DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 8, 2025

Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: March 20, 2025

Dear Administrator:

On April 16, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 8, 2025

Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, MN 55807

Re: Reinspection Results
Event ID: UK6E12

Dear Administrator:

On April 16, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 20, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2025

Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: March 20, 2025

Dear Administrator:

On March 20, 2025, a survey was completed at your facility by the Minnesota Department of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 20, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 20, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/17/25-3/20/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/17/25-3/20/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54839961C (MN00109846), H54839886C (MN00110027), H54839887C (MN00110020), H54839888C (MN00109603). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

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

Electronically Signed | 04/07/2025

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise the care plan after discontinuation of self-administered medication for 1 of 1 residents (R50) reviewed for care planning.	F 657	F657 – Care Planning Resident R50's care plan for self-assessment of meds was resolved from the care plan. All residents' care plans were reviewed for	4/9/25

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F 657	Continued From page 2 Findings include: R50's 5 day Minimum Data Set (MDS) dated 1/20/25, identified intact cognition, and diagnoses that included amputation of lower right leg, congestive heart failure, obesity, gastritis, hypo-osmality (low concentration of solutes in the blood) and hyponatremia (low levels of sodium in the blood), type 2 diabetes, ascites, hyperparathyroidism of renal origin (increase in parathyroid hormone in the blood caused by chronic kidney failure), and end stage renal disease. R50's care plan last reviewed on 1/3/25, identified a focus of 'resident chooses to self administer tenapanor' (medication that lowers phosphorus levels in the blood). Care plan further identified a goal started on 10/17/24 of 'resident will safely self administer tenapanor per physicians orders.' R50's care plan also identified interventions for staff to follow: 'monitor usage of bedside meds, assess that resident is capable of self administering tenapanor correctly on a quarterly basis, assess safe storage, amount left, and expiration date of tenapanor weekly.' R50's order summary report dated 3/19/25, did not identify a current order for tenapanor. Review of R50's discontinued orders identified an order starting 10/15/24 and discontinued on 10/31/24, prescribing tenapanor oral tablet 30 milligrams (mg) to be given twice a day before first and last meals of the day. During joint interview on 3/20/25 at 9:57 a.m., director of nursing (DON) and licensed practical nurse (LPN)-B stated expectation care plans to	F 657	accuracy for care planning of self-administration of medications. Education completed with clinical leaders on the need for accuracy of care planning of self-administration of medications and updating care plans with changes. The care planning policy has been reviewed and remains current. The DON or designee will audit the self-administration of medications care plan for 5 residents weekly for four weeks, then monthly for three months for all residents self-administering medications to ensure that the care plan is correct, then bring to QAPI to review. Date Certain: 4/9/2025	

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F 657	Continued From page 3 be updated when needed. DON stated care plan updates would happen for changes in treatments. DON and LPN-B identified nurse managers would be reponsible for updating care plans for residents on their unit. During interview on 3/20/25 at 11:29 a.m., administrator stated expectation care plans were to be updated when treatments for the resident were changed. Facility policy 'Care Planning' last revised 11/2024, identified 'the care plan is to be modified and updated as the condition and care needs of the resident changes.'	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		4/9/25

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F 660	Continued From page 4 developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and	F 660		

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F 660	Continued From page 5 data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing, comprehensive discharge (DC) planning to a lower level-of-care for 1 of 2 residents (R49) reviewed for discharge planning. Findings include: R49's admission Minimum Data Set (MDS) dated 8/14/24, identified R49 was admitted to the nursing home from the acute hospital. The MDS listed a section, "Q0400," which was answered an active discharge plan was in place for the resident to return to the community. R49's most recent quarterly Minimum Data Set (MDS), dated 2/5/25, identified R49 was cognitively intact and needed some assistance with bathing, dressing, and transfers. R49 was wheelchair dependent but was independent in the wheelchair. Diagnoses included cancer and traumatic brain injury. Further, the MDS outlined under section Q0400. Discharge Plan, that an active discharge plan was not in place for R49 to	F 660	F660 – Discharge Planning Discharge planning was discussed with resident R49. A MNCHOICE assessment was scheduled with county for 4/29/2025. All other residents' discharge plans were reviewed for accuracy. The discharge planning policy has been reviewed and remains current. The DON or designee will review the residents care conference form indicating their discharge plan for 5 residents weekly for four weeks, then monthly for three months to ensure appropriate discharge planning in place, then bring to QAPI to review. Date Certain – 4/9/2025	

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F 660	Continued From page 6	F 660		

return to the community, and no referrals to the local agencies had been made due to referrals not wanted.

R49's care plan, dated 8/11/23, identified R49 wanted to be "discharged to Assisted Living Facility (ALF) knowing that there is a chance to possibly go home once resident gets stronger". Resident MNCHOICE assessment (assessment performed to qualify for ALF under county waiver program) was completed on 3/6/24. Interventions included staff would make necessary referrals as needed to carry out resident's DC goals.

R49's progress notes from 2/21/24 to 3/19/25 were reviewed and indetified the following:

- 2/23/24 4:07 a.m., social services (SS) met with resident today. Resident interested in getting own apartment. Explained due to eviction history on file would not be able to. Social worker did offer an ALF or group home, and resident agreed to that. Would work on this Monday.
- Progress notes lacked any other notations related to discharge planning related to this note.
- 11/12/24 3:01 p.m., SS met with resident today. Resident interested in discharge to ALF. Writer reached out to the county to see who case worker was to get MNCHOICE assessment.
- 11/19/24 at 3:24 p.m., care conference held and provided contact information for assisted living locators.
- Progress notes lacked documentation follow up was made to assist with ALF referrals of is resident needed assistance in discharge planning.

R49's care conference note dated 11/19/24, indicated resident was interested in moving to a

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F 660	Continued From page 7	F 660		

handicapped accessible apartment or ALF. Provided resident with resource for Assisted Living Locators to assist with independent living/ALF connections.

R49's care conference note dated 2/18/25, indicated R49 wanted to move to an ALF.

During an interview on 3/17/25 at 2:41 p.m., R48 stated he really wanted to move to an ALF. The discharge plan had been brought up with the facility social worker around a year ago, but they never did follow up with me related to anything discharge related. I keep bringing it up at every care conference but nobody ever follow ups on it. I am starting to give up on the idea.

During an interview on 3/19/25 at 10:53 a.m., the social services designee (SSD) stated the social services department was responsible to assist residents who wanted to DC from the facility to home or a lower level of care facility. Discussion would occur with the resident related to where they would like to go. If discharge to an ALF or group home was requested, social services would assist by getting insurance information and waivers gathered and completed, and assist the resident by sending referrals to different ALF facilities and setup tours if the resident wished. The social services department would follow through the entire DC process. The SSD was not aware of the resident wishes from 2/23/24 due to a different social worker being present at that time. She did acknowledge the notes existed and stated the process should have started at that time. The SSD reviewed R49's medical record and acknowledged nothing indicated a follow through was completed. The SSD stated during the care conference on 2/18/25, the resident

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F 660	Continued From page 8 again vocalized wanting to go to an ALF but was ok staying at the care center. SSD stated she had not done any referrals to ALFs or follow up with the resident related to DC planning. SSD stated she was only at the facility twice a week and any staff member could have performed the follow up and the referrals. During an interview on 3/19/25 at 12:11 p.m., the regional licensed social worker (RLSW)-A stated the Assisted Living Locators is a private company that can assist in finding placement. Social services would send referrals to them, they would visit with the resident and then communicate with the facility related to ALF's the resident was interested in. Social services would stay in contact with the ALF locators throughout the DC process. RLSW-A acknowledged a care conference was held on 11/19/24, and information related to the ALF locators had been provided to the resident and a referral was made. RLSW-A stated no follow up was done with the resident or the ALF locators since the information was first provided on 11/19/24 but should have been done by somebody in the facility as part of the discharge planning process. That would ensure referrals are sent out as the resident requests. During an interview on 3/20/25 at 9:52 a.m., the administrator stated social services would follow the resident related to the discharge from the time of admission. If the resident is interested in DC to home or a lower level of care like an ALF conversations should be had in the interdepartmental team (IDT) so everybody is on the same page related to the discharge plans. Assistance would be made to send referrals to the ALF's requested to see if the resident	F 660		

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F 660	Continued From page 9 qualified. Assistance with insurance issues and possible waivers would also occur. The provider would be notified towards the end to see if they agreed with the discharge plan and to get discharge orders to transfer or send home. Facility policy, Discharge Planning Policy dated 1/25, indicated discharge planning started at admission. The health care center would make every effort possible to meet the goal of the resident relative to their choices.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral cares were completed for 1 of 3 residents (R18) reviewed for personal cares. Findings include: R18's quarterly Minimum Data Set (MDS) dated 2/5/25, identified R18 had diagnoses which included multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves). R18's MDS identified R18 was cognitively intact. R18 had no rejections of care and required set up for oral hygiene and was dependent of staff for personal hygiene and required substantial to maximum assistance for dressing.	F 677	F677 – ADL Care Provided for Dependent Residents Resident R18 had oral care provided and was given a new toothbrush. All other dependent residents had oral care provided. The ADL policy was reviewed and remains current. All nursing staff received education on ADL's, including completing oral care. The DON or designee will audit oral cares being offered and completed for 5 random residents weekly for four weeks and monthly for three months, then bring to QAPI to review. Date Certain – 4/9/2025	4/9/25

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F 677	Continued From page 10 R18's nursing assistant care guide dated 3/20/25, identified R18 required an assist of one for bathing, dressing and grooming. R18's care guide also identified R18 had his own teeth. R18's care plan dated 9/21/23, identified R18 had a self care deficit. It further identified staff were to provide assistance with oral cares morning, bedtime, and as needed and to assist with personal hygiene. On 3/18/25 at 10:30 a.m., nursing assistants (NA)-A and NA-B entered R18's room to assist him with morning cares and to get him up, they told R18 what they were planning to do. A brief change was completed with peri-cares and pants were put on R18. A sling for the ceiling lift was placed under R18 and he was lifted out of bed and into his wheelchair. NA-A showed R18 three shirts and let him choose which one he wanted to wear. R18's shirt was changed, no face washing, hand washing or washing under his arms was offered or done. R18's hair was brushed, but he was not offered an opportunity to brush his teeth. R18 was given his soft touch call light and the NA's left the room. During an interview on 3/18/25 at 10:44 a.m., NA-A verified he was not offered an opportunity to brush his teeth and said he should be offered a chance to brush his teeth after he eats. During an interview on 3/19/25 at 10:41 a.m., NA-B stated morning cares included peri-care, dressing, combing hair, and oral cares. During an interview on 3/19/25 at 2:53 p.m., licensed practical nurse (LPN)-B stated morning cares for residents should include face and hands	F 677		

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F 677	Continued From page 11 washed, under arms washed, peri-care, and oral cares (teeth or dentures brushed). During an interview on 3/19/25 at 3:18 p.m., the director of nursing (DON) stated oral care should be offered to prevent teeth problems and infections. During an interview on 3/20/25 at 8:04 a.m., R18 stated staff didn't ask him if he wanted to brush his teeth. Said, "there's a tooth brush around here some place". R18 stated he had been offered an opportunity to brush his teeth "maybe twice" this week. R18 stated he would be happy to be able to brush his teeth once a day. The policy Activities of Daily Living dated 3/31/23, identified the facility would ensure a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility would provide care and services to include hygiene, bathing, dressing, grooming, and oral care.	F 677		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		4/9/25

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F 757	Continued From page 12 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to identify diagnoses or indications for use of medications for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1's significant change Minimum Data Set (MDS) dated 2/5/25, indicated intact cognition, and diagnoses that included schizoaffective disorder, type 2 diabetes with other skin complications, osteoarthritis (degenerative joint disease resulting from cartilage and bone breakdown), chronic bronchitis, rash, polyneuropathy (disease or damage to the peripheral nerves that presents as weakness, numbness, and pain), and chronic pain syndrome. R1's physician's orders dated 3/18/25, included the following medications and supplements but lacked diagnoses or indication for use: -benzonatate oral capsule 100 milligram (mg), give one capsule by mouth three times a day -cadexomer iodine external gel 0.9%, apply to affected area topically every 72 hours -carbidopa-levodopa oral tablet 25-100mg, give one tablet by mouth every morning and bedtime	F 757	F757 – Drug Regimen is Free from Unnecessary Drugs Resident R1's orders were reviewed and diagnoses were determined for all medications. All other residents' orders were reviewed for missing diagnoses. Diagnoses were determined for any resident's orders that needed them. All licensed nurses received education on having a diagnosis for any medication that is ordered. The medication administration policy was reviewed and remains current. The DON or designee will audit orders for ten residents weekly for four weeks, then monthly for three months to ensure a diagnosis is in place for every medication. The findings will be reviewed with QAPI. Date Certain – 4/9/2025	

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F 757	Continued From page 13 -clobetasol propionate external cream 0.05%, apply to breasts/abdominal area folds topically two times a day -gabapentin 8% gel, apply to bilateral feet topically three times a day -guaifenesin ER oral tablet extended release 600mg, give one tablet by mouth twice a day -interdry 10, apply to affected area topically every day shift -menthol-methyl salicylate external cream, apply to affected area topically as needed -miconazole nitrate powder 2%, apply to affected area topically two times a day -sarna external lotion 0.5-0.5%, apply to affected area topically as needed -zinc oral tablet 50mg, give one tablet by mouth in the morning R1's medication administration record (MAR) also lacked indication for use and administration of above medications. During interview on 3/19/25 at 10:38 a.m., registered nurse (RN)-A verified carbidopa-levodopa tablet and gabapentin gel did not have a diagnosis or indication for use. RN-A stated R1 had been on both medications for a while. RN-A stated medications should have a diagnosis or indication for use as part of the order. During interview on 3/19/25 at 3:24 p.m., RN-B stated expectation for each medication to have a diagnosis or indication for use. RN-B explained even without a diagnosis or indication listed she would know what the general reason was for based on the type of medication. During joint interview on 3/20/25 at 9:57 a.m.,	F 757		

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F 757	Continued From page 14 director of nursing (DON) and licensed practical nurse (LPN)-B stated the expectation was for each medication to have a diagnosis or indication for use. DON stated this was part of the order for the medication. DON explained nursing staff should seek clarification from the provider if a medication order was missing a diagnosis or indication for use. During interview on 3/20/25 at 11:29 a.m., administrator stated the expectation for every medication order to have a diagnosis or indication for use connected to it. Facility policy 'Medication Administration- General Guidelines' dated May 2022, indicated 'if a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification.'	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		4/9/25

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F 758	Continued From page 15 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete orthostatic blood pressure monitoring for an antipsychotic medication for 1 of 5 residents (R49), reviewed	F 758	F758 – Free from Unnecessary Psychotropic Meds Resident R49 had an orthostatic blood pressure completed.	

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F 758	Continued From page 16 for unnecessary medication use. Findings include: R49's quarterly Minimum Data Set (MDS) dated 2/10/25, indicated R49 had intact cognition. Diagnoses included anxiety disorder, manic depression, schizophrenia, and post traumatic stress disorder. The MDS indicated R49 received antipsychotic medications on a routine (daily) basis only. R49's Order Summary Report (OSR) identified on 8/25/23, an order was started for Quetiapine (antipsychotic mental health medication) 400mg by mouth at bedtime. R49's treatment administration record (TAR) and vital signs records reviewed from 1/1/25 to 3/1/25, lacked documentation of any orthostatic blood pressures taken. During an interview on 3/20/25 at 9:35 a.m., licensed practical nurse (LPN)- A stated blood pressures needed to be taken monthly for anybody on antipsychotic medications. The orthostatic blood pressures would be taken and documented in the TAR as laying, sitting and standing. If the resident was unable to stand the laying and sitting would still be obtained. During an interview on 3/20/25 at 10:09 a.m., LPN-B stated side effect monitoring included orthostatic blood pressures that would be taken once a month. LPN-B reviewed R49's TAR and acknowledged orthostatic vital signs had not been taken but that they should have been. LPN-B stated orthostatic blood pressure monitoring was important because antipsychotic medications can	F 758	All other residents on antipsychotic medications were reviewed to ensure an orthostatic blood pressure had been completed within the last 30 days. All licensed nurses received education on completing an orthostatic blood pressure when scheduled. The psychotropic med use policy was reviewed and remains current. The DON or designee will audit all residents on antipsychotic medications monthly for 4 months to ensure an orthostatic blood pressure is completed. Date Certain – 4/9/2025	

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F 758	Continued From page 17 cause sudden drops in blood pressure which could cause harm to the resident. During an interview on 3/6/25 at 10:27 a.m. the director of nursing (DON) stated orthostatic blood pressures needed to be done once a month and then documented in the medical record. Facility policy Psychotropic Medication Use last reviewed 1/25 indicated orthostatic blood pressures would be taken on a monthly basis, unless otherwise indicated by provider.	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		4/9/25

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F 880	Continued From page 18 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 19 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure ice packs for personal use were not stored with resident food. This had the potential to affect residents who stored or consumed food from the unit freezers. Findings include: On 3/17/25 at 7:13 p.m., the administrator unlocked the refrigerator and freezer in the first floor dining room. The freezer had food that was labeled for residents, it however also had a large blue ice pack approximately 18 inches by 12 inches labeled to use on the body, with R58's name. There were also two large re-usable ice packs approximately 12 inches by six inches labeled with a resident's name. The administrator stated the resident was no longer in the facility and threw the ice packs away. The administrator verified if ice packs were for use on the body they should not be stored in the freezer with resident food. On 3/19/25 at 1:43 p.m., the culinary director (CD)-C stated the dietary department was responsible for the unit refrigerator/freezers. CD-C stated she would expect staff to notify the nurse and herself if they saw non-food items in the freezers. On 3/19/25 at 2:58 p.m., licensed practical nurse (LPN)-B stated ice packs were not re-usable and should never be in the unit freezers, LPN-B stated she would expect staff to remove non-food items from the freezers.	F 880	F880 – Infection Prevention and Control All ice packs were removed from resident congregate use refrigerators. All staff received education on ice packs and appropriate storage. The resident food storage policy was reviewed and remains current. The Culinary Director or designee will audit the resident freezers weekly for four weeks, and monthly for three months to ensure there are no resident ice packs in the freezers. Date Certain – 4/9/2025	

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F 880	Continued From page 20 On 3/19/25 at 3:21 p.m., the director of nursing (DON) verified non-food items (ice packs) should not be stored with resident food, stated it was an infection control concern and could contaminate the food. Refrigerators and Freezers policy dated 12/2014, did not address ice pack storage in unit freezers.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2025

Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, MN 55807

Re: State Nursing Home Licensing Orders
Event ID: UK6E11

Dear Administrator:

The above facility was surveyed on March 17, 2025 through March 20, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

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 feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/17/25-3/20/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54839961C (MN00109846), H54839886C (MN00110027), H54839887C (MN00110020), H54839888C (MN00109603). No citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to review and revise the care plan after discontinuation of self-administered medication for 1 of 1 residents (R50) reviewed for care planning. Findings include:	2 570	Corrected	4/9/25

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2 570	Continued From page 3 R50's 5 day Minimum Data Set (MDS) dated 1/20/25, identified intact cognition, and diagnoses that included amputation of lower right leg, congestive heart failure, obesity, gastritis, hypo-osmality (low concentration of solutes in the blood) and hyponatremia (low levels of sodium in the blood), type 2 diabetes, ascites, hyperparathyroidism of renal origin (increase in parathyroid hormone in the blood caused by chronic kidney failure), and end stage renal disease. R50's care plan last reviewed on 1/3/25, identified a focus of 'resident chooses to self administer tenapanor' (medication that lowers phosphorus levels in the blood). Care plan further identified a goal started on 10/17/24 of 'resident will safely self administer tenapanor per physicians orders.' R50's care plan also identified interventions for staff to follow: 'monitor usage of bedside meds, assess that resident is capable of self administering tenapanor correctly on a quarterly basis, assess safe storage, amount left, and expiration date of tenapanor weekly.' R50's order summary report dated 3/19/25, did not identify a current order for tenapanor. Review of R50's discontinued orders identified an order starting 10/15/24 and discontinued on 10/31/24, prescribing tenapanor oral tablet 30 milligrams (mg) to be given twice a day before first and last meals of the day. During joint interview on 3/20/25 at 9:57 a.m., director of nursing (DON) and licensed practical nurse (LPN)-B stated expectation care plans to be updated when needed. DON stated care plan updates would happen for changes in treatments. DON and LPN-B identified nurse managers would be reponsible for updating care plans for	2 570		

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2 570	Continued From page 4 residents on their unit. During interview on 3/20/25 at 11:29 a.m., administrator stated expectation care plans were to be updated when treatments for the resident were changed. Facility policy 'Care Planning' last revised 11/2024, identified 'the care plan is to be modified and updated as the condition and care needs of the resident changes.' SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate;	2 915		4/9/25

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2 915	Continued From page 5 (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral cares were completed for 1 of 3 residents (R18) reviewed for personal cares. Findings include: R18's quarterly Minimum Data Set (MDS) dated 2/5/25, identified R18 had diagnoses which included multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves). R18's MDS identified R18 was cognitively intact. R18 had no rejections of care and required set up for oral hygiene and was dependent of staff for personal hygiene and required substantial to maximum assistance for dressing. R18's nursing assistant care guide dated 3/20/25, identified R18 required an assist of one for bathing, dressing and grooming. R18's care guide also identified R18 had his own teeth. R18's care plan dated 9/21/23, identified R18 had a self care deficit. It further identified staff were to provide assistance with oral cares morning, bedtime, and as needed and to assist with personal hygiene.	2 915	Corrected	

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2 915	Continued From page 6 On 3/18/25 at 10:30 a.m., nursing assistants (NA)-A and NA-B entered R18's room to assist him with morning cares and to get him up, they told R18 what they were planning to do. A brief change was completed with peri-cares and pants were put on R18. A sling for the ceiling lift was placed under R18 and he was lifted out of bed and into his wheelchair. NA-A showed R18 three shirts and let him choose which one he wanted to wear. R18's shirt was changed, no face washing, hand washing or washing under his arms was offered or done. R18's hair was brushed, but he was not offered an opportunity to brush his teeth. R18 was given his soft touch call light and the NA's left the room. During an interview on 3/18/25 at 10:44 a.m., NA-A verified he was not offered an opportunity to brush his teeth and said he should be offered a chance to brush his teeth after he eats. During an interview on 3/19/25 at 10:41 a.m., NA-B stated morning cares included peri-care, dressing, combing hair, and oral cares. During an interview on 3/19/25 at 2:53 p.m., licensed practical nurse (LPN)-B stated morning cares for residents should include face and hands washed, under arms washed, peri-care, and oral cares (teeth or dentures brushed). During an interview on 3/19/25 at 3:18 p.m., the director of nursing (DON) stated oral care should be offered to prevent teeth problems and infections. During an interview on 3/20/25 at 8:04 a.m., R18 stated staff didn't ask him if he wanted to brush his teeth. Said, "there's a tooth brush around here some place". R18 stated he had been offered an	2 915		

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2 915	Continued From page 7 opportunity to brush his teeth "maybe twice" this week. R18 stated he would be happy to be able to brush his teeth once a day. The policy Activities of Daily Living dated 3/31/23, identified the facility would ensure a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility would provide care and services to include hygiene, bathing, dressing, grooming, and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535		4/9/25

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21535	Continued From page 8 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to identify diagnoses or indications for use of medications for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1's significant change Minimum Data Set (MDS) dated 2/5/25, indicated intact cognition, and diagnoses that included schizoaffective disorder, type 2 diabetes with other skin complications, osteoarthritis (degenerative joint disease resulting from cartilage and bone breakdown), chronic bronchitis, rash, polyneuropathy (disease or damage to the peripheral nerves that presents as weakness, numbness, and pain), and chronic pain syndrome. R1's physician's orders dated 3/18/25, included the following medications and supplements but lacked diagnoses or indication for use: -benzonatate oral capsule 100 milligram (mg), give one capsule by mouth three times a day -cadexomer iodine external gel 0.9%, apply to	21535	Corrected	

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21535	Continued From page 9 affected area topically every 72 hours -carbidopa-levodopa oral tablet 25-100mg, give one tablet by mouth every morning and bedtime -clobetasol propionate external cream 0.05%, apply to breasts/abdominal area folds topically two times a day -gabapentin 8% gel, apply to bilateral feet topically three times a day -guaifenesin ER oral tablet extended release 600mg, give one tablet by mouth twice a day -interdry 10, apply to affected area topically every day shift -menthol-methyl salicylate external cream, apply to affected area topically as needed -miconazole nitrate powder 2%, apply to affected area topically two times a day -sarna external lotion 0.5-0.5%, apply to affected area topically as needed -zinc oral tablet 50mg, give one tablet by mouth in the morning R1's medication administration record (MAR) also lacked indication for use and administration of above medications. During interview on 3/19/25 at 10:38 a.m., registered nurse (RN)-A verified carbidopa-levodopa tablet and gabapentin gel did not have a diagnosis or indication for use. RN-A stated R1 had been on both medications for a while. RN-A stated medications should have a diagnosis or indication for use as part of the order. During interview on 3/19/25 at 3:24 p.m., RN-B stated expectation for each medication to have a diagnosis or indication for use. RN-B explained even without a diagnosis or indication listed she would know what the general reason was for based on the type of medication.	21535		

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21535	Continued From page 10 During joint interview on 3/20/25 at 9:57 a.m., director of nursing (DON) and licensed practical nurse (LPN)-B stated the expectation was for each medication to have a diagnosis or indication for use. DON stated this was part of the order for the medication. DON explained nursing staff should seek clarification from the provider if a medication order was missing a diagnosis or indication for use. During interview on 3/20/25 at 11:29 a.m., administrator stated the expectation for every medication order to have a diagnosis or indication for use connected to it. Facility policy 'Medication Administration- General Guidelines' dated May 2022, indicated 'if a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification.' SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published	21535		

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21535	Continued From page 11 in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/18/2025**

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THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/18/2025. At the time of this survey The North Shore Estates LLC 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/07/2025

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
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/18/2025**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The North Shores Estates LLC is a two-story building with a full basement. The building was constructed at two different times. The original building was constructed in 1971 with an addition built in 2005. Both buildings are of Type II(111) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building, the 2005 building is support services only. The facility is fully protected throughout by an automatic fire sprinkler system. The facility	K 000		

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K 000	Continued From page 2 also have a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The two resident sleeping floors are each divided into three separate smoke compartments. The facility has a capacity of 70 beds and had a census of 63 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by observation that there was medical equipment (medical bed) in the egress	K 211	K211 – Means of Egress The medical equipment was removed from the first-floor east wing. All other means of egress were assessed for the need for items to be removed. Education was provided to maintenance. The administrator or designee will audit all means of egress for a clear path, weekly for 4 weeks, then monthly for three months, and review findings with QAPI. Date Certain – 4/4/2025	4/4/25

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K 211	Continued From page 3 corridor at the end of the First Floor East Wing which was removed at the time of discovery. An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 211		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a	K 353	K353 – Sprinkler System Summit Fire Protection to come back to facility to reassess and show facility where there is damage, as facility does not physically see damage on 4/8/2025. If there is indeed a crack to the pipe where water flows into the facility, the facility will fix.	4/8/25

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K 353	Continued From page 4 widespread impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by a review of available documentation the facility failed to document repairs to fire sprinkler system as identified on annual report. During interview Maintenance Director indicated that he had followed up on report with Summit Fire Protection, but could not provide documentation. An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 353	Maintenance received education. The administrator or designee will audit sprinkler inspection forms, for completed follow up with sprinkler company, monthly for 12 months and review findings with QAPI. Date Certain – 4/8/2025	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per	K 372	K372 – Subdivision of Building Spaces -Smoke Barrier Construction	4/4/25

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K 372	Continued From page 5 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors i8n the following areas: 1) First Floor East wing main doors 2) Second Floor West wing main doors 3) Second Floor Stairwell door = three penetration found 4) Second Floor above doors leading into cafeteria An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 372	The first floor east wing main doors penetration was fixed. The second floor west wing main doors penetration was fixed. The second floor stairwell door, all three penetrations were fixed. The second floor penetration above the cafeteria doors was fixed. All areas above doors that are a smoke barrier were checked for penetrations, and fixed. Maintenance received education. The administrator or designee will audit for any penetrations in the smoke barriers monthly for four months, and review findings with QAPI. Date Certain: 4/4/2025	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be	K 541		4/8/25

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K 541	Continued From page 6 provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. On 03/18/2025 between 10:00am and 12:30pm, it was revealed by observation that the laundry chute door located on the East Wing, second floor was missing self-closing device and/or a device to secure chute door in the closed position. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	K541- Rubbish Chute's. Incinerators, and Laundry Chutes The latch on the rubbish chute was replaced. All other rubbish chutes were checked for a working latch. Maintenance received education. The administrator or designee will audit for any missing latches on the rubbish chute, weekly for four weeks and monthly for three months, and review findings with QAPI. Date Certain: 4/8/2025	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and	K 712		4/4/25

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K 712	Continued From page 7 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by a review of available documentation that fire drills were not completed: second shift, second quarter 06/11/24 @ 1534 and second shift, third quarter 09/06/24 @ 1517. These drill did not demonstrate varying times. An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 – Fire Drills A fire drill was completed on 3/31/2025 at 6:28PM. Maintenance received education. The administrator or designee will audit all fire drills monthly for the next 12 months to ensure varied timing, then review with QAPI. Date Certain: 4/4/2025	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids,	K 741		4/4/25

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K 741	Continued From page 8 combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by observation that the smoking was occurring on the outside patio area located on first floor outside of first floor cafeteria as evident by discarded cigarette butts and a visible pack of cigarettes in bushes and lawn area. .	K 741	K741 – Smoking Regulations The cigarette butts on the ground and the pack of cigarettes were disposed of. All other smoking areas were assessed for cigarette butts, and the cigarette butts were disposed of. Maintenance received education. The administrator or designee will audit all smoking areas for cigarette butts, weekly for 4 weeks, then monthly for three months, and review findings with QAPI. Date Certain 4/4/2025	

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K 741	Continued From page 9 An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 741		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		4/18/25

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K 918	Continued From page 10 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by a review of available documentation of the emergency generator had not been annual inspected. Last inspection was preformed on 01/17/2024 be Zeigler Cat. An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 918	K918 – Electrical Systems – Essential Electric System The generator is scheduled to have an annual inspection completed on 4/18/2025. Maintenance has received education. The administrator or designee will audit to ensure generator has annual inspection monthly for 12 months, and review findings with QAPI. Date Certain: 4/18/2025	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of	K 920		4/4/25

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K 920	Continued From page 11 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00am and 12:30pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following area; 1) Microwave plugged into an extension cord in records office at the end on the West Wing.	K 920	K920 – Electrical Equipment – Power Cords and Extension Cords The microwave was unplugged from the extension cord. All rooms and offices were checked for appliances that were plugged into a power strip or extension cord. All offices and areas with microwaves will be audited monthly for 4 months to ensure there are not any power cords or extension cords in use. The finding will be brought to QAPI for review. Date Certain: 4/4/2025	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	**7700 GRAND AVENUE** **DULUTH, MN 55807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 12 An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 920		