



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 29, 2025

Administrator
NORTH SHORE HEALTH
515 - 5TH AVENUE WEST
GRAND MARAIS, MN 55604

RE: CCN: 245384

Cycle Start Date: July 31, 2025

Dear Administrator:

On September 25, 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,

A handwritten signature in cursive script that reads '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



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September 29, 2025

Administrator
NORTH SHORE HEALTH
515 - 5TH AVENUE WEST
GRAND MARAIS, MN 55604

Re: Reinspection Results
Event ID: XQL7-H2

Dear Administrator:

On 09/25/2025 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 07/31/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads '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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An equal opportunity employer.



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August 28, 2025

Administrator
NORTH SHORE
HEALTH
515 - 5TH AVENUE WEST
GRAND MARAIS, MN 55604

RE: CCN:245384

Cycle Start Date: July 31, 2025

Dear Administrator:

On July 31, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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 October 31, 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 January 31, 2026, (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, 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



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August 28, 2025

Administrator
NORTH SHORE HEALTH
515 - 5TH AVENUE WEST
GRAND MARAIS, MN 55604

Re: State Nursing Home Licensing Orders

Event ID: XQL711

Dear Administrator:

The above facility survey was completed on July 31, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

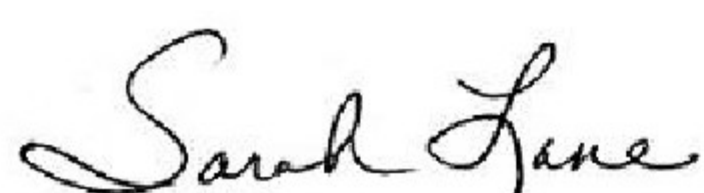
Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

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, 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2025	
NAME OF PROVIDER OR SUPPLIER NORTH SHORE HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 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	
E0000	Initial Comments On 7/28/25 to 7/31/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.		E0000			08/29/2025	
F0000	INITIAL COMMENTS On 7/28/25 - 7/31/25, 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 citations. Incident 1171415, (MN00108713, H53842021C) Incident 1171416, (MN00110629, H53841071C) 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 regulations has been attained.		F0000			08/29/2025	
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2);		F0628	F628 – Discharge Process Preparation, submission and implementation of this Plan		09/19/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025
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F0628 SS = E	Continued from page 1 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628	Continued from page 1 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 policy regarding Bed Hold Notice will be reviewed and updated by Social Services by September 19, 2025. With the transition to PointClickCare and the electronic medical record (EMR), Nurses will utilize the transfer to hospital component in the EMR that will highlight the resident transfer to the members of the IDT and the Business Office Director for review during the next business day to verify completion of the bed hold notification. The Ombudsman Notice of Transfer have been sent to Minnesota State Ombudsman's Office in July 2025 and August 2025. A policy for Ombudsman Notification of Resident Discharge/Transfer will be reviewed and updated by Social Services by September 19, 2025. The policy continues to include the requirement for all monthly reporting of emergency transfers be faxed to MN State Ombudsman's Office by the 15th day of the following month. Monitoring: The Social Services Designee will review all transfers and discharges to ensure that notifications have been provided appropriately. The results of this monitor will be reported quarterly to the Quality Improvement/Peer Review Committee for one year. The Social Worker will review all transfers monthly to ensure all notifications to the Minnesota State Ombudsman's Office has been completed. The results of this monitor will be reported to Quality Improvement/Peer Review Committee quarterly for one year with the first report being submitted in September 2025.	

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F0628 SS = E	Continued from page 2 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;			F0628			

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F0628 SS = E	Continued from page 3 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan,		F0628				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2025	
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F0628 SS = E	Continued from page 4 under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide a written bed hold for 2 of 2 residents (R5, R30) reviewed for hospitalization. In addition, the facility failed to notify the Ombudsman of the transfers to the hospital. Findings include: R30 R30's quarterly Minimum Data Set (MDS) identified resident as cognitively intact with diagnoses of hemiplegia (paralysis affecting one side of the body) following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease (progressive lung disease that makes it			F0628			

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F0628 SS = E	Continued from page 5 difficult to breathe), depression, anxiety, anemia, dysuria (pain or discomfort during urination), obstructive and reflux uropathy (condition affecting the urinary tract and the flow of urine), and a personal history of prostate cancer. Progress note, dated 5/24/25, indicated "... it is evident that resident is not feeling well. T (temperature) 99.2 R (respirations) 40, P (pulse) 81 BP (blood pressure) 97/53. Update left with SMC MD who advised for resident to be seen in the ED. Resident transferred to the ED at approx. 1430. Sister received update on current status and ED visit- reports that she has provided update to son as well." Progress note lacked evidence of a bed hold being discussed with resident or representative at the time of transfer on 5/24/25 or during hospitalization. During review of R30's entire electronic medical record (EMR), the EMR lacked a completed bed hold form relating to resident's transfer to the emergency department on 5/24/25. Email received from administrator on 7/31/25 at 7:33 a.m., stated "I wish I could give you the notice but I can't. The notification process to the resident/family got lost in personnel change." R5 R5's quarterly MDS dated 6/2/25 identified resident as cognitively intact with diagnoses that included age related decline, cerebral infarction, repeated falls, anxiety, irritable bowel syndrome, diabetes, gout, and anemia. During interview on 7/28/25 at 3:25 p.m., R5 indicated she went to the emergency room on 7/27/25. R5 stated she is not sure if she had to sign anything but understood why she was going to the emergency room. During interview on 7/30/25 at 9:48 a.m., registered nurse (RN)-A stated when sending a resident to the hospital the nurse would call the primary provider to give an update on the situation. RN-A also stated the resident's family would be called as well. RN-A explained the business office would complete the bed hold when residents stay overnight in the hospital but not if they only go to the emergency room. During interview on 7/30/25 at 12:34 p.m., assistant director of nursing (ADON) stated her understanding was anytime a resident goes to the emergency room they should get a bed hold. ADON confirmed she did not ask R5 about a bed hold. During interview on 7/30/25 at 1:03 p.m., licensed practical nurse (LPN)-A stated when a resident was			F0628			

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NAME OF PROVIDER OR SUPPLIER NORTH SHORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 55604	
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F0628 SS = E	Continued from page 6 admitted to the hospital they would get a bed hold. LPN-A verified she did not obtain a bed hold for R5 on 7/27/25. During interview on 7/31/25 at 10:45 a.m., social worker (SW)-A stated it was her understanding that the facility should send the ombudsman a list of residents who were sent to the hospital monthly. SW-A explained she became aware of this requirement three weeks ago, and had sent a notice to the ombudsman on 7/18/25 for the previous 30 days. SW-A stated being unaware of requirement and the notices were not being sent before that time. During interview on 7/31/25 at 11:30 a.m., director of nursing (DON) stated the bed hold should be given when the resident leaves for the emergency room. DON indicated the bed hold was important to make sure the resident had a bed upon their return. Email received from administrator on 7/31/25 at 11:53 a.m., stated "attached is the ombudsman notification for the last month [July 2025]. We do not have notification from previous months." Bed Hold Notice Policy last approved 8/20/2024, stated "all nursing home residents must receive a bed hold notice and copy of the bed hold policy if they are placed on a bed hold, for either a planned absence or emergency event, a notice regarding that bed hold must be issued to the resident and/or the resident's representative prior to or at the time of departure."	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F0656	F656 – Comprehensive Care Plan 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. A physician order for the aquathermia heating therapy pad (aqua-K pad) was received for R19 on August 1, 2025. The indications for use of the aquathermia heating therapy pad (aqua-K pad) has been included on R19's care plan. The aquathermia heating therapy pad system is a closed system with water in the reservoir. The equipment was immediately assessed by Maintenance and it was verified that water was in the reservoir as expected.	09/02/2025

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F0656 SS = D	Continued from page 7 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to incorporate provider orders as well as indications for use for aquathermia heating therapy pad (aqua-K pad) intervention in care plan for 1 of 3 residents (R19) reviewed for care planning. Findings include: R19's quarterly Minimum Data Set (MDS) dated 6/2/25, identified the resident was severely cognitively impaired with diagnoses that included Alzheimer's disease, depression, anxiety, varicose veins of lower extremity, hypocholesteremia, osteoarthritis, hypothyroidism, gastroesophageal reflux disease, and peripheral vascular disease. Review of R19's provider orders on 7/30/25, no order	F0656	Continued from page 7 An aquathermia heating therapy pad (aqua-K pad) is not being used with any other resident. A reminder email of the need for a physician order for the use of the aquathermia heating therapy pad (aqua-K pad) was sent to the Care Center Nurses on September 2, 2025. Monitoring: The Director of Nursing or designee will review the use aquathermia heating therapy pad (aqua-K pads) monthly and verify that a physician order has been received and is included on the resident's care plan. The results of this monitor will be reported to Quality Improvement/Peer Review Committee monthly for three months with the first report being submitted in September 2025.	

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F0656 SS = D	Continued from page 8 for use of aqua-K pad for back pain in resident's electronic medical record (EMR). During interview on 7/30/25 at 2:12 p.m., registered nurse (RN)-B stated R19 did use an aqua-K pad but was not sure how long the resident had been using it. RN-B identified the pump for the aqua-K pad was set to 100 degrees and on continuous mode, with an empty water reservoir. RN-B stated there was not an order for R19 to use the aqua-K pad. During joint interview on 7/30/25 at 3:03 p.m., director of nursing (DON) and assistant director of nursing (ADON) stated expectation that the provider would enter orders for the use of the aqua-k pad. DON and ADON explained the order would have the temperature settings, the frequency of use, and whether continuous use would have been allowed. DON and ADON stated being unsure if there was any danger in using the aqua-K pad without water or in using the pad continuously. DON and ADON confirmed that during the facility's switch from one EMR to another, the provider order for R19 to use the aqua-K pad did not transfer over. DON and ADON verified there was no order in the current EMR and staff did not have necessary directions on use and care of aqua-K pad. During interview on 7/31/25 at 1136, DON stated expectation of having a provider order for R19's use of aqua-K pad, and that information should have been in the resident's care plan. Aquathermia Pad policy, last revised on 1/27/2025, stated "the use of an aquathermic pad is initiated by a physician's/advance practice provider's order that specifies duration and frequency." Policy continued on to state in preparation section "review physician's/advance practice provider's order to determine treatment area, type of application, and temperature of treatment."		F0656				
F0880 SS = C	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.		F0880	F880 – Infection Control 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 linen was moved from the lowest shelf in the linen		09/03/2025	

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F0880 SS = C	Continued from page 9 §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; §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	F0880	Continued from page 9 stock room on July 30, 2025. The lowest shelf is currently being used for wrapped linen not actively in use. An email will be sent to Housekeeping staff about the location of linen storage on September 2, 2025. The policy (NSH Laundry – Collection, Transportation and Handling of Soiled Linen) for linen handling and use of gowns was updated on August 20, 2025. The education for Housekeeping staff regarding the updated policy will be completed by September 3, 2025. The Blood Glucose Testing policy was updated September 3, 2025 to include the manufacturer information for ACCU-Check Inform II system. An email will be sent to the Care Center Nursing staff regarding the updated policy and they will be assigned to review and acknowledge the updated policy. The Oxiver wipes were removed from the Nurses carts on July 30, 2025. Monitoring: Observations will be performed by the Infection Preventionist or Designee daily to review the placement in the linen storage area for proper placement and the use of PPE during routine linen sorting for the month of September 2025. With compliance, observations will then be performed weekly for three months. The results of these monitors will be reported to Quality Improvement/Peer Review Committee monthly with the first report being submitted in September 2025. The Director of Nursing or Designee will monitor the cleaning of the glucometer daily for two weeks. With compliance, observations will then be performed twice per week for three months. The results of this monitor will be reported to Quality Improvement/Peer Review Committee monthly for three months with the first report being submitted in September 2025.	

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F0880 SS = C	Continued from page 10 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. 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 record review the facility failed to ensure infection prevention measures were in place to ensure linen was properly handled and stored. These deficient practices had the potential to impact all residents who resided at the facility. In addition, the facility failed to ensure proper glucometer sanitization occurred. This deficient practice had the potential to impact all residents who received glucometer testing at the facility. Findings include: During a tour of the laundry area on 7/29/25 at 12:31 p.m., the lead housekeeping staff (HS-A) stated dirty laundry was brought to laundry in clear plastic bags from all areas. Their process was to remove the plastic bags and sort laundry in the dirty linen area of laundry. Staff were to always wear gloves when they sorted linen. Staff would also wear a gown or a jacket when they sorted linen that was obviously soiled. HS-A confirmed staff were not required to wear a gown/jacket over their clothing for routine linen sorting, it was their process to wear gloves for routine linen sorting and then gown up for laundry that was visibly soiled. During a tour of the clean linen storage area on 7/29/25 at 12:35 p.m., wooden shelves and metal carts lined the walls of the linen room. On the right wall, the bottom wooden shelves were less than an inch thick and flush to the floor. The bottom shelves contained mattress pads and blankets, some directly touching the floor. During an interview on 7/29/25 at 12:49 p.m., HS-A stated laundry should not be stored so close to the floor because it could become contaminated. HS-A removed the linen from the bottom shelves and stated they would need to re-wash the linen before it could be			F0880			

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F0880 SS = C	Continued from page 11 used. During an interview on 7/30/25 1:50 p.m., the director of nursing (DON) stated they were not sure if it was an infection prevention requirement for staff to wear a gown and gloves or just gloves when sorting linen. They would have to look at the facility policy to know for sure. During an interview on 7/30/25 at 2:02 p.m., environmental services aide EVS-A stated they also got assigned to laundry. On laundry days they were responsible for sorting dirty linen, washing, drying, and folding linen. EVS-A stated they had to always wear gloves to sort dirty laundry. When they had yellow or red bags of linen that needed to be sorted, they also wore a gown or a jacket in addition to their gloves. EVS-A confirmed they were instructed they only needed to wear gloves to handle dirty linen unless it was from a yellow or red linen bag. During an interview on 7/31/25 at 9:51 a.m., the infection preventionist (IP) stated for infection prevention the laundry staff should be wearing gown and gloves at all times when sorting dirty laundry. The laundry policy should include direction to wear gown and glove at all times for laundry sorting. Gowning and gloving when sorting linen should be done to prevent cross contamination of the clean laundry. Laundry should not be stored where it can touch the floor and become contaminated. The facility policy Departmental (Environmental Services) - Laundry and Linen dated 11/2014, section: Sorting Linen, instructed employees sorting or washing linen must wear a gown and gloves. During an interview on 7/30/25 at 1:37 p.m., registered nurse (RN-B) stated blood sugars were normally done by the night staff at 5:30 a.m. so they hadn't had to clean the glucometer. RN-B picked up the oxiver wipes and stated if they had to clean the glucometer, they would wipe it down with oxiver wipes and make sure the glucometer remained wet for the dwell time of 1 minute. The ADON was present and stated they would use the oxiver wipes to sanitize the Accu-Chek inform II between residents. The ADON pulled the infection control manual to see how to clean the glucometer, then left, returned, and shared cleaning instructions for the Accu-check Inform (not the instructions for the current glucometer Accu-Chek Inform II) The instructions instructed not to use bleach. During an interview on 7/31/25 at 9:21 a.m., the IP		F0880				

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F0880 SS = C	Continued from page 12 stated they were not sure what the requirements were for cleaning the facility glucometer, as the nurse managers and the ADON did the glucometer training. The IP indicated the infection prevention program should include oversight of the training of staff to ensure staff were using the right products and processes to clean patient care for equipment for infection prevention and control. During an interview on 7/31/25 at 11:24 a.m. the DON stated the IP was responsible for setting the policies and procedures for equipment cleaning and then nursing was responsible for the training/teaching which took place in orientation. The DON indicated they would expect training to occur when new equipment was put into use, however they were not certain when the newer glucometer model was put into use. The DON stated they were not aware what wipes were being used by staff for the glucometer, but they would expect the IP would do periodic audits on equipment sanitization including the glucometer. The facility policy Cleaning of Non-Critical and Semi-Critical Reusable Resident Care Equipment in North Shore Living Care Center dated 8/23/24, identified the glucometer as equipment staff was to clean. The policy directed it was the responsibility of the person using the equipment to ensure it was properly cleaned before and after use. Alcohol wipes could be used on equipment with smooth, hard surfaces, and thermometers. Equipment should be left to air dry after wiped down. The facility policy Blood Glucose Testing dated 12/30/24, instructed blood glucometer meters should be cleaned and disinfected after every use. Attached manufacturer information recommended the use of Clorox Germicidal wipes. The attached document Maintenance and Care, how to clean and disinfect the ACCU-Check Inform II system, page 129, number 3, directed: use a Clorox Germicidal Wipe or a Super Sani-Cloth Germicidal Disposable Wipe to clean the meter.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(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	F0883	F883 – Influenza and Pneumococcal Immunizations 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.	09/19/2025

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F0883 SS = D	Continued from page 13 effects of the immunization; (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. §483.80(d)(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; (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.	F0883	Continued from page 13 Information and consent forms were sent to all residents/responsible party(s) on July 31, 2025. Pneumococcal vaccinations will be provided to all residents who have consented to immunization by September 19, 2025. The "Admission / Readmission" policy was updated on September 3, 2025, to include obtaining the entire / current vaccination status prior to resident admission/readmission. The admission standing orders allows the administration of the immunizations when consents have been obtained. Monitoring: The Infection Preventionist or Designee will monitor the resident's immunization status monthly. The results of these monitors will be reported to Quality Improvement/Peer Review Committee for six months with the first report being submitted in September 2025.	

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F0883 SS = D	Continued from page 14 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 6 residents (R7, R10, R12, R15, R60) reviewed for immunizations were offered or received timely administration of pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The Centers for Disease (CDC) document Pneumococcal Vaccine Timing for Adults dated March 2025, included the following recommendations for adults 50 years or older: --PCV15 only at any age: administer PPSV23 on or after one year. --PCV15 & PPSV23 or PCV20 or PCV21 at any age: no additional administrations recommended. --PPSV23 only at any age: administer PCV20 or PCV21 at or after 1 year. OR administer PCV15 at or after 1 year. --PCV13 at any age: administer PCV20 or PCV21 at or after 1 year. --PCV13 at any age and PPSV23 at or before age 65: administer PCV20 or PCV21 at or after one year. --Together with the patient providers may choose to administer PCV20 or PCV21 to adults 65 years or older who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of 65 years old. The facility policy Pneumococcal Vaccination dated 1/16/25, directed vaccinations for the prevention of pneumococcal pneumonia were to be assessed and provide upon admission to those residents who had not previously had the vaccines. In addition, pneumococcal vaccine would be provided throughout the Calander year to residents based on their immunization status. Revaccination with pneumococcal vaccine will occur per CDC guidelines. The policy lacked evidence to support the most current CDC guidelines were being utilized for pneumococcal administration. R7 was admitted to the facility on 6/25/25. R7's		F0883				

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NAME OF PROVIDER OR SUPPLIER NORTH SHORE HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 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
F0883 SS = D	Continued from page 15 undated, Minnesota Immunization Information Connection (MIIC) report indicated R7 had received PCV13 on 7/16/15. Per CDC recommendations R10 qualified for shared decision making for an additional pneumococcal administration. R10 was admitted to the facility on 6/10/25. The facility document titled Client information indicated R10 had last received the pneumococcal immunization PCV13 on 10/17/17. Per CDC recommendations R10 qualified for shared decision making for an additional pneumococcal administration. R12 was admitted to the facility on 1/29/25. R12 received an unspecified pneumococcal immunization on 8/15/17, and a dose of PPSV23 on 11/5/08. CDC recommendations indicated R12 qualified for PCV20 or PCV21 at least one year after PPSV23. R15 was admitted to the facility on 6/2/25. The facility provided document Client Information indicated R15 had received PCV13 on 10/2/13. CDC recommendations indicated R12 qualified for PCV20 or PCV21 administration. R60 was admitted to the facility on 4/3/25. The facility document Client Information indicated R60 had received PCV13 on 1/30/18. Per CDC recommendations R60 qualified to receive PCV20 Or PCV21. During an interview on 7/30/25 at 2:23 p.m., the assistant director of nursing (ADON) stated the infection preventionist (IP) at the facility calculated when residents needed vaccinations such as pneumococcal and then documents for consent would go out to residents and or family. The ADON indicated a provider had informed them the CDC had decreased the screening age to 50 so they had been working to get the policy changed to 50 instead of 65. The ADON pulled up their policy and stated it currently didn't address screen residents between 50 and 64, but they policy was in process of being updated. During an interview on 7/31/25 at 8:59 a.m., the IP stated the infection prevention policies should reflect the most current and up to date CDC recommendations and confirmed their Pneumococcal Vaccination policy dated 1/16/25, did not reflect CDC recommendation changes			F0883			

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F0883 SS = D	Continued from page 16 made in October of 2024. The IP indicated the facility offered pneumococcal immunizations yearly and they were in the process of getting ready to offer pneumococcal immunizations to residents next month (August 2025). Nine residents had been identified. Once approved for administration, the facility would be sending out consents to residents/family. The IP indicated if there were a lot of residents that needed a pneumococcal vaccination at the end of the year they would not necessarily wait until August to administer the pneumococcal vaccine to those residents. They would try and do it sooner if four or more residents needed the vaccination. The IP provided a list of residents that had been identified for pneumococcal administration. In addition to R7, R10, R12, R15, and R60, R20 admitted on 4/16/25, R21 admitted on 6/5/25, and R26 admitted on 9/17/24, were also identified as needing pneumococcal administration. The facility guidelines for determining when to administer pneumococcal vaccinations to residents was requested but not received.			F0883			

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20000	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 7/28/25 through 7/31/25, a recertification survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.			20000			08/29/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2025	
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20000	Continued from page 1 The following complaints were reviewed with no citations; INCIDENT NUMBER: 1171415 (H# 53842021C MN#: MN00108713) INCIDENT NUMBER: 1171416 (H#: 53841071C MN#: MN00110629) 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 surveyor's 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 14-01, available at 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 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.		20000				
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3		21426	Corrected		09/04/2025	

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21426	Continued from page 2 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure healthcare worker tuberculosis (TB) screening and TB testing occurred for 2 of 5 staff according to the Centers for Disease Control (CDC) guidelines. Findings include: The director of nursing's (DON) employee file showed the DON had been screened for TB symptoms on 6/4/25. The most current TST result was dated 6/7/24. The DON's employee file lacked evidence to show a single TST had been completed in June of 2025. The nursing assistant 's (NA-A) employee file showed NA-A had a first step TST completed on 4/16/25. NA-A's employee file lacked evidence of completion of a previous TST result or a step two TST upon starting assignment at the facility on 4/28/25. In addition, NA-A's file lacked evidence of completion of required TB symptom screening. During an interview on 7/31/25 at 8:59 a.m. the infection preventionist (IP) stated the facility followed state and federal guidance for TB testing and screening for healthcare works and indicated TB screening and testing should be on record for all employees based on those guidelines. The IP stated another employee who was out the week of the survey was responsible for managing Tb testing but ultimately the			21426			

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21426	Continued from page 3 facility was responsible for compliance with guidelines. The facility policy Tuberculosis Infection Control Plan dated 3/22/25, identified the facility as low risk for TB and directed: new hires will have the Quantiferon blood test prior to start date, and will be required to complete an individual risk assessment and symptom evaluation of TB form for a pre-employment baseline. SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the current TB policy to ensure staff were tested and screened for symptoms of TB when hired to the facility. The Quality Assurance and Assessment committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.		21426				
21675	Linen CFR(s): MN Rule 4658.1410 Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper handling and storage of linens occurred for infection prevention. This deficient practice had the potential to impact all residents residing at the facility. Findings include: During a tour of the laundry area on 7/29/25 at 12:31 p.m., the lead housekeeping staff (HS-A) stated dirty laundry was brought to laundry in clear plastic bags from all areas. Their process was to remove the plastic bags and sort laundry in the dirty linen area of laundry. Staff were to always wear gloves when they sorted linen. Staff would also wear a gown or a jacket when they sorted linen that was obviously soiled. HS-A confirmed staff were not required to wear a gown/jacket		21675	Corrected		09/03/2025	

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21675	Continued from page 4 over their clothing for routine linen sorting, it was their process to wear gloves for routine linen sorting and then gown up for laundry that was visibly soiled. During a tour of the clean linen storage area wooden shelves and metal carts lined the walls of the linen room. On the right wall, the bottom wooden shelves were less than an inch thick and flush to the floor. The bottom shelves contained mattress pads and blankets, some directly touching the floor. During an interview on 7/29/25 at 12:49 p.m., HS-A stated laundry should not be stored so close to the floor because it could become contaminated. HS-A removed the linen from the bottom shelves and stated they would need to re-wash the linen before it could be used. During an interview on 7/30/25 1:50 p.m., the director of nursing stated they were not sure if it was a infection prevention requirement for staff to wear a gown and gloves or just gloves when sorting linen. They would have to look at the facility policy to know for sure. During an interview on 7/30/25 at 2:02 p.m., environmental services aide EVS-A stated they also got assigned to laundry. On laundry days they were responsible for sorting dirty linen, washing, drying, and folding linen. EVS-A stated they had to always wear gloves to sort dirty laundry. When they had yellow or red bags of linen that needed to be sorted, they also wore a gown or a jacket in addition to their gloves. EVS-A confirmed they were instructed they only needed to wear gloves to handle dirty linen unless it was from a yellow or red linen bag. During an interview on 7/31/25 at 9:51 a.m., the infection preventionist stated for infection prevention the laundry staff should be wearing gown and gloves at all times when sorting dirty laundry. The laundry policy should include direction to wear gown and glove at all times for laundry sorting. Gowning and gloving when sorting linen should be done to prevent cross contamination of the clean laundry. Laundry should not be stored where it can touch the floor and become contaminated. SUGGESTED METHOD OF CORRECTION: The director of nursing		21675				

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21675	Continued from page 5 (DON), or designee, could review applicable policies and procedures on soiled linen handling and transport to ensure accuracy; then educate floor staff and audit routinely to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days		21675				
21942	Establish Resident and Family Councils CFR(s): MN St. Statute 144A.10 Subd. 8b Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to attempt to develop a family council group. This had to potential to affect all family members, significant others, and guardians for all residents currently residing in the facility. Findings include: On 7/29/25 at 1:11 p.m. the administrator provided a letter dated 4/17/23, that was sent to resident family members to attempt to create a family council. During a follow-up interview on 7/29/25 at 2:00 p.m., the administrator stated they had not made any subsequent attempts to start a family council since the letter the facility sent out on 4/17/23. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee should delegate an individual to be responsible for the annual attempt to establish a family council. The administrator and/or designee should audit the delegate's efforts at forming a family council, and record when a meeting (if established) or attempts at establishing the family council occurred within each calendar year. Audits on the success or inability to form resident council should be taken to the QAPI committee for oversight to ensure compliance		21942	Corrected		07/31/2025	

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21942	Continued from page 6 is achieved. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			21942			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - NORTH SHORE HEALTHCARE B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/30/2025. At the time of this survey, North Shore Health 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			08/29/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - NORTH SHORE HEA... B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
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K0000	Continued from page 1 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 facility was inspected as one building: North Shore Health, is a 1-story building with no basement. The 100 and 400 wings of the facility were constructed in 2016 and was determined to be of Type II(111) construction. In 2017 the 200 and 300 wings were constructed to the building that were determined to be of Type II(111) construction. The 100,200,300, & 400 wings were constructed to replace the original facility and the plans for these wings were approved on 04/30/2015, prior to the 2012 code adoption and are considered to be of existing construction. The building is attached to a hospital and is properly separated by a 2 hour fire rated separation. The building is separated into 2 smoke compartments by a 1 hour fire rated smoke barrier. The building is fully sprinkled throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. The facility has a capacity of 37 beds and had a census			K0000			

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K0000	Continued from page 2 of 29 at the time of the survey.		K0000				
K0345 SS = D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/30/2025 at 12:00 pm, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Director that the facility could not provide current documentation verifying that a semiannual inspection of initiating devices had been completed. 2. On 07/30/2025 at 12:00pm, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Director that the facility could not provide an annual fire alarm testing documentation that provided a complete listing of each individual device tested, to include device type, address, location and the test results for each individual device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0345	K0345 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 Director of Facilities printed a copy of the semiannual and annual inspections of initiating devices that were performed on 5/23/25 and 11/14/24, respectively, and added them to the Fire Prevention binder. Moving forward, the Director of Facilities or designee will obtain the report following inspection and add a copy to the Fire Prevention binder. As a reminder, the semiannual and annual inspections and subsequent follow-ups have been added to a spreadsheet created to track annual compliance requirements by month. The Director of Facilities or designee will report to the Quality Improvement/Peer Review Committee quarterly for one year, a summary of the completion of required documentation identified in the annual compliance tracking spreadsheet.		09/03/2025	
K0353 SS = F	Sprinkler System - Maintenance and Testing		K0353	K0353		09/03/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245384		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - NORTH SHORE HEALTHCARE B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER NORTH SHORE HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST , GRAND MARAIS, Minnesota, 55604			
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K0353 SS = F	Continued from page 3 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 STANDARD is NOT MET as evidenced by: 1) Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2025 at 12:29pm, it was revealed by a review of available documentation the facility failed to perform one (1) of the quarterly fire system inspections. On 07/30/2025 at 12:35pm, It was revealed by a review of available documentation the facility failed to perform monthly fire system inspections. 2) Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition),			K0353	Continued from page 3 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 Director of Facilities printed copies of the quarterly fire system inspections and added them to the Fire Prevention binder. Moving forward, the Director of Facilities or designee will obtain the reports following inspections and add copies to the Fire Prevention binder. As a reminder, the semiannual and annual inspections and subsequent follow-ups have been added to a spreadsheet created to track annual compliance requirements by month. The Director of Facilities completed the monthly inspections of the sprinkler system for July (7/23/25), August (8/29/25), and September (9/2/25) of 2025 and added them to the Monthly Flow Test and Fire Inspection Forms binder. Moving forward, the Director of Facilities or designee will perform the inspection monthly and log it in the Monthly Flow Test and Fire Inspection Forms binder. As a reminder, the monthly inspection of the sprinkler system has been added to the spreadsheet created to track annual compliance requirements by month. The summary of sprinkler system inspections completion will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year. On 8/1/25, the Director of Facilities labeled all wire racks in the Kitchen Pantry area with orange marking tape to delineate required clearance from sprinkler heads. On 8/29/25, the Director of Facilities emailed the Dietary Manager to increase awareness of proper storage and clearance requirements from sprinkler heads. Moving forward, the Director of Facilities or designee will perform twelve random inspections (three per quarter) of the Kitchen Pantry for sprinkler head clearance issues. This report will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.		

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K0353 SS = F	Continued from page 4 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 07/30/2025 at 12:48pm it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in Kitchen Pantry. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0353			
K0712 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 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 STANDARD 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 07/30/2025 at 11:55am, it was revealed by a review of available documentation that fire drills were not completed: third shift missing first quarter (January - March) second quarter (April - June) and third quarter (July - September) have drills completely missing. An interview with the Maintenance Director verified			K0712	K0712 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 Director of Facilities conducted third quarter fire drills for the first, second, and third shifts on 7/29/25, 8/15/25, and 9/1/25, respectively. The completed Fire Drill Reports for these events have been logged in the Fire Drill Report Book. Moving forward, the Director of Facilities or designee will perform one drill per shift per quarter. As a reminder, fire drills have been added to the spreadsheet created to track annual compliance requirements by month. The summary of fire drills will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year by the Director of Facilities or designee.		09/01/2025

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K0712 SS = F	Continued from page 5 these deficient findings at the time of discovery.	K0712		
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 at 12:12pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0761	K0761 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 Director of Facilities and designees completed fire door assembly inspections/testing on August 30, 2025 and September 1, 2025. The completed Annual Fire Door Inspection Report has been logged in the Fire Door Assembly Inspection binder. Moving forward, the Director of Facilities or designee will perform annual inspections/testing of fire door assemblies. As a reminder, fire door assembly inspections/testing has been added to the spreadsheet created to track annual compliance requirements by month. The Director of Facilities or designee will report to the Quality Improvement/Peer Review Committee quarterly for one year, a summary of the completion of required documentation identified in the annual compliance tracking spreadsheet.	09/01/2025
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and	K0914	K0914 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	09/01/2025

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K0914 SS = F	Continued from page 6 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 a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 at 12:02pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0914	Continued from page 6 improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. The Director of Facilities and designees completed electrical receptacle inspections/testing on August 30, 2025 and September 1, 2025. The completed Electrical Outlet Inspection and Testing Report has been logged in the Electrical Test binder. Moving forward, the Director of Facilities or designee will perform annual inspections/testing of electrical receptacles. As a reminder, electrical receptacle inspections/testing has been added to a spreadsheet that tracks annual compliance requirements by month. The Director of Facilities or designee will report to the Quality Improvement/Peer Review Committee quarterly for one year, a summary of the completion of required documentation identified in the annual compliance tracking spreadsheet.		
K0918 SS = D Bldg. 04	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			K0918	K0918 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 Director of Facilities verified the fuel sample was		09/15/2025

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K0918 SS = D Bldg. 04	Continued from page 7 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 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD 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 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 07/30/2025 at 12:21pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a fuel sample test had been performed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0918	Continued from page 7 taken in conjunction with the annual service performed on 5/22/25 and is currently being processed. Total Energy Systems (Generator Maintenance Company) stated that the test results will be available by 9/12/25. The fuel sample test results will be printed and add it to the Generator binder by the 9/15/25. Moving forward, the Director of Facilities or designee will follow up with the vendor and include the fuel sample test results with the annual service report in the Generator binder. As a reminder, the Director of Facilities has added labels to the Generator binders to include the fuel test with the annual service report, and has added the annual service and subsequent follow-up to the spreadsheet that was created to track annual compliance requirements by month. The Director of Facilities or designee will report to the Quality Improvement/Peer Review Committee quarterly for one year, a summary of the completion of required documentation identified in the annual compliance tracking spreadsheet.		