenting or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901		
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99	K 914	K914 The Maintenance Department Manager and Maintenance Staff Members will	9/12/17

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K 914	Continued From page 8 Standards for Health Care Facilities 2012 edition, section 10.3. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 31 of 31 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 08/01/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	complete the annual electrical outlet inspection and testing in the resident rooms by September 12, 2017. This information will be forwarded to the Administrator and the Safety Committee.	
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of	K 923		8/2/17

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K 923	Continued From page 9 noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 15 of 31 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 08/01/2017, observations revealed that the oxygen storage room does not have the oxygen	K 923	K923 The Maintenance Department Manager placed the oxygen cylinders in a noncombustible container and separated the empty and full cylinders on August 2, 2017. The Maintenance Department Manager or his designee will complete a quarterly monitor regarding the storage of oxygen. This monitor will begin on September 1, 2017. The results of this monitor will be reported to Quality Improvement/Peer Review Committee for one year.	

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K 923	Continued From page 10 cylinders separated and tabled as full and empty. This deficient condition was verified by a Maintenance Supervisor.	K 923		