DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	YIIU
Faci	lity ID: 00080

MEDICARE/MEDICAID PROVIDE (L1) 245384		3. NAME AND ALL (L3) COOK CO N	NORTHSHOR	RE HOSP &	& C&NC	4. TYPE OF ACT 1. Initial	ION: 7 (L8) 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 365745100	10.	(L4) 515 - 5TH AV (L5) GRAND MA		1	(L6) 55604	3. Termination5. Validation	4. CHOW6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	IPPLIER CATEG	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Af	9. Other ter Complaint		
6. DATE OF SURVEY 10/14 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENI	DING DATE: (L35)		
11LTC PERIOD OF CERTIFICATION	1	10.THE FACILITY X A. In Complia		AS:	And/Or Approved Waivers Of	The Following Require	mente:		
From (a): To (b):		Program R	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN		Services Limit		
12.Total Facility Beds	37 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code		oom Size		
13.Total Certified Beds	37 (L17)		npliance with Progents and/or Appli		* Code: A	(L12)			
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS				
18 SNF 18/19 SNF 37	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):					
See Attached Remarks									
17. SURVEYOR SIGNATURE						' APPROVAL	Date:		
Kimberly Settergren,	HFE NEII	1	0/27/2015	(L19)	mark Meath, Enforcement Specialist 10/27/2015 (L20				
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY			
19. DETERMINATION OF ELIGIBIL _X	articipate		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Str			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)		
OF PARTICIPATION 01/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		UNTARY o Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		o Meet Agreement		
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	ider Status Change		
(L27)	B. Rescind St	uspension Date:	(L45)						
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)					
				` '					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 08/20/2015	OF APPROVAL						
	(L32)			(L33)	DETERMINATION APP	ROVAL			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: 00080

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5384

On October 14, 2015, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR completed on August 28, 2015. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of September 28, 2015. Based on our visit, we have determined that the facility has achieved compliance with the deficiencies issued pursuant to our PCR completed on August 28, 2015, effective September 28, 2015.

As a result that the facility has achieved compliance, this Department is discontinug the Category 1 remedy of State monitoring, effective September 28, 2015.

In addition, this Department recommended to the CMS Region V Office (CMS), the following action related to the imposed remedy in this Departments letter of September 14, 2015. CMS concurs, and has authorized this Department to notify the facility of the following:

Mandatory Denial of payment for new Medicare and Medicaid admissions effective October10, 2015, be rescinded. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended survey where Substandard Quality of Care (SQC) has been identified. Therefore, Cook County Northshore Hospital & C&NC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 10, 2015.

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

Effective September 28, 2015, the facility is certified for 37 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245384

October 27, 2015

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

Dear Ms. Wraalstad:

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

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

Effective September 28, 2015 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

Email: mark.meath@state.mn.us

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 27, 2015

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

RE: Project Number S5384025

Dear Ms. Wraalstad:

On September 14, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 19, 2015. (42 CFR 488.422)

In addition, on September 14, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

Furthermore, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended survey where Substandard Quality of Care (SQC) has been identified. Therefore, Cook County Northshore Hospital & C&NC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 10, 2015.

This was based on the deficiencies cited by this Department for an extended survey completed on July 10, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on August 28, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 14, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 28, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 28, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 28, 2015, as of September 28, 2015.

Cook County Northshore Hospital & C&NC October 27, 2015 Page 2

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 28, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 14, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 10, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 10, 2015, is to be rescinded.

Furthermore, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended survey where Substandard Quality of Care (SQC) has been identified. Therefore, Cook County Northshore Hospital & C&NC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 10, 2015. Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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

Sincerely,

Mark Meath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245384	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/14/2015
Name	of Facility		Street Address, City, State, Zip Code	
CC	OK CO NORTHSHORE HOSP & C&NC		515 - 5TH AVENUE WEST	
			GRAND MARAIS, MN 55604	

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

(Y4) Item	(Y5)) Date	(Y4) Item	(Y5) Date	(Y4)	Item	(Y5)	Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0225	_09/28/2015	ID Prefix	F0226	09/28/2015		ID Prefix	F0323	09/28/2015
	483.13(c)(1)(ii)-(iii), (c)(2) -	(4)	_	483.13(c)				483.25(h)	
LSC		-	LSC				LSC		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #				Reg. #		
LSC		_							
		-			<u> </u>	 -			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix	-			ID Prefix		
Reg. #		_	Reg. #				Reg. #		
LSC		-	LSC				LSC		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg.#		_	Reg. #				Reg. #		
		_					LSC		
		-							
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix				ID Prefix		
Reg. #		_	Reg. #	_			Reg. #		
LSC		-	LSC				LSC		
Reviewed By	Reviewed	Ву	Date:	Signature of Su	ırveyor:			Dat	te:
State Agency	, CC/mm	า	10/27/20			089		10)/14/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Su	ırveyor:			Dat	te:
CMS RO									
Followup to	Survey Completed on:			Check for	any Uncorrected	d Defic	encies. Was	a Summary of	
	7/10/2015			Uncorre	ected Deficienci	es (CM	S-2567) Sent	to the Facility?	ES NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: Y1IU13

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Y1IU Facility ID: 00080

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MEDICARE/MEDICAID PROVID (L1) 245384 STATE VENDOR OR MEDICAID (L2) 365745100		3. NAME AND AL (L3) COOK CO N (L4) 515 - 5TH AN (L5) GRAND MA	NORTHSHOR VENUE WES	RE HOSP &	k C&NC (L6) 55604	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	PION: 7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU		GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey At	9. Other
6. DATE OF SURVEY 08/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	8/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	S CERTIFIED	AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of		
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of 7. Medical l	
12.Total Facility Beds	37 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code		oom Size
13.Total Certified Beds	37 (L17)	X B. Not in Con Requirement	npliance with Pro ents and/or Appl		* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN	•			15. FACILITY MEETS		
18 SNF 18/19 SNF 37	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Kimberly Settergren,	HFE NEII	1	0/05/2015	(L19)	Mark Meath	, Enforcement Spe	ecialist 10/27/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBIE X 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL	21. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure St	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 01/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHE</u>	<u> </u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1100	rider Status Change
(L27)	B. Rescind Su	uspension Date:	(L44)			00-Acti	ve
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	L DATE			
	(L32)	08/20/2015		(L33)	DETERMINATION APP	ROVAL	
-							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00080

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5384

On August 28, 2015, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended standard survey, completed on July 10, 2015. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of August 18, 2015. Based on our visit, we have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 10, 2015. The deficiencies not corrected are as follows:

F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals

F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

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

F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in your facility were found to be be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D). As a result of our finding that your facility is not in substantial compliance, this Department is imposing the Category 1 remedy of State monitoring, effective September 19, 2015.

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify the facility of the imposition:

Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended survey where Substandard Quality of Care (SQC) has been identified. Therefore, Cook County Northshore Hospital & C&NC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 10, 2015.

Refer to the CMS 2567 for health along with the facilitys plan of correction, CMS 2567b for both health and life safety code. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 14, 2015

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

RE: Project Number S5384025

Dear Ms. Wraalstad:

On July 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on July 10, 2015. Conditions at the time of the extended survey contituted Substandard Quality of Care (SQC) to resident health or safety. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 28, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended standard survey, completed on July 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 18, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 10, 2015. The deficiencies not corrected are as follows:

- F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) (4) -- Investigate/report Allegations/individuals
- F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

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

• F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

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

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

• State Monitoring effective September 19, 2015. (42 CFR 488.422)

Cook County Northshore Hospital & C&NC September 14, 2015 Page 2

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 10, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended survey where Substandard Quality of Care (SQC) has been identified. Therefore, Cook County Northshore Hospital & C&NC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 10, 2015. Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than

Cook County Northshore Hospital & C&NC September 14, 2015 Page 3

sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: chris.campbell@state.mn.us

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER

Cook County Northshore Hospital & C&NC September 14, 2015 Page 5

THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meeth

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245384	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/28/2015
Name	of Facility		Street Address, City, State, Zip Code	
COOK CO NORTHSHORE HOSP & C&NC			515 - 5TH AVENUE WEST	
			GRAND MARAIS, MN 55604	

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

(Y4) Item	(Y	5) Date	(Y4) I	Item	C	Y5)	Date	(Y4	l) Item		(Y5)	Date
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix		08/18/2015	IL		F0315		08/18/2015		ID Prefix			08/18/2015
	483.10(b)(2)				483.25(d)					483.65		_
			ļ	LSC		_						_
		Correction					Correction					Correction
		Correction Completed					Completed					Correction
ID Prefix	F0465	08/18/2015	II	D Prefix			·		ID Prefix			
Reg. #	483.70(h)			Reg. #					Reg. #			
LSC		_		LSC					LSC			_
		Correction					Correction					Correction
ID Prefix		Completed	l ır	D Prefix			Completed		ID Prefix			Completed
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LSC		_		LSC					LSC			_
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ID Prefix		_	II	D Prefix					ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC		_		LSC					LSC			_
Reviewed By		•	Date		Signature of Su	irve	=				Date:	
State Agency	CC/1	nm	09/1	4/201	5		3498	33			08/28	/2015
Reviewed By	Reviewed	d By	Date	:	Signature of Su	irve	yor:				Date:	
CMS RO												
Followup to	Survey Completed on:					-				a Summary of		
	7/10/2015				Uncorre	cte	d Deficiencies	(CI	WS-2567) Sent	to the Facility?	YES	NO

PRINTED: 10/13/2015 FORM APPROVED OMB NO. 0938-0391

245384 NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL R STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604 (EACH CORRECTION SHOULD BE COMPLETED R O8/28/201		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION		E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (FOOD) (FOOD) INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An onsite resurvey was conducted by surveyors of this department on 8/27 and 8/28/15, to determine compliance with Federal deficiencies issued during a recertification survey exited on 77/10/15. During this visit the following regulations			245384			1	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An onsite resurvey was conducted by surveyors of this department on 8/27 and 8/28/15, to determine compliance with Federal deficiencies issued during a recertification survey exited on 7/10/15. During this visit the following regulations	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/	28/2015
PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLET TAG F 000} INITIAL COMMENTS {F 000} The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An onsite resurvey was conducted by surveyors of this department on 8/27 and 8/28/15, to determine compliance with Federal deficiencies issued during a recertification survey exited on 7/10/15. During this visit the following regulations	соок с	CO NORTHSHORE HO	SP & C&NC				
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as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An onsite resurvey was conducted by surveyors of this department on 8/27 and 8/28/15, to determine compliance with Federal deficiencies issued during a recertification survey exited on 7/10/15. During this visit the following regulations	{F 000}	INITIAL COMMENT	ΓS	{F 000	}		
(F 00F) 400 40()(4)(") (") ()(0) (4)		as your allegation of Department's accept enrolled in ePOC, you at the bottom of the form. Your electron be used as verificated. Upon receipt of an accomplishment of the properties of your validate that substate regulations has been your verification. An onsite resurvey of this department of determine compliant issued during a receipt of this department of determined not assued during a receipt of this were determined not assued during a receipt of this were determined not assued during a receipt of this department of determined not assued during a receipt of this department of the facility must not been found guilty of mistreating resident had a finding enterer registry concerning of residents or misating and report any know court of law against indicate unfitness for other facility staff to or licensing authority	of compliance upon the obtance. Because you are rour signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance. Cacceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with was conducted by surveyors on 8/27 and 8/28/15, to ince with Federal deficiencies ertification survey exited on its visit the following regulations of to be in compliance. (c)(2) - (4) PORT DIVIDUALS It employ individuals who have a fabusing, neglecting, or its by a court of law; or have end into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wiedge it has of actions by a an employee, which would or service as a nurse aide registry ites.	{F 225			9/28/15

Electronically Signed

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

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245384	B. WING			08/2	8/2015	
	PROVIDER OR SUPPLIER O NORTHSHORE HO	•		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 225}	involving mistreath including injuries o misappropriation o immediately to the to other officials in through establishe State survey and of the facility must have violations are those prevent further pot investigation is in part to the administrator representative and with State law (includent, and if the	nent, neglect, or abuse, f unknown source and f resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). ave evidence that all alleged oughly investigated, and must ential abuse while the	{F 2	25}				
	by: Based on intervier facility failed to implement for 2 reportable incident Findings include: R23 eloped from the facility did not immediate included demonstrated and included demonstrated facility and included demonstrated facility facility did not immediate facility and facility did not immediate facility and facility did not immediate facility did not immediate facility and facility did not immediate facility and facility facility and facility	w and document review, the mediately notify the State opement and allegations of of 2 (R23, R41, R32) ts reviewed. The facility on 8/26/15, and the nediately report to the SA. The quarterly Minimum ated 8/16/15, indicated R23 had			F225 During the earlier meetings held wemployees, the Social Worker emphasized the importance to repincidents immediately to a Charge Department Manger, Social Worker Director of Nursing, Administration On-Call or the Administrator. A chobe used in conjunction with the Prevention Policy, B-1 was created provide support in the immediate reprocess the State Agency. The chowas updated to eliminate confusion further refine the process. The resident process.	ort Nurse, er, ecklist Abuse d to reporting necklist in and		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	1	LETED
		245384	B. WING			08/2	8/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0012	O/LO TO
					15 - 5TH AVENUE WEST		
COOK C	O NORTHSHORE H	OSP & C&NC		G	RAND MARAIS, MN 55604		
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{F 225}	Continued From pasevere cognitive of was able to ambut care plan dated 5 risk for self-negle directed staff to midstract and redirected staff to midstract and redirected part of the main go home can when frustrated by the main entrance wand go home can when frustrated by the main entrance of the main entrance resident observed found a block away with staff. The stab bracelet, as it main entrance on 8/27/15, at 2: interviewed, and Wanderguard systems.	deficit, wandered 1-3 days, and alate with supervision. R23's /31/15, identified R23 was at ct and wandering away, and nonitor her whereabouts, and ect when she is insistent on the care plan further identified fused regarding where she is a need to get out of the facility result in increased agitation by the Wanderguard door system is a sensor that will alarm when that to leave the facility). The care of R23 as wearing a neelet. DRT: 21 p.m. R23 exited the facility by the in the dining room. Another did this, and alerted staff. R23 was any from the facility, and returned aff replaced her Wanderguard by have malfunctioned. 15 p.m. the administrator was stated the main door stem did not lock and alarm	{F 2:		checklist was reviewed at the Cha Nurse meeting by the Director of N Social Worker and Administrator of September 22, 2015. Nurses una attend the Charge Nurse Meeting meet individually with the Director Nursing by September 28, 2015. reporting, investigation and follow specifically reviewed and the use checklist was demonstrated with vexamples. To identify incidents that may not been reported, the Director of Nurcontinue to review every submitter incident to determine if an event is reportable to the State Agency and that appropriate reports have bee submitted. The Interdisciplinary Todocuments for events that may be reportable to the State Agency and that appropriate reports have bee submitted. Completion date of September 28, 2015.	rge Nursing, on ble to will of Initial up were of the various nave sing will d Clarity d verify n chart e d verify n	
	stated the facility checked R23's W returned to the fa doors. The admir not reported the i and the director of process of report On 8/27/15, at 3: interviewed and s	the facility. The administrator maintenance department had landerguard once she was icility, and it had worked at all histrator stated the facility had incident immediately to the SA, of nursing (DON) was in the cing. 05 p.m. the DON was stated she had not yet completed he SA. The DON continued to			As an additional compliance mon Administrative Staff (Administrato Director of Nursing ¿ Care Cente Director of Nursing ¿ Hospital and Director of Finance) will continue all Clarity incident submissions at weekly Monday Administrative Stameetings. If the Staff meeting is cancelled for any reason, the Administrative Person On-Call will complete the review. In addition general review, the incidents will	r, d to review the aff ll to a	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245384	B. WING			08/2	R 28/2015
	PROVIDER OR SUPPLIEI			51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
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{F 225}	state all incidents interdisciplinary to is made after that reportable. The D SA on 8/27/15, at R23 eloped. The exited the building witnessed by ano Three staff looked away, and brough about 10 minutes working, so it was out. The Wanderg The facility review system video whibuilding, the staff staff and R23 return the facility first dereported to the SA once an incident facility then reportadministrator staff process had not of incident, but the restated that the fact to the SA as within felt R23's elopem because it was wadministrator lear resident, not by sreportable event. R41 and R32 had facility did not improved the same resident, and the same resident in the same resi	are reviewed by the eam (IDT), and a determination meeting regarding if incident is ON completed the report to the 3:15 p.m., nearly 21 hours after report to the SA indicated R23 g through the main entrance, ther resident who alerted staff. If for R23, found her a block at her back to the facility after a R23's Wanderguard was a unclear how she had gotten guard bracelet was changed. Wed their surveillance camera ch showed R23 leave the going to look for her, and the urning to the building. Department of the saministrator stated termines if an event should be a the administrator stated that his determined reportable, the test immediately to the SA. The ead that this decision-making occurred at the time of the next day. The administrator collity defines immediate reporting in 24 hours. The administrator tent was not a reportable event, itnessed. The following day the rined it was witnessed by another taff, and at that time deemed it a day a physical altercation and the mediately report to the SA. Drider Sheet identified diagnoses		25}	to be reviewed to verify that if in topinion of the Administrative Staffincident is deemed to be reportal. State Agency, it was appropriately reported and to review submission to verify immediate reporting. The monitor worksheet has been modinclude the time from the incident submission of the Report to the Stagency. This review will be compone year, through October 31, 20 Administrator will compile the modinformation and will submit the Rtagency a	f an ole to the y on timing e diffied to treport to state oleted for 16. The onitor eport to w orrection of or occlusions decion is neans to of care, e and and	

AND DIAN OF CODDECTION IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		245384	B. WING	: 	08	R / 28/2015
	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		STREET ADDRESS, CITY, STATE, ZIR 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		72072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 225}	MDS dated 8/9/15, cognitive impairmed verbal behavioral stays, wandered 4-independently. R4 identified her as vurdementia, at risk of and that she could combative with restredirected. R41's of problems that included the resident room hugs, pats and stay Interventions including was at and interventions including was at and interventions. R32's Physician Of that included demed disorders. The quaindicated R32 had was independent with did not exhibit behaved and saw independent with the care plan also frequent re-oriental gentle distraction. INCIDENT REPORT On 8/18/15, at 9:18 "Get out! Get out!" arrived and saw RR32's right arm. Not immediately report nurse.	entia. The significant change indicated R41 had severe int, exhibited physical and symptoms towards others 1-3 days and was able to walk 1's care plan dated 8/14/15, Inerable due to advanced early fretaliation by other residents, become resistant or ident and staff when being care plan indicated behavior ided wandering at times into ins, providing other residents residents are that may not be welcome. Ided keeping track of where she ining and redirecting when arder Sheet identified diagnoses entia and persistent mental arterly MDS dated 8/13/15, severe cognitive impairment, with transfers and walking, and aviors. R32's care plan dated R32 as vulnerable for abuse in the diagnosis of dementia. Identified R32 needed tion and no arguments but	{F 22	25}		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	2) MULTIPLE CONSTRUCTION BUILDING			COMPLETED	
		245384	B. WING			1	28/2015	
	PROVIDER OR SUPPLIER O NORTHSHORE HO			51	TREET ADDRESS, CITY, STATE, ZIP CODE I5 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
{F 225}	8/19/15, at 12:15 poccurred). In an in a.m. the social serevent was reporte evaluate R32 on 8 pain in her wrist. Submit the incident of the facility's Marevealed the DON and the Investigat Investigative Reports at the facility, not to exceed that the facility, not to exceed that maybe they were no injuries. Not harmed, she comorning. In a follow-up interest to the SA, then report within On 8/28/15, at 1:00 the facility first dereported to the SA, then reports the SA, then reports the same of	o.m. (15 hours after the incident terview on 8/28/15, at 10:16 vices director (SSD) stated the decause a nurse went back to 6/19/15, and R32 said she had Then the IDT recommended to it to the SA at that time. Review ndated Reporter Checklist submitted the Incident Report ive Report to the SA. The ort was submitted on 8/26/15. 8/28/15, at 10:16 a.m. the SSD ility is to report "immediately or When asked to clarify, the SSD itate is "at your earliest possible ed 24 hours." The SSD stated yould wait if there was a as financial abuse. 8/28/15, at 11:06 a.m. the DON and R32 were safe and there Since the nurse said R32 was chose to report the next rview with the SSD on 8/28/15, SSD stated that the staff are to rge nurse immediately. For they review the incident and		25}				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IG	1	PLETED
		245384	B. WING_		08/2	8/2015
	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
{F 225} {F 226} SS=D	day. The administrate defines immediate 24 hours. The facility Abuse If directed any suspice maltreatment, injurorigin, resident to resulting harm, and immediately be reported. The facility Abuse If directed any suspice maltreatment, injurorigin, resident to resulting harm, and immediately be reported. ABUSE/NEGLECT The facility must depolicies and proceed mistreatment, negliand misappropriation. This REQUIREME by: Based on interview facility failed to impolicy which requires state Agency (SA) allegations of mistreatments.	Prevention Policy dated 8/15, sions of patient/resident ies of unknown source or esident altercations with dunattended elopements shall forted to the State Agency. Prevention Policy dated 8/15, sions of patient/resident ies of unknown source or esident altercations with dunattended elopements shall forted to the State Agency. Prevention Policy dated 8/15, sions of patient/resident ies of unknown source or esident altercations with dunattended elopements shall forted to the State Agency. Prevention Policy dated 8/15, sions of patient/resident ies of unknown source or esident altercations with dunattended elopements shall forted to the State Agency. Prevention Policy dated 8/15, sions of patient/resident ies of unknown source or esident altercations with dunattended elopement written dures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced wand document review, the element their abuse prevention ed immediate notification to the episodes of elopement and reatment prior to conducting	{F 22		with port e Nurse,	9/28/15
	reportable incident	of 2 (R23, R41, R32) s reviewed.		Director of Nursing, Administration On-Call or the Administrator. Act to be used in conjunction with the	n hecklist	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245384	B. WING	_		08/2	R 28/2015
NAME OF F	PROVIDER OR SUPPLIE		l T		REET ADDRESS, CITY, STATE, ZIP CODE	1 0012	.0/2013
NAME OF F	- NOVIDER OR SUFFEIE	IX.	515 - 5TH AVENUE WEST		, , ,		
COOK C	O NORTHSHORE H	IOSP & C&NC			RAND MARAIS, MN 55604		
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{F 226}	R23 eloped from facility did not immodiately did not immodiately and resulting harm, and immediately be resulting that included den Data Set (MDS) of severe cognitive was able to ambut care plan dated frisk for self-negled directed staff to redistract and redirected staff to redistract and redir	the facility on 8/26/15, and the mediately report to the SA. Prevention Policy dated 8/15, bicions of patient/resident uries of unknown source or resident altercations with and unattended elopements shall eported to the State Agency. Order Sheet identified diagnoses mentia. The quarterly Minimum dated 8/16/15, indicated R23 had deficit, wandered 1-3 days, and ulate with supervision. R23's 5/31/15, identified R23 was at ect and wandering away, and monitor her whereabouts, and ect when she is insistent on y. The care plan further identified a need to get out of the facility in result in increased agitation by the Wanderguard door system as a sensor that will alarm when nots to leave the facility). The care ed R23 as wearing a accelet.		26}	Prevention Policy, B-1 was created provide support in the immediate reprocess the State Agency. The chewas updated to eliminate confusion further refine the process. The reschecklist was reviewed at the Chan Nurse meeting by the Director of Noscial Worker and Administrator of September 22, 2015. Nurses una attend the Charge Nurse Meeting meet individually with the Director Nursing by September 28, 2015. reporting, investigation and follow specifically reviewed and the use checklist was demonstrated with vexamples. To identify incidents that may not been reported, the Director of Nurcontinue to review every submitted incident to determine if an event is reportable to the State Agency and that appropriate reports have been submitted. The Interdisciplinary Todocumentation and INTERACT documents for events that may be reportable to the State Agency and that appropriate reports have been submitted. Completion date of September 28, 2015.	reporting necklist on and vised arge Nursing, on able to will of Initial up were of the various have raing will d Clarity s d verify nechart	
	the main entrance resident observe found a block aw with staff. The statement of the statem	21 p.m. R23 exited the facility by se in the dining room. Another d this, and alerted staff. R23 was ray from the facility, and returned aff replaced her Wanderguard ay have malfunctioned. 15 p.m. the administrator was			As an additional compliance moning Administrative Staff (Administrato Director of Nursing ¿ Care Center Director of Nursing ¿ Hospital and Director of Finance) will continue all Clarity incident submissions at weekly Monday Administrative Sta	or, r, d to review the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION ((X3) DATE COMP	SURVEY LETED
		245384	B. WING			08/2	8/2015
NAME OF E	PROVIDER OR SUPPLIER		'т	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00.12	0,20.0
10 11112 01 1	TO THE TOTAL OF TH				15 - 5TH AVENUE WEST		
COOKC	O NORTHSHORE HO	SP & C&NC			RAND MARAIS, MN 55604		
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{F 226}	interviewed, and st Wanderguard systewhen R23 exited the stated the facility mechecked R23's Wareturned to the facility mechecked R23's Wareturned to the facility mechecked R23's Wareturned to the facility frequency of the state all incidents a interviewed and state all incidents a interdisciplinary tea is made after that reportable. The DOSA on 8/27/15, at 3:05 interviewed and state all incidents a interdisciplinary tea is made after that reportable. The DOSA on 8/27/15, at 3:05 interviewed and state all incidents a interdisciplinary tea is made after that reportable. The DOSA on 8/27/15, at 3:05 interviewed by anott Three staff looked away, and brought about 10 minutes. working, so it was out. The Wanderg The facility reviewed system video which building, the staff of staff and R23 returned to the SA once an incident is facility then reports	ated the main door em did not lock and alarm ne facility. The administrator naintenance department had underguard once she was flity, and it had worked at all strator stated the facility had cident immediately to the SA, nursing (DON) was in the	{F 2.	26}	meetings. If the Staff meeting is cancelled for any reason, the Administrative Person On-Call will complete the review. In addition to general review, the incidents will conto be reviewed to verify that if in the opinion of the Administrative Staff a incident is deemed to be reportable State Agency, it was appropriately reported and to review submission to verify immediate reporting. The monitor worksheet has been modificinclude the time from the incident resubmission of the Report to the State Agency. This review will be comple one year, through October 31, 2016 Administrator will compile the monit information and will submit the Report Quality Improvement/Peer Review Committee on a monthly basis. Preparation, submission and implementation of this Plan of Correct does not constitute an admission of agreement with the facts and concluset forth in the statement of deficient The facility has appealed the deficient stated herein. This Plan of Correct prepared and/or executed as a mean continuously improve the quality of to comply with all applicable state a federal regulatory requirements and constitutes the facility all sallegation of compliance.	ntinue n to the timing ed to eport to te eted for ort to ection f or usions ncies. encies ion is eans to care, and d	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	1 0012	.0/2010
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{F 226}	stated that the faci to the SA as within felt R23's elopeme because it was with administrator learn resident, not by stareportable event. R41 and R32 had facility did not immore facility did not im	age 9 ext day. The administrator lity defines immediate reporting 24 hours. The administrator int was not a reportable event, nessed. The following day the red it was witnessed by another aff, and at that time deemed it a physical altercation and the nediately report to the SA. Prevention Policy dated 8/15, cions of patient/resident ries of unknown source or resident altercations with dunattended elopements shall corted to the State Agency. Indicated R41 had severe ent, exhibited physical and symptoms towards others 1-3 6 days and was able to walk at scare plan dated 8/14/15, alnerable due to advanced early of retaliation by other residents, become resistant or sident and staff when being care plan indicated behavior uded wandering at times into ms, providing other residents ares that may not be welcome, ded keeping track of where she ening and redirecting when		26}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245384	B. WING		08	R /28/2015	
	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		STREET ADDRESS, CITY, STATE, ZIP CO 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	and a second property of the second property	SHOULD BE	(X5) COMPLETION DATE	
{F 226}	that included demedisorders. The quaindicated R32 had was independent will did not exhibit behas 8/23/15, identified from others related. The care plan also frequent re-oriental gentle distraction. INCIDENT REPORON 8/18/15, at 9:18 "Get out! Get out!" arrived and saw RR32's right arm. Nimmediately report nurse. The incident was resolved and save revent was reported evaluate R32 on 8 pain in her wrist. Submit the incident of the facility's Mair revealed the DON and the Investigation of the facility's Mair revealed that the fac within 24 hours." Stated that immediability, not to exceived.	entia and persistent mental arterly MDS dated 8/13/15, severe cognitive impairment, with transfers and walking, and aviors. R32's care plan dated R32 as vulnerable for abuse d to the diagnosis of dementia. Identified R32 needed tion and no arguments but		26}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245384	B. WING			08/2	28/2015
	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 226}	stated that R41 and were no injuries. So not harmed, she chemorning. In a follow-up internat 11:31 a.m. the So report to their charge reports to the SA, then report within 20 the facility first deterported to the SA once an incident is facility then reports stated that this decocurred at the time day. The administ	3/28/15, at 11:06 a.m. the DON d R32 were safe and there since the nurse said R32 was nose to report the next view with the SSD on 8/28/15, SD stated that the staff are to ge nurse immediately. For they review the incident and 24 hours. 2 p.m., the administrator stated ermines if an event should be a The administrator stated that determined reportable, the sto the SA. The administrator cision-making process had not e of the incident, but the next rator stated that the facility	{F 2	26}			
F 323 SS=D	24 hours. 483.25(h) FREE O HAZARDS/SUPER The facility must elenvironment remains is possible; and adequate supervisity prevent accidents. This REQUIREMED by:	nsure that the resident ins as free of accident hazards each resident receives ion and assistance devices to	F	323	F323		9/28/15
	Based on observa	ation, interview and document			F323		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	COME	E SURVEY PLETED
		245384	B. WING			R 28/2015
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F 323	implemented to president (R23) wh had the potential tutilized a Wanderg Findings include: R23's Physician Conthat included dem Data Set (MDS) disevere cognitive of was able to amburcare plan dated 5. risk for self-negled directed staff to midistract and redirected staff to midistracted st	failed to assess interventions revent elopement for 1 of 1 no eloped from the facility. This o affect any residents who	F 32	R23¿s wanderguard was imme changed on Wednesday, Augu 2015, following her elopement facility. This was completed even the door locked and alarmed a upon her re-entry into the facili Maintenance Director contacted at 16:08 on August 26 for 14 mediscuss the incident and inquiresteps that should be taken and should be reviewed to identify system seemed not to work and determine why it did not work. Accutech representative called with the Maintenance Director August 26 for 10 minutes. The Maintenance Director asked a length of the battery life inside tag. The code system was expass directed the Maintenance Director tested the field of the door in content of the door in the determine if there were any deand none were identified. Duritesting, other residents came	ust 26, from the ven though appropriately ity. The ed Accutech inutes to e about the d what why the ed Another d and spoke at 16:31 on e bout the the resident blained and Director question to ead spots ng this	
	Wanderguard bra INCIDENT REPO On 8/26/15, at 6:2 the main entrance resident observed found a block awa with staff. The sta bracelet, as it ma there was no futl for the malfunctio On 8/27/15, at 2:	RT: 21 p.m. R23 exited the facility by e in the dining room. Another I this, and alerted staff. R23 was ay from the facility, and returned iff replaced her Wanderguard y have malfunctioned. However, her investigation into the cause		door and it function correctly well. Each door has its own cand work independently from a the Maintenance Director che door equipped with a wanderg August 31, 2015, the Maintena Director again spoke with Acc with their assistance he recaliful antennas on the door in quest sure that everything is working An adjustment was made to a antennas to make the locking door a little larger and more so	ontrol box each other. ecked each guard. On ance utech and brated the cion to make g at its best. one of the zone of the ensitive.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R		
		245384	B. WING				28/2015	
	PROVIDER OR SUPPLIER O NORTHSHORE HO			51	REET ADDRESS, CITY, STATE, ZIP CODE 5 - 5TH AVENUE WEST RAND MARAIS, MN 55604	1		
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F 323	Continued From pa	age 13	F3	323				
	when R23 exited the stated the facility in checked R23's Wareturned to the facility of the fac	em did not lock and alarm ne facility. The administrator naintenance department had anderguard once she was ility, and it had worked at all 5 p.m. the director of nursing ewed and stated the facility had anderguard bracelet, but had ther residents who were at risk wore Wanderguard bracelets e working. O p.m. R23 was observed andently in her room and in the a Wanderguard bracelet on her			how R23 was able to open the do Based upon a review of the surve camera, the code access at the diquestion had not been entered for 10 minutes, well outside the 40 sereset time. Using the resident tag wore at the time of the incident, the Maintenance Director was unable replicate the incident at the door in question and all other doors locked alarmed appropriately. The wand tag was replaced on R23 immediated following the incident. The doors locked and/or alarmed appropriated R23 is near the alarmed doors. Note that incident of a similar nature involving or any other resident wearing a wanderguard has occurred since 26, 2015.	illance oor in r at least econd y R23 ne to n ed and derguard ately have ely when lo ng R23		
	the facility had not bracelets of other elopement. The ac facility had not cor company when R2 could not determine function. On 8/28/15, at 2:1 viewed the surveill R23 left the facility or visitors were arbuilding, and the V did not lock or alar	15 a.m. the administrator stated checked Wanderguard residents who were at risk for dministrator also verified the ntacted the Wanderguard 23 exited the facility when they ne why the alarm did not 8 p.m. the DON stated she had lance tape that showed when 7. The DON stated no other staff ound when R23 exited the Wanderguard alarm on the door rm. The DON stated R23 was or about 10 minutes when the			The policy and procedure regardi wanderguard will be updated. It winclude the verification of the syst operability with all Resident wand for a door if a Resident elopes witknown reason. The revisions to twill be reviewed at the Charge Numeeting by the Director of Nursin September 22, 2015. Nurses unattend the Charge Nurse Meeting meet individually with the Director Nursing by September 28, 2015 the policy. Completion date of Se 28, 2015.	will em erguards thout a the policy urse g on able to y will r of oo review eptember		
	staff brought her b	or about 10 minutes when the back in. The DON also stated utside previously when a visitor a visitor was educated, and the			and verification of the wandergua system operability on a monthly be six months. The information will be	ard pasis for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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TVAINE OF T	NOVIDEN ON OUT FIEN	•			15 - 5TH AVENUE WEST		
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				6	GRAND MARAIS, MN 55604		
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F 323	check with staff be The DON was uns elopement had oc months. The facility policy a Guard Accutech S Accutech Exit See System is used to residents suffering tendencies, from s	age 14 by the doors to alert visitors to efore letting residents outside. Sure of when the previous curred, but it was in the last few and procedure on Wander system dated 9/14, directed the eker\TM (ES) Prevention help prevent special care grom wandering malady and straying into unauthorized areas lity, the residents monitor is	F	3323			

DEPARTMENT OF HEALTH

	MAN SERVICES ICARE/MEDICAID CERTIFICATION I - TO BE COMPLETED BY THE STA	AND TRANSMITTAL	ICARE & MEDICAID SERVICES ID: Y1IU Facility ID: 00080
MEDICARE/MEDICAID PROVIDER NO. (L1) 245384 2.STATE VENDOR OR MEDICAID NO. (L2) 365745100 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) (L2) (2015 - L2)	3. NAME AND ADDRESS OF FACILITY (L3) COOK CO NORTHSHORE HOSP (L4) 515 - 5TH AVENUE WEST (L5) GRAND MARAIS, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	(L6) 55604 02 (L7) 13 PTIP 22 CLIA	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07/10/2015 (L3 8. ACCREDITATION STATUS: (L10 0 Unaccredited 1 TJC 2 AOA 3 Other		14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 37 (L1) 13. Total Certified Beds 37 (L1)	The National State of the	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: * Code: * * Code: * * * * * * * * * * * * * * * * * * *	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 37 (L37) (L38) (L3		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APF See Attached Remarks 17. SURVEYOR SIGNATURE	LICABLE SHOW LTC CANCELLATION DATE): Date:	18. STATE SURVEY AGENCY A	APPROVAL Date:

See	Att	ac	hed	R	lema	ark	S
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Kathie Killoran, HFE NEII		07/31/2015 (L19)	Mark Meath, Enforce	cement Specialist 08/19/2015 (L20)
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY				
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMENT BEGINNING DATE (L41) 27. ALTERNATIVE SANG A. Suspension of Admir		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change
(L27)	B. Rescind Suspension	(L44) Date: (L45)		00-Active
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS		
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE (L32) (L33)			DETERMINATION APPROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART L. TO BE COMPLETED BY THE STATE SUBVEY A GENCY

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

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5384

An extended survey was completed on July 10, 2015 which identified conditions in the facility constituted substandard quality of care to resident health of safety. The facility has been given an opportunity to correct before remedies would be imposed.

As a result of substandard quality of care being identified. The facility is prohibited from offering or conducting NATCEP for a two year period, effective July 10, 2015 as a result of the extended survey that identified substandard quality of care.

Refer to the CMS 2567 for both health and life safety code, along with the facilitys plan of correction. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 23, 2015

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

RE: Project Number S5384025

Dear Ms. Wraalstad:

On July 10, 2015, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor Minnesota Department of Health Health Regulation Division Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802 Telephone: (218) 302-6151

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 19, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 19, 2015 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Cook Co Northshore Hosp & C&nc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 10, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

Cook County Northshore Hospital & C&NC July 23, 2015 Page 4

copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above.

Cook County Northshore Hospital & C&NC July 23, 2015 Page 6

If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 10, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Cook County Northshore Hospital & C&NC July 23, 2015 Page 7

> Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact Mark Meath, Program Specialist at 651-201-4118 or me at the number below if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 08/18/2015 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245384	B. WING			07/1	0/2015
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F 000	INITIAL COMMEN	ΓS	F0	00			
	as your allegation of Department's acce enrolled in ePOC, yat the bottom of the form. Your electron be used as verifica. Upon receipt of an on-site revisit of your validate that substate your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
F 153 SS=F	Minnesota Departn 7/10/15. 483.10(b)(2) RIGH	y was conducted by the nent of Health on 7/9/15 and T TO ACCESS/PURCHASE DRDS	F 1	53			8/17/15
	the right upon an o access all records including current cl (excluding weeken receipt of his or he purchase at a cost standard photocop	or her legal representative has ral or written request, to pertaining to himself or herself linical records within 24 hours ds and holidays); and after r records for inspection, to not to exceed the community ies of the records or any oon request and 2 working ce to the facility.					
	by: Based on intervieved facility failed to developed.	NT is not met as evidenced w and document review, the velop policies and procedures ccess to medical records for			Our ¿Patient Access to Records¿ will be updated to the current Fede Guidelines for the Care Center to in	ral	

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

TITLE

(X6) DATE

Electronically Signed

07/30/2015

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

Facility ID: 00080

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	required a written or This has the ability residing in the facility resident of access or obtain writing. The policy had 10 days to proor copy medical resident referenced to Minn Insurance Portability (HIPPA) the policy Medicare/Medicare/Medicare/Medicare/Medicare/Insurance Portability review of the facility and interview the facility administy management (HIM) coordinator stated current policy and	ble person. The facility also request for medical records. to affect all 29 residents ity. Ity's policy "Patient Access to patients must make requests a copies of their records in further identified the facility vide the opportunity to review cords. Although the policy resota statutes and Health ity and Accountability Act failed to comply with Center for a Services (CMS) regulations. Ity's Resident and Family red the facility had 10 days to or copies of, medical records request. In on 7/10/15, at 11:48 a.m. with trator and health information of the policy provided, was the practice of the facility.	F1		allowing both oral and written requiviewing of resident; s records with hours and a photocopy of record working days if requested. Our R and Family Handbook will also be with the current policy for distributing these actions are currently being on and will be completed and in plantage on and will be completed and in plantage on and will be completed and of August 17. Completion date of August 17. Completed and the Care Center staff by resident their legal representatives will be completed by the Health Unit Coord the Care Center. This request sent to the HIM Department immediate mail and will be entered into the Release of Information function will Meditech system by the HIM Coord or their designee in a Logged state Once the request is completed and email will be sent to the HIM Department will be sent to the HIM Department will be changed to a complete and then quarterly to ensure that the Patient Access to Records is bein followed. The information will be recommittee on a quarterly basis.	n 24 vithin 2 esident updated on. worked ace by ugust n, made ats or rdinator will be diately he thin the dinator us. other artment e status. Il Care months he g eported	0140/45	
F 225 SS=E		PORT	F:	225			8/18/15	
		ot employ individuals who have of abusing, neglecting, or						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 225	mistreating reside had a finding enteregistry concerning of residents or misted and report any know court of law agains indicate unfitness other facility staff for licensing authoral The facility must be involving mistreating including injuries of misappropriation of immediately to the toother officials in through established State survey and The facility must be violations are thore prevent further poinvestigation is in The results of all it to the administrating representative an with State law (indicertification agencincident, and if the	Ints by a court of law; or have red into the State nurse aide g abuse, neglect, mistreatment sappropriation of their property; by by by a st an employee, which would for service as a nurse aide or to the State nurse aide registry rities. Insure that all alleged violations ment, neglect, or abuse, of unknown source and of resident property are reported a administrator of the facility and accordance with State law ed procedures (including to the certification agency). Inave evidence that all alleged oughly investigated, and must tential abuse while the		225				
	by: Based on intervie facility failed to im	ENT is not met as evidenced ew and document review the imediately report allegations of streatment to the State Agency			F225 The Abuse Prevention Policy, B-1 updated and enhanced to include			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 225	of 9 residents (R3 abuse. In addition reference checks hired dietary aides Findings include: R37 alleged verba or thoroughly invested (MDS) admissindicated the resident experience of the resident indicated him shortly after hindicated she had he requested an einterview with R3 resident indicated the requested an einterview with R3 resident indicated the requested an einterview with R3 resident indicated the everyone. He thoronge than his shall because of his diawith the director of event the following concerns. Telephone interview: 2:31 p.m. indicate reported. LPN-B residents care place.	nly investigate allegations for 4 7, R22, R7, R34) reviewed for , the facility failed to ensure were completed for 2 of 2 newly	F 22	<u>`</u>	re provided to Vorker by investigation ally reviewed. Eview every determine if State Agency have been ary Team rentation and vents that he Agency have been of August 18, ministrator, enter, al and ew all Clarity veekly meetings. If d for any erson On-Call addition to a will be vare by and verify completed as completed ator will tion and will	
	promote self care resident about ea	LPN-B "confronted" the atting ice cream, and R37 said he what he wanted and that was		The Dietary Manager will recreterences of the two recent		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 225	between him and did not believe the was eating, but sh morning when the room, he alleged sto him during the rimmediately went allegation. Interview with the identified she initial LPN-B. The LPN is discourage food coverbal abuse. She the LPN had a "redetermined it was did not report the agency or complete agency or complete the Abuse Preventindicated, "Report mistreatment, negproperty or injuries promptly and thore R22 reported an astaff member and According to the CSet (MDS) dated intact. R22's nursing asseculd use the gral independently, no assist of one for powel and bladde cognition, the care	age 4 his doctor. LPN-B told R37 she doctor was aware of what he e would notify him. The next LPN went into the residents she had been verbally abusive hight. LPN-B reported she to the DON and reported the DON on 7/9/15, at 9:30 a.m. ally heard about the event from ndicated she was attempting to hoices, but the resident called it e spoke with R37 who inferred gimented attitude." The DON not verbal abuse through and event to the administrator, state te a thorough investigation. Intion Policy dated 12/00 s of alleged abuse, plect, misappropriation of s of unknown origin will be oughly investigated." Allegation of verbal abuse by a it was not reported to the SA. DBRA quarterly Minimum Data 6/14/15, R22 was cognitively sistant care sheet indicated R22 to bar in bathroom to transfer t able to use urinal reliably, and berineal care and continent of r. Regarding behavior and e sheet indicated R22 was alert could get anxious about falling	F	225	employees. A reference check documentation form has been dev and will be utilized for every new has the Human Resources Coordinated not complete the Offer letter to a memployee until all required docume including the references checks has been completed. The revised probe reviewed at the Leadership Commeeting on August 11, 2015. Commeeting on August 11, 2015. The Human Resource Coordinated designee will review the employee all new employees at the end of earnorth to verify that documentation reference checks is included in the This monitor will be completed mosix months and the information will reported to Quality Improvement/F Review Committee on a quarterly Preparation, submission and implementation of this Plan of Cordoes not constitute an admission agreement with the facts and conset forth in the statement of deficient the facility has appealed the deficit stated herein. This Plan of Correct prepared and/or executed as a mecontinuously improve the quality of to comply with all applicable state federal regulatory requirements at constitutes the facility is allegation compliance.	ire. or will ew entation; ave cess will uncil apletion r or her files of ach of effile. onthly for l be Peer basis. rrection of or clusions encies. siencies ction is eans to f care, and		

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F 225	during transfers. The provide encourage here to help him." According to a prowas very upset with (NA-M) who provide care reported the NAR sass." R22 reported and that he was place facility removed NA was thoroughly involved and that he was place facility removed NA was thoroughly involved answered R22's based with personal care addition to the infor R22 also felt he was upplies to assist with the washcloth was have enough perithat he did not was anymore. R22 state upset to the point evening meal and incident. According to other documentation provinterviewed involve on information gat facility determined R22. On 5/21/15,	gress note on 5/12/15, R22 In a specific nursing assistant led cares. He did not want that is to him anymore. R22 Isaid, "Wash your own damn I that he nearly fell while wiping anning on turning her in. The A-M from work until the event		225	

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION IG	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
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F 225	In an interview on DON confirmed the investigated, but we Notes from the inverted that the fact right away, and did they may not alway informed the adm "probably" the DO (SW)-A. The DO notify the adminis "just know" they not a decision to not the decision to not was based on diffication interviewed (staff "tendency to emb	g care to him. 7/10/15, at 10:44 a.m., the nat the incident did get was not reported to the SA. Westigation provided by the DON 5 and 5/14/15. The DON also cility did inform the administrator d so in this incident. However, mays document when and who inistrator. In this case, it was an or the facility social worker in the stated that the process to trator is not formalized, but they eed to tell the administrator. In the safety Zone is in determining if the inotified or when. 17/10/15, the DON explained at report the incident to the SA fering stories from those and resident) and R22 has a ellish."	F 22					
	According to the price diagnoses including personality disord anxiety. An OBR indicated R7 was R7's vulnerability she was vulnerabil	ort the incident to the SA. ohysician order sheet, R7 had ng persistent mental disorder, ler, hemiplegia, depression and A quarterly MDS dated 5/21/15 cognitively intact. care plan dated 4/3/15 indicated le for abuse from others related ular Accident (CVA), mental led to total assistance. cted staff to allow time for		·				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 225	Continued From p	page 7 attentive listening, and continue	F:	225				
		dent to interact with others, and						
	expression of fee relationship, lister reassuring approacknowledge her and comfort, and techniques. R7's to check and cha hours while awak Staff were to use over bedpan and staff for peri-care	plan directed staff to encourage lings, establish a trusting in attentively, use a calm ach, explain all procedures, feelings, provide reassurance encourage the use of relaxation toileting care plan directed staffinge as needed every 2 to 2.5 e and during rounds at night. a Hoyer lift in bed to position R7 provide total assist of 1 to 2 s. R7's quarterly MDS dated she was always incontinent of bowel.						
	Worker Summary NA-N approached 9/23/14, with commaking about NA a progress note of met with R7 who very tearful and in upset." During the she is in the dining bowel movement pants or wait. In numerous bowel tell her "no one gotimes a day." The concerned about interview and beit trouble. Handwrit were dated 9/25/	undated "VA Report Social y", nursing assistant (NA)-O and d Social Worker (SW)-A on cerns about statements R7 was A-M. According to the report and dated 9/23/14, at 5:32 p.m. SW-A was "visually upset, sobbing, nitially unable to talk due to being is interview, R7 told SW-A when ag room and felt the need for a c, NA-M will tell her to go in her addition, R7 reported having movements daily, NA-M would oes to the bathroom that many e report further identified R7 was NA-M finding out about the ng mad at her and causing her ten notes from NA-O and NA-N 14 and 9/24/15 respectively knowledge og the incident.	3					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604			
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F 225	In the report, SW-with the director of nurse (RN)-A, RN report concluded county in the "after interview on 7/9/1 that she called rethe administrator. In an interview on DON stated they concerns and reported they concerns and reported lip. The DOW was not reported. R34 eloped from reported to the SA Portal and the Reindicated R34 left member of anoth knowledge. R34 her to a local bar called the facility. The abar but R34 refusto a local cafe with the state of the same called the facility.	A indicated that she consulted of nursing (DON), registered I-B, NA-N and NA-O. The that a report was filed with the ernoon of 9/24/14". In an 5, at 1:54 p.m., SW-A stated ports into the county, but only has access to report to the SA. 1.7/10/15, at 10:44 a.m., the thoroughly investigated R7's corted them to the county. They informed the administrator of the administrator informed IN also confirmed this incident	F 22				
	indicated R34's or visual loss. R34' 3/3/15, indicated from others related due to the diagno	Order Sheet dated 7/10/15, liagnoses included dementia and s vulnerability care plan dated R34 was vulnerable for abuse ed to short term memory loss osis of dementia. The care plan monitor the whereabouts of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 225	was to wear a wan the resident that so when the resident on 7/10/15, at 11:1 (DON) verified the The DON stated R herself, the family was a high school alone while away f	d residents and redirect. R34 der guard (a device worn by ecures the door and alerts staff gets near the door). 15 a.m. the director of nursing elopement was not reported. 34 removed the wander guard member that gave her a ride classmate and R34 was never rom the facility. The DON was any written information	F	225			
	believed R34 left a classmate. The classmate in the classmate in the classmate in the classmate in the R34 for the wande AD was able to geattempted to put the pushed her away at the AD walked to a (SW) arrived at apcalled the police a	30 a.m. the AD stated she around 4:00 p.m. with the assmates's family called the arrived at the bar. The AD to the bar. The AD checked or guard and it was not on. The t R34 into her car but when she he seat belt on R34, R34 and got out of the car. R34 and a local cafe. The social worker oproximately 4:30 p.m. The SW and R34 went willingly with the was returned to the facility.					
	returned to the factorial approximately 5:45 classmate entered order to exit the factorial sounded because guard on was sitting guard was placed facility. The SW states approximately a	50 a.m. the SW stated she sility from the cafe at 5 p.m. The SW stated the d the code to open the door in a cility with R34. The door alarm another resident with a wander on R34 upon returning to the tated she reported the nurse on duty and the	1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245384	B. WING	i		07/	10/2015	
	ROVIDER OR SUPPLIE			5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 225	call (AC) was interested informed of the elep.m. The AC state elopement to the the ability to do so administrator mal stated the facility "clarity" (incident) know. The AC also the administrator town. On 7/09/15, at 2:3 the facility had not abuse, neglect SA since the prevadministrator state an investigation, act as my surrogareported to the Screport allegations stated she had into reference. Reference check employment for 2 DA-A was hired of lacked evidence completed prior to the state of th	2:40 p.m. the administrator on rviewed. The AC stated she was opement at on 4/28/15, at 5:15 ed she did not report the SA because she does not have on the AC stated the kes the SA reports. The AC is made aware through the report and she lets the SW to stated she usually informed but in this case she was out of a p.m. the administrator verified that any reports of allegations or mistreatment reported to the red the AC's were able to start answer questions and "actually ate." If something needed to be a all ACs have the ability to sto the SA. The administrator structions in a folder for the ACs as were not completed prior to a newly hired dietary employees. On 6/8/15. The personnel record reference checks were of employment at the facility.		225				
	lacked evidence completed prior to On 7/9/15, at 10: (DM), verified the	on 6/16/15. The personnel record reference checks were o employment at the facility. 45 a.m. the dietary manager e record did not contain evidence cks. The DM stated she does						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X	COMPLETED		
		245384	B. WING			07/1	0/2015	
	PROVIDER OR SUPPLIER O NORTHSHORE HO			5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604			
(X4) ID PREFIX TAG			1	(X5) COMPLETION DATE				
	On 7/9/15, at 12:1 stated there was neference checks responsibility of the complete the refer have any systems completion of reference checks responsibility of the complete the reference checks responsibility of the complete the reference any systems completion of reference and reference and potential employers Abus 10/11, indicated pure head would reque all potential employers to verifin formation about performance. All a documented on the 483.13(c) DEVEL ABUSE/NEGLEC The facility must opolicies and process and process and misappropriate. This REQUIREMED by: Based on interview	oy notifying the last employer ment it anywhere. 7 p.m. human resources (HR) tot a system to ensure were done. It was the e department supervisor to rence checks. The HR did not in place to monitor the rence checks. e Prevention Policy revised rior to hiring the department st employment references from yees. The department head contact current and past y employment and request the potential employee's attempts and contacts would be e job application. OP/IMPLMENT		225	F226 The Abuse Prevention Policy, B-1, w		8/18/15	
	Prevention Policy reporting to the act (SA). The policy of	that required immediate dministrator and State Agency lirected staff to thoroughly tions before reporting to the SA.			updated and enhanced to include a checklist. The revised policy will be reviewed and education will be proviall employees by the Social Worker	ided to		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 226	The facility failed to of abuse/neglect/r thoroughly investig residents (R37, R abuse. In addition reference checks hired dietary aides practice had the pin the facility. Findings include: The facility Abuse procedure dated alleged abuse, minisappropriation unknown origin winvestigated. The would be responsinvestigation. At the plan of correct with the appropriation of the policy incorrectly investigation of the reports were made. The policy also distinguished immediately make report internally to worker, director of administrator. For the administrator the person received contact the administrator the administrator.	to immediately report allegations mistreatment to the SA and gate allegations for 4 of 9 22, R7, R34) reviewed for , the facility failed to ensure were completed for 2 of 2 newly s. (DA-A, DA-B). This deficient potential to effect all 29 residents of interesting to the facility and thoroughly administrator or the designee sible for appointing an and conducting the he conclusion of the ritten report of the findings and the tion would be prepared and filed ate agencies. However, the directed staff to conduct an he allegation BEFORE any le to the State agency. Trected mandated reporters to be an oral report to the county or the charge nurse, social of nursing (DON) or the rincidents after business hours are person on call (AC) would be all reporting procedures directed ming the report to immediately histrator or the AC. Reporting to "immediately" shall mean "as but no longer than 24 hours of	F 22	August 18, 2015. Reporting and follow up will be specif. The Director of Nursing will submitted Clarity incident the analysis and that appropriate reports submitted. The Interdiscip (IDT) will review chart documents for may be reportable to the Sand that appropriate reports submitted. Completion da 2015. The Administrative Staff (ADirector of Nursing ¿ Care Director of Nursing ¿ Hosp Director of Finance) will reincident submissions at the Monday Administrative Staff Meeting is cance reason, the Administrative will completed the review. general review, the incider reviewed to determine if the reportable to the State Age that the reports have been required. This review will for one year. The Adminicompile the monitor inform submit the Report to Qual Improvement/Peer Review a monthly basis. The Dietary Manager will references of the two received and will be utilized for every will be utilized for eve	fically reviewed. Il review every to determine if the State Agency ts have been blinary Team tumentation and the events that state Agency ts have been the of August 18, Administrator, the Center, bital and the weekly the weekly the meetings. If the for any the Person On-Call the addition to a the will be the are the completed as the completed	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (>	COMPI	
		245384	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIEF			51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	the discovery of the reportable the adrivould report the in SA. Both reports to f discovery of the Prevention policy resident to reside. On 7/9/15, at 2:23 policy lacked the altercations. The reporting an alleg assistant (NA) was the charge nurse administrator, the DON. If the allega were to contact the appointed to be the inthe hospital, the director. Each of DON described the go to the facility as an allegation were trained on what in DON stated if an front line worker, home and ask the investigation." The completion of integration and there, the report to the SA. abuse should be following an investigation. On 7/09/15, at 2:3 the facility had not should be	ne incident." If the incident was ministrator or the designee ncident to the county then to the must be made "within 24 hours e incident." The facility Abuse also lacked the definition of		2226	The Human Resources Coordinator not complete the Offer letter to a new employee until all required documen including the references checks have been completed. The revised proce be reviewed at the Leadership Coun meeting on August 11, 2015. Complete of August 11, 2015. The Human Resource Coordinator of designee will review the employee fil all new employees at the end of each month to verify that documentation or reference checks is included in the fil This monitor will be completed month six months and the information will be reported to Quality Improvement/Pereview Committee on a quarterly based on the statement of deficient the facility has appealed the deficient violations stated herein. This Plan of Correction is prepared and/or executed a means to continuously improve the quality of care, to comply with all applicable state and federal regulator requirements and constitutes the facility allegation of compliance.	tation; e ss will icil letion or her les of the child for oe er asis.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER O NORTHSHORE HO		•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST BRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	investigation, answas my surrogate." reported to the SA allegations to the She had instruction reference. The adlacked the definitional tercations. The adetermined if incide the investigation. In definition of report R37 alleged verbal or thoroughly investigated the residence of the second control of the se	age 14 ad the AC was able to start an over questions and "actually act over questions and the ability to report SA. The administrator stated as in a folder for the AC to ministrator verified the policy on of resident to resident administrator stated she ents were reportable based on a finished the allegation met "the able" it would be reportable. I abuse that was not reported stigated. The Minimum Data ion assessment dated 5/31/15, ent was cognitively intact. ident reports or investigations time of admission through	F:	2226			
	resident indicated (LPN)-B had verba admission to the fabecome "pissy" wievening snack. Fr 7/8/15, at 1:08 p.n asked for a snack snacks were for eimplied he was eashouldn't have the R37 stated he speevent the following concerns. Telephone intervies 2:31 p.m. indicate	on 7/7/15, at 11:30 a.m. the licensed practical nurse ally abused him shortly after his acility. He indicated she had th him when he requested an urther interview with R37 on a. the resident indicated he and LPN-B had told him the veryone. He thought that ting more than his share and he am because of his diabetes. Ske with the DON about this g day, and has had no further lew with LPN-B on 7/8/15, at d she recalled the event R37 stated she was following the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
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	NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC			515	EET ADDRESS, CITY, STATE, ZIP CODE - 5TH AVENUE WEST AND MARAIS, MN 55604	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	food choices, dec promote self care resident about ea was going to eat between him and did not believe th was eating, but s morning when the room, he alleged to him during the immediately wen allegation. Interview with the identified she init LPN-B. The LPN discourage food verbal abuse. Si the LPN had a "r determined it wa report the event	page 15 an that said to encourage better crease carbohydrates and the LPN-B "confronted" the ting ice cream, and R37 said he what he wanted and that was his doctor. LPN-B told R37 she ele doctor was aware of what he he would notify him. The next ele LPN went into the resident's she had been verbally abusive night. LPN-B stated she to the DON and reported the ele DON on 7/9/15, at 9:30 a.m. ally heard about the event from indicated she was attempting to choices, but the resident called it he spoke with R37 who inferred egimented attitude." The DON is not verbal abuse and did not to the administrator, State ete a thorough investigation.		226			
	identified mental threats of punish identified verbal derogatory terms R22 reported an staff member an According to the 6/14/15, R22 wa R22's nursing as could use the graindependently, nassist of one for	ention Policy dated 10/11 abuse included humiliation and ment or deprivation. It further abuse to include disparaging and it. allegation of verbal abuse by a dit was not reported to the SA. OBRA quarterly MDS dated is cognitively intact. sistant care sheet indicated R22 ab bar in bathroom to transfer of able to use urinal reliably, and perineal care and continent of er. Regarding behavior and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COMF	PLETED
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	PROVIDER OR SUPPLIE			518	STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
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F 226	cognition, the car and oriented and during transfers. "provide encoura here to help him. According to a proper was very upset wo (NA-M) who provide car reported the NAF ass." R22 reported and that he was facility removed I was thoroughly in According to inveded 5/13/15 arransisted R22 to 5/11/15. NA-M abathroom call lig cares after a bove information in the was not offered this care after toil warm enough no it. R22 told the NA-M providing that he was scar his appetite for the program because According to othe documentation in the reviews dated.	re sheet indicated R22 was alert could get anxious about falling. The care sheet indicated gement and assure him you are " rogress note on 5/12/15, R22 with a specific nursing assistant rided cares. He did not want that res to him anymore. R22 R said, "Wash your own damned that he nearly fell while wiping planning on turning her in. The NA-M from work until the event	F	226			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
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F 226	In an interview on DON confirmed the investigated, but we DON also stated the administrator right incident. However, document when an administrator. In the DON or the facility DON stated that the administrator is not know! they need to of the facility's Head does not assist in was notified or when the decision to not was based on different interviewed (staff a "tendency to embed facility did not reported verbal facility did not reported to the position of the decision to not was based on different interviewed (staff a "tendency to embed facility did not reported verbal facility did not r	med that NA-M would no g care to him. 7/10/15, at 10:44 a.m., the at the incident did get was not reported to the SA. The hat the facility did inform the away, and did so in this r, they may not always and who informed the this case, it was "probably" the was social worker (SW)-A. The ne process to notify the ot formalized, but they "just to tell the administrator. Review althcare Safety Zone Portal determining if the administrator in 7/10/15, the DON explained to treport the incident to the SA ering stories from those and resident) and R22 has a cellish."	F	226	BELLOCITY		
	diagnoses includir personality disord	physician order sheet, R7 had ng persistent mental disorder, er, hemiplegia, depression and A quarterly MDS dated 5/21/15, cognitively intact.					
	indicated she was others related to c (CVA), mental illne	care plan dated 4/3/15, s vulnerable for abuse from cerebral vascular accident ess and the need to total ventions directed staff to allow					

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMF	PLETED
		245384	B. WING			07/1	0/2015
NAME OF PROVIDE				5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
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time fronting others R7's rexpression expression expre	mood care plassion of feelings in a proper care some or peri-cares or pe	naking, attentive listening, and rage resident to interact with out of her room. an directed staff to encourage ings, establish a trusting attentively, use a calmuch, explain all procedures, feelings, provide reassurance encourage the use of relaxation toileting care plan directed staffinge as needed every 2 to 2.5 e and during rounds at night. A Hoyer lift in bed to position R7 provide total assist of 1 to 2 s. R7's quarterly MDS dated she was always incontinent of		226			

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
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			51	5 - 5TH AVENUE WEST		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	1		(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
In the report, SW-with the DON, reg NA-N and NA-O. report was filed wi of 9/24/14". In an p.m., SW-A stated county, but only the report to the SA. In an interview on DON stated they to concerns and report (DON and SW-A) verbally and keep verbally. The DO was not reported to the SA Portal and the Reindicated R34 left member of another knowledge. R34 a her to a local bar called the facility. The action but R34 refus to a local cafe with called and R34 with police officer. R34's Physician Coindicated R34's divisual loss. R34's 3/3/15, indicated from others related from others related from the same police officer.	A indicated that she consulted istered nurse (RN)-A, RN-B, The report concluded that a th the county in the "afternoon interview on 7/9/15, at 1:54 I that she called reports into the re administrator has access to 7/10/15, at 10:44 a.m., the horoughly investigated R7's orted them to the county. They informed the administrator the administrator the administrator informed N also confirmed this incident to the SA. The Healthcare Safety Zone sidents Notes dated 4/28/15, the facility with a family er resident without staff asked the family member to take in town. Another family member and reported the elopement to civity director (AD) went to the ed to leave. R34 agreed to walk in the AD. Law enforcement was as returned to the facility with		2226			
	ROVIDER OR SUPPLIES NORTHSHORE HO SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From p In the report, SW- with the DON, reg NA-N and NA-O. report was filed wi of 9/24/14". In an p.m., SW-A stated county, but only th report to the SA. In an interview on DON stated they t concerns and report (DON and SW-A) verbally and keep verbally. The DOI was not reported to R34 eloped from t reported to the SA Portal and the Re indicated R34 left member of anothe knowledge. R34 a her to a local bar called the facility a the facility. The ac bar but R34 refus to a local cafe wit called and R34 w the police officer. R34's Physician O indicated R34's d visual loss. R34's 3/3/15, indicated from others related due to the diagno directed staff to m	ROVIDER OR SUPPLIER D NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 In the report, SW-A indicated that she consulted with the DON, registered nurse (RN)-A, RN-B, NA-N and NA-O. The report concluded that a report was filed with the county in the "afternoon of 9/24/14". In an interview on 7/9/15, at 1:54 p.m., SW-A stated that she called reports into the county, but only the administrator has access to report to the SA. In an interview on 7/10/15, at 10:44 a.m., the DON stated they thoroughly investigated R7's concerns and reported them to the county. They (DON and SW-A) informed the administrator verbally and keep the administrator informed verbally. The DON also confirmed this incident was not reported to the SA. R34 eloped from the facility and it was not reported to the SA. The Healthcare Safety Zone Portal and the Residents Notes dated 4/28/15, indicated R34 left the facility with a family member of another resident without staff knowledge. R34 asked the family member to take her to a local bar in town. Another family member called the facility and reported the elopement to the facility. The activity director (AD) went to the bar but R34 refused to leave. R34 agreed to walk to a local cafe with the AD. Law enforcement was called and R34 was returned to the facility with the police officer. R34's Physician Order Sheet dated 7/10/15,	ROVIDER OR SUPPLIER D NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 In the report, SW-A indicated that she consulted with the DON, registered nurse (RN)-A, RN-B, NA-N and NA-O. The report concluded that a report was filed with the county in the "afternoon of 9/24/14". In an interview on 7/9/15, at 1:54 p.m., SW-A stated that she called reports into the county, but only the administrator has access to report to the SA. In an interview on 7/10/15, at 10:44 a.m., the DON stated they thoroughly investigated R7's concerns and reported them to the county. They (DON and SW-A) informed the administrator verbally and keep the administrator informed verbally. The DON also confirmed this incident was not reported to the SA. R34 eloped from the facility and it was not reported to the SA. The Healthcare Safety Zone Portal and the Residents Notes dated 4/28/15, indicated R34 left the facility with a family member of another resident without staff knowledge. R34 asked the family member to take her to a local bar in town. Another family member called the facility and reported the elopement to the facility. The activity director (AD) went to the bar but R34 refused to leave. R34 agreed to walk to a local cafe with the AD. Law enforcement was called and R34 was returned to the facility with the police officer. R34's Physician Order Sheet dated 7/10/15, indicated R34's diagnoses included dementia and visual loss. R34's vulnerability care plan dated 3/3/15, indicated R34 was vulnerable for abuse from others related to short term memory loss due to the diagnosis of dementia. The care plan directed staff to monitor the whereabouts of	ROVIDER OR SUPPLIER D NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 In the report, SW-A indicated that she consulted with the DON, registered nurse (RN)-A, RN-B, NA-N and NA-O. The report concluded that a report was filed with the county in the "afternoon of 9/24/14". In an interview on 7/9/15, at 1:54 p.m., SW-A stated that she called reports into the county, but only the administrator has access to report to the SA. 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R34's vulnerability care plan dated 3/3/15, indicated R34 was vulnerable for abuse from others related to short term memory loss due to the diagnosis of dementia. The care plan directed staff to monitor the whereabouts of	ROVIDER OR SUPPLIER D NORTHSHORE HOSP & C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 In the report, SW-A indicated that she consulted with the DON, registered nurse (RN)-A, RN-B, NA-N and NA-O. The report concluded that a report was filled with the county in the "afternoon of 9/24/14". In an interview on 7/9/15, at 1:54 p.m., SW-A stated that she called reports into the county, but only the administrator has access to report to the SA. In an interview on 7/10/15, at 10:44 a.m., the DON stated they thoroughly investigated R7's concerns and reported to the SA. R34 eloped from the facility and it was not reported to the Rsi-dints Notes dated 4/28/15, indicated R34 left the facility and reported the family member of another resident without staff knowledge. R34 asked the family member to take her to a local bar in town. Another family member called the facility and reported the object of the Sa to a local bar in town. Another family member called the facility and reported the object of the Sa to a local cafe with the AD. Law enforcement was called and R34 was returned to the facility with the police officer. R34's Physician Order Sheet dated 7/10/15, indicated R34's diagnoses included dementia and visual loss. R34's vulnerability care plan dated 3/3/15, indicated R34 was unlnerable for abuse from others related to short term memory loss due to the diagnosis of dementia. The care plan directed staff to monitor the whereabouts of	ROVIDER OR SUPPLIER 245384 B. WING TONTHSHORE HOSP & CANC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 In the report, SW-A indicated that she consulted with the DON, registered nurse (RN)-A, RN-B, NA-N and NA-O. The report concluded that a report was filled with the county in the "afternoon of 19/24/14". In an interview on 7/9/15, at 1.54 p.m., SW-A stated that she called reports into the county, but only the administrator has access to report to the SA. In an interview on 7/10/15, at 10:44 a.m., the DON astaed they thoroughly investigated R7's concerns and reported them to the county. They (DON and SW-A) informed the administrator verbally and keep the administrator formed verbally. The DON also confirmed this incident was not reported to the SA. R34 eloped from the facility and it was not reported to the SA. R34 eloped from the facility and it was not reported to the SA. R34 eloped from the facility with a family member of another resident without staff knowledge. R34 asked the family member called the facility and reported the elopement to the facility and reported the elopement to the facility and reported the elopement to the facility and reported the facility with the police officer. R34's Physician Order Sheet dated 7/10/15, indicated R34's diagnoses included dementia and visual loss. R34's vulnerability care plan dated 3/3/15, indicated R34 was returned to the facility with the police officer. R34's Physician Order Sheet dated 7/10/15, indicated R34 was returned to the memory loss due to the diagnosis of dementia. The care plan directed staff to monitor the whereabouts of

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245384	B. WING _		07	/10/2015
	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	was to wear a wan the resident that se when the resident of th	der guard (a device worn by ecures the door and alerts staff gets near the door). 15 a.m. the DON verified the treported. The DON stated wander guard herself, the t gave her a ride was a high and R34 was never alone while lity. The DON was unable to information regarding the 180 a.m. the AD stated she round 4:00 p.m. with the assmates's family called the arrived at the bar. The AD checked r guard and it was not on. The treat R34 into her car but when she are seat belt on R34, R34 and got out of the car. R34 and a local cafe. The SW-A arrived and got out of the car. R34 and a local cafe. The SW-A stated the nt willingly with the police urned to the facility. 180 a.m. the SW-A stated she ility from the cafe at the code to open the door in cility with R34. The door alarm another resident with a wander on R34 upon returning to the ed she reported the elopement the door, and the administrator on call.		26		

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 21 call (AC) was interviewed. The AC stated she was informed of the elopement at on 4/28/15, at 5:15 p.m. The AC stated she did not report the elopement to the SA because she does not have the ability to do so. The AC stated the administrator makes the SA reports. The AC stated the facility incident) report and she lets the SW know. The AC also stated she usually informed the administrator but in this case she was out of town. On 7/09/15, at 2:51 p.m. the administrator verified the facility had not had any reports of allegations of abuse, neglect or mistreatment reported to the SA since the previous survey in 8/14. The administrator stated the ACs were able to start an investigation, answer questions and "actually act as my surrogate." If something needed to be		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		PLETED
COOK CO NORTHSHORE HOSP & C&NC (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Call (AC) was interviewed. The AC stated she was informed of the elopement at on 4/28/15, at 5:15 p.m. The AC stated she did not report the elopement to the SA because she does not have the ability to do so. The AC stated the administrator makes the SA reports. The AC stated the facility is made aware through the "clarity" (incident) report and she lets the SW know. The AC also stated she usually informed the administrator but in this case she was out of town. On 7/09/15, at 2:51 p.m. the administrator verified the facility had not had any reports of allegations of abuse, neglect or mistreatment reported to the SA since the previous survey in 8/14. The administrator stated the ACs were able to start an investigation, answer questions and "actually act as my surrogate." If something needed to be			245384	B. WING			07/	10/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 21 call (AC) was interviewed. The AC stated she was informed of the elopement at on 4/28/15, at 5:15 p.m. The AC stated she did not report the elopement to the SA because she does not have the ability to do so. The AC stated the administrator makes the SA reports. The AC stated the facility is made aware through the "clarity" (incident) report and she lets the SW know. The AC also stated she usually informed the administrator but in this case she was out of town. On 7/09/15, at 2:51 p.m. the administrator verified the facility had not had any reports of allegations of abuse, neglect or mistreatment reported to the SA since the previous survey in 8/14. The administrator stated the ACs were able to start an investigation, answer questions and "actually act as my surrogate." If something needed to be					515	- 5TH AVENUE WEST		
call (AC) was interviewed. The AC stated she was informed of the elopement at on 4/28/15, at 5:15 p.m. The AC stated she did not report the elopement to the SA because she does not have the ability to do so. The AC stated the administrator makes the SA reports. The AC stated the facility is made aware through the "clarity" (incident) report and she lets the SW know. The AC also stated she usually informed the administrator but in this case she was out of town. On 7/09/15, at 2:51 p.m. the administrator verified the facility had not had any reports of allegations of abuse, neglect or mistreatment reported to the SA since the previous survey in 8/14. The administrator stated the ACs were able to start an investigation, answer questions and "actually act as my surrogate." If something needed to be	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPROPRIES	JLD BE	(X5) COMPLETION DATE
reported to the SA an ACs have the administrator stated she had instructions in a folder for the ACs to reference. The facility Abuse Prevention Policy dated 10/11 defined neglect as the failure to provide the goods and services to avoid physical harm. Reference checks were not completed prior to employment for 2 newly hired dietary employees. DA-A was hired on 6/8/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. DA-B was hired on 6/16/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.	F 226	call (AC) was interinformed of the elp.m. The AC state elopement to the the ability to do so administrator mal stated the facility "clarity" (incident) know. The AC also the administrator town. On 7/09/15, at 2: the facility had not of abuse, neglect SA since the prevadministrator statinvestigation, and as my surrogate. reported to the S report allegations stated she had into reference. The facility Abuse defined neglect a goods and service Reference checkemployment for SDA-A was hired lacked evidence completed prior DA-B was hired lacked evidence	rviewed. The AC stated she was opement at on 4/28/15, at 5:15 ed she did not report the SA because she does not have of the AC stated the kes the SA reports. The AC is made aware through the report and she lets the SW to stated she usually informed but in this case she was out of the AC survey in 8/14. The ted the ACs were able to start an ower questions and "actually act" If something needed to be A all ACs have the ability to sto the SA. The administrator estructions in a folder for the ACs to the SA. The administrator is tructions in a folder for the ACs to avoid physical harm. The swere not completed prior to 2 newly hired dietary employees. On 6/8/15. The personnel record reference checks were to employment at the facility.		226			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245384	B. WING			07/1	10/2015
	PROVIDER OR SUPPLIER O NORTHSHORE HC	SP & C&NC		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	of reference checks reference checks to but does not docur. On 7/9/15, at 12:13 stated there was not reference checks to responsibility of the complete the reference any systems.	record did not contain evidence is. The DM stated she does by notifying the last employer ment it anywhere. 7 p.m. human resources (HR) of a system to ensure were done. It was the department supervisor to ence checks. The HR did not in place to monitor the	F2	226			
F 315 SS=D	10/11, indicated price head would request all potential emplowould attempt to demployers to verify information about performance. All adocumented on the The facility Abuse failed to identify whatercations would 483.25(d) NO CAT RESTORE BLADE Based on the resident who enteresident who enteresident's clinical catheterization was who is incontinent treatment and serious would serious assessment, the face individually catheter individual catheter was assessment, the face individual catheter who enteresident's clinical catheterization was who is incontinent treatment and serious catheterization and serious catheterization was who is incontinent treatment and serious was allowed at the catheterization was allowed	e Prevention Policy revised ior to hiring the department at employment references from yees. The department head ontact current and past yemployment and request the potential employee's ttempts and contacts would be e job application. Prevention Policy dated 10/11 nen resident to resident be considered abuse. THETER, PREVENT UTI,		315			8/11/15

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245384	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER O NORTHSHORE HO	SP & C&NC		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST RAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	_	F:	315			
	by: Based on interview facility failed to pro assessment that in for a resident enter catheter for 1 of 2 urinary catheter us: Findings include: R42 was admitted end of life care. Than indwelling cather medical diagnosis A physicians note of has an indwelling F	NT is not met as evidenced wand document review, the vide a comprehensive bladder cluded risk benefit educationing the facility with a Foley residents (R42) reviewed for e. to the facility on 6/23/15 for the resident was admitted with eter in place. There was no for the Foley catheter. dated 7/8/15 indicated, "She Foley catheter to manage urine rause she only has pain when			F315 R42 was admitted to the facility for life care on 06/23/15. On 07/08/15 was seen by her PMD for routine reand his notes stated: ¿The patient remains on end of the life cares for metastatic lung cancer. She is too ambulate, remains bed bound. She an indwelling Foley catheter to maurine per her choice because she pain when trying to get up. Continuindwelling catheter to avoid the dis of transfer or using a bedpan.; Or 07/23/15, her husband attended he conference and he was presented the risk/benefit education of an indicatheter. Resident passed away or 24, 2015.	she ounds r weak to e has nge only has se with comfort or care with welling	
	related to the cather the director of nurse Comprehensive Bl 6/24/15 indicated the bladder, but had in and cancer. There or family had been with an indwelling alternatives were.	nent and risk benefit education eter use was requested from sing on 7/8/15. The adder Assessment dated he resident was continent of inpaired mobility, history of falls was no evidence the resident explained the risks associated catheter or what the			Newly admitted residents with a Focatheter in place and any other residents the facility who may need a Foley of placed will have a comprehensive assessment completed that will independent diagnosis and risk/benefit education. The document to gather information will be revised to include medical diagnosis and risk/benefit education. Completion date of Au 2015.	sident of catheter bladder clude a er this de a gust 11,	
	practical nurse (LF admitted with the i	PN)-C identified R42 was ndwelling catheter. LPN-C did catheter in place and stated			The Comprehensive Bowel/bladde will be revised to include documer educating the resident on the risk/	itation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	COMPLETED	
		245384	B. WING			07/1	0/2015
NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC					TREET ADDRESS, CITY, STATE, ZIP CODE 15 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)		BE	(X5) COMPLETION DATE
F 315	Continued From page 24 R42 does not complain of pain very often. At 1:34 PM registered nurse (RN)-A stated R42 had catheter because "she's dying" and "it's a doctors order".		F3	315	of an indwelling catheter. The revision the policy will be reviewed with the Resident Care Managers. Completed date of August 11, 2015. The next five residents who may not provide the properties of a medical diagnosis and risk/beineducation. The information will be reported to Quality Improvement/P Review Committee on a monthly be	RN ion eed a vidence nefit eer	
F 441 SS=F	SPREAD, LINENS The facility must es Infection Control P safe, sanitary and to help prevent the of disease and infe (a) Infection Control The facility must es Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied to (3) Maintains a rec actions related to i (b) Preventing Spr. (1) When the Infection	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection. Of Program stablish an Infection Control ich it - controls, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections.		141			7/29/15
	prevent the spread isolate the residen (2) The facility must communicable dis	d of infection, the facility must					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245384	B. WING			07/1	0/2015		
NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC				STREET ADDRESS, CITY, STATE, ZIP COI 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 441	Continued From page 25 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			141					
	by: Based on observer review, the facility linens and supplies oiled linens and The facility also far housekeeping state between soiled and This had the potenthe facility. Findings include: On 7/8/15, at 10:2 by the laundry are red biohazard congarbage, a box of containers, clean heads, containers curtains and a calan interview on 7, follow-up interview	ation, interview and document failed to ensure that clean as were stored separately from waste in two soiled linen rooms. Alled to ensure that aff perform hand hygiene and clean tasks in the laundry. Initial to effect all 29 residents in the laundry and the sequence of clean tasks in the laundry. The sequence is of washer chemicals, clean room to the sequence of the sequence of washer that the sequence of the s			On July 9, 2015, the Housekeeping/Laundry Supervisor changes to the soiled utility room removing anything that is conside The room was labeled at ¿Clean Storage¿. The Dirty Utility Room inspected on July 28, 2015; any it considered ¿clean¿ were remove Completion date of July 28, 2015. The Housekeeping/Laundry Super her designee will monitor the facil Dirty Utility Rooms for ¿clean¿ ite weekly for the next three months monthly for an additional three monthly for an addition	by red dirty. HSKP s were ems d. rvisor or ity¿s ms and the onths. o Quality nittee on re r of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245384	B. WING			07/1	0/2015
NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC					STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	hazardous waste. During observation again on 7/9/15, at room in the facility' contain an open bir recycling container. The shelves in the supplies used by A commode/bucket I disinfectant that is interview on 7/8/15 that this room is us linens and clothes the containers of d clean bathtubs. On 7/8/15 at 10:28 take a broom from machines and swe under each facility the floor, but an arheld up the dryers can and using bare bottom of the broothen returned the k without washing he sanitizer, pushed of the dryer, shut the cycle. During an interview at 8:17 a.m., H-A sthat addresses the washing hands aft she had not thoug between these tas	age 26 Is on 7/8/15, at 10:46 a.m., and 8:17 a.m., the soiled utility is blue hallway was observed to in with bags of soiled linens, is, a commode, and a hopper. It room contained cleaning ctivities, several buckets and ids, and containers of used for bathtubs. During an idea to store bags of soiled and clean supplies including isinfectant that are used to the wall by the washing sep up lint from a boxed area dryer; this space was not on ea surrounded by metal that H-B then went to the garbage is hands, pulled the lint from the minto the garbage can. H-B broom to its wall holder and, are hands or using hand clean white laundry back into dryer and started the dryer. In with H-A and H-B on 7/9/15, stated they do not have policy is policy of lint removal or er this task. H-B stated that he about the need for hand ks. H-B stated she should have shetween the tasks.		141	Housekeeping and Laundry staff we attendance. Discussion included the importance of washing hands betwe touching dirty and clean linens and general infection control practices. Completion date of July 29, 2015. The Housekeeping/Laundry Supervher designee will monitor each Housekeeping/Laundry employee regarding appropriate handwashing weekly for the next five weeks and monthly for an additional five month Depending upon the results of the monitor, additional monitoring may continue. The information will be reto Quality Improvement/Peer Reviet Committee on a quarterly basis.	eeen visor or then ns.	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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SP & C&NC						
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
of the stove had a covering of them. The side of the hood and spigot were greasy to touch. It little greasy. C-A stated the med weekly and the hood was be kitchen on 7/8/15, at 11:15 my manager (DM), the left side mood and the tops of the stove the left side of the stove the same covering of dust. The DM stated the hood filters erly and the wall behind the	F		pipes/spigots was cleaned on 7/18. Dietary staff. Now that the area had cleaned it is safe, functional, sanitate a comfortable environment for resistaff and the public. The hoods incomplete the pipes/spigots will be cleaned qualong with the hood filters. Complete date of July 18, 2015. The Dietary Manager or her design monitor the hood area including the pipes/spigots monthly for six monthly quarterly thereafter. During the monitoring process if it is seen that hood area including the pipes/spigots monthly for six monthly for six monthly designed and area including the pipes/spigots monthly for six	15 by as been ary and dents, cluding uarterly etion hee will ens and the ots tly the d. The allity	7/18/15	
	245384 SP & C&NC TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) AL/SANITARY/COMFORTABL Tovide a safe, functional, ortable environment for I the public. NT is not met as evidenced tion, interview, and document failed to ensure the ventilation ove in the kitchen was cleaned and dust for the prevention of lad the potential to affect all 29 sility. E kitchen on 7/6/15, at 5:40 (C)-A, the left side of the nod the tops of the pipes/spigots of the stove had a covering of the stove the same covering of the tops of the stove the left side of the stove the same covering of dust. The DM stated the hood filters	A BUILD 245384 B. WING SP & C&NC TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) Tage 27 AL/SANITARY/COMFORTABL Tovide a safe, functional, ortable environment for I the public. NT is not met as evidenced tion, interview, and document failed to ensure the ventilation ove in the kitchen was cleaned and dust for the prevention of the potential to affect all 29 cility. E kitchen on 7/6/15, at 5:40 (C)-A, the left side of the nod and the tops of the pipes/spigots of the stove had a covering of the stove had a covering of the m. The side of the hood and spigot were greasy to touch. I little greasy. C-A stated the tined weekly and the hood was the kitchen on 7/8/15, at 11:15 ry manager (DM), the left side mood and the tops of the stove the same covering of dust. The DM stated the hood filters erly and the wall behind the weekly. There was no schedule	245384 B. WING TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Tage 27 AL/SANITARY/COMFORTABL Ovide a safe, functional, ortable environment for Ithe public. NT is not met as evidenced tion, interview, and document failed to ensure the ventilation ove in the kitchen was cleaned and dust for the prevention of lad the potential to affect all 29 cility. Ekitchen on 7/6/15, at 5:40 (C)-A, the left side of the not the tops of the pipes/spigots of the stove had a covering of lem. The side of the hood and spigot were greasy to touch. It little greasy. C-A stated the left side of the side of the hood and the tops of the years (DM), the left side not and the tops of the stove the same covering of dust. The DM stated the hood filters or the weekly. There was no schedule	A BUILDING 245384 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604 PREFIX TAGS PRECEDED BY FULL SCIDENTIFYING INFORMATION) TAGS DENTIFYING INFORMATION) TO THE PROPERTY TAGS PREFIX TAGS PROPIDERS PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) THE PROPIDER PROPIDER PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) THE PROPIDER PROP	245384 B. WING 245384 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY AL/SANITARY/COMFORTABL Ovide a safe, functional, ortable environment for the public. NT is not met as evidenced tion, interview, and document failed to ensure the ventilation ove in the kitchen was cleaned and dust for the prevention of lad the potential to affect all 29 sility. A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 155 - 5TH AVENUE WEST GRAND MARAIS, MN 55604 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 465 The Dietary hood area including the pipes/spigots was cleaned on 7/18/15 by Dietary staff. Now that the area has been cleaned it is safe, functional, sanitary and a comfortable environment for residents, staff and the public. The hoods including the pipes/spigots will be cleaned quarterly along with the hood filters. Completion date of July 18, 2015. The Dietary Manager or her designee will monitor the hood area including the pipes/spigots of the stove had a covering of em. The side of the hood and filters of the same covering of dust. The DM stated the hood was exit the hood area including the pipes/spigots monthly for six months and quarterly thereafter. During the monitoring process if it is seen that the hood area including the pipes/spigots monthly for six months and quarterly thereafter. During the monitoring process if it is seen that the hood area including the pipes/spigots monthly for six months and quarterly thereafter. During the monitoring process if it is seen that the hood area including the pipes/spigots on the fitter of the public. The Dietary Mondard and including the pipes/spigots was cleaned on 7/18/15 by manager or her designee will monitor the hood area including the pipes/spigots monthly for six months and quarterly thereafter. During the monitoring process if it is seen that the hood area including the pipes/spig	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMPLETED			
		245384	B. WING			07/	10/2015		
NAME OF PROVIDER OR SUPPLIER COOK CO NORTHSHORE HOSP & C&NC				STREET ADDRESS, CITY, STATE, ZIP COD 515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604					
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
cleaned. The and the pipe stove were of DM stated should develop the hood. The facility process the indicated the cleaned as a directed the maintenance exhaust hood.	eaned e DM s/spig lusty a he nee pping a colicy a cods ar e hood neede DM o e with d and ndicate	age 28 It when the filters were verified the left side of the hood ots over the left side of the and had grease on them. The eded to talk to maintenance a routine schedule for cleaning and procedure for Cleaning of the filters dated 6/20/14, It and ancillary spigots would be done of the policy and procedure assistant to email a work order to clean the ancillary spigots as needed, and the dietary staff may also	F	465					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245384

B. WING _____

07/07/2015

NAME OF PROVIDER OR SUPPLIER

COOK CO NORTHSHORE HOSP & C&NC

STREET ADDRESS, CITY, STATE, ZIP CODE

515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

	GRAND MARAIS, MN 55604								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE					
K 000	INITIAL COMMENTS	K 000							
	FIRE SAFETY								
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cook County Northshore Hospital C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.								
	Cook County Northshore Hospital C & NC, is a 1-story building with no basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1999 additions were constructed to the building that was determined to be of Type V(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has a hospital attached that is properly separated.								
	The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 37 beds and had a census of 29 at the time of the survey.								
	It is the determination of this Life Safety Code		TITLE	(X6) DATE					

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

Printed: 07/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
245384			B. WING		07/0	7/2015		
1	PROVIDER OR SUPPLIER	HOSP & C&NC		RESS, CITY, S	STATE, ZIP CODE IE WEST			
00011					, MN 55604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	Continued From pa Surveyor that the firesident rooms is a unobstructed cover wardrobe closets in (99) and CMS S&C	age 1 ire sprinkler coverage adequate to provide o rage to the exterior o in accordance with N	e in the complete of the FPA 13	K 000				

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