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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245384**

2.STATE VENDOR OR MEDICAID NO.
(L2) **365745100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK CO NORTHSHORE HOSP & C&NC**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/14/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 10/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/20/2015
(L33)

DETERMINATION APPROVAL

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, 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.

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, 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245384	A. Building B. Wing	10/14/2015

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	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	09/28/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	09/28/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	09/28/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	10/27/2015	34089	10/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK CO NORTHSHORE HOSP & C&NC**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **08/28/2015** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 10/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1987** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE: (L27)

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/20/2015** (L33)

DETERMINATION APPROVAL

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 October10, 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)

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

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

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 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245384	A. Building B. Wing	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	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0153 Reg. # 483.10(b)(2) LSC	08/18/2015	ID Prefix F0315 Reg. # 483.25(d) LSC	08/18/2015	ID Prefix F0441 Reg. # 483.65 LSC	08/18/2015
ID Prefix F0465 Reg. # 483.70(h) LSC	08/18/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	CC/mm	09/14/2015	34983	08/28/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 7/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	R 08/28/2015

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{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 were determined not to be in compliance.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	{F 225}		9/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | 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.

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{F 225}	Continued From page 1 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the State Agency (SA) of elopement and allegations of mistreatment for 2 of 2 (R23, R41, R32) reportable incidents reviewed. Findings include: R23 eloped from the facility on 8/26/15, and the facility did not immediately report to the SA. R23's Physician Order Sheet identified diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 8/16/15, indicated R23 had	{F 225}	F225 During the earlier meetings held with employees, the Social Worker emphasized the importance to report incidents immediately to a Charge Nurse, Department Manger, Social Worker, Director of Nursing, Administration On-Call or the Administrator. A checklist to be used in conjunction with the Abuse Prevention Policy, B-1 was created to provide support in the immediate reporting process the State Agency. The checklist was updated to eliminate confusion and further refine the process. The revised	

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{F 225}	Continued From page 2 severe cognitive deficit, wandered 1-3 days, and was able to ambulate with supervision. R23's care plan dated 5/31/15, identified R23 was at risk for self-neglect and wandering away, and directed staff to monitor her whereabouts, and distract and redirect when she is insistent on leaving the facility. The care plan further identified R23 as being confused regarding where she is and her perceived need to get out of the facility and go home can result in increased agitation when frustrated by the Wanderguard door system (a system that has a sensor that will alarm when a resident attempts to leave the facility). The care plan also identified R23 as wearing a Wanderguard bracelet. INCIDENT REPORT: On 8/26/15, at 6:21 p.m. R23 exited the facility by the main entrance in the dining room. Another resident observed this, and alerted staff. R23 was found a block away from the facility, and returned with staff. The staff replaced her Wanderguard bracelet, as it may have malfunctioned. On 8/27/15, at 2:15 p.m. the administrator was interviewed, and stated the main door Wanderguard system did not lock and alarm when R23 exited the facility. The administrator stated the facility maintenance department had checked R23's Wanderguard once she was returned to the facility, and it had worked at all doors. The administrator stated the facility had not reported the incident immediately to the SA, and the director of nursing (DON) was in the process of reporting. On 8/27/15, at 3:05 p.m. the DON was interviewed and stated she had not yet completed the reporting to the SA. The DON continued to	{F 225}	checklist was reviewed at the Charge Nurse meeting by the Director of Nursing, Social Worker and Administrator on September 22, 2015. Nurses unable to attend the Charge Nurse Meeting will meet individually with the Director of Nursing by September 28, 2015. Initial reporting, investigation and follow up were specifically reviewed and the use of the checklist was demonstrated with various examples. To identify incidents that may not have been reported, the Director of Nursing will continue to review every submitted Clarity incident to determine if an event is reportable to the State Agency and verify that appropriate reports have been submitted. The Interdisciplinary Team (IDT) will also continue to review chart documentation and INTERACT documents for events that may be reportable to the State Agency and verify that appropriate reports have been submitted. Completion date of September 28, 2015. As an additional compliance monitor, the Administrative Staff (Administrator, Director of Nursing ¿ Care Center, Director of Nursing ¿ Hospital and Director of Finance) will continue to review all Clarity incident submissions at the weekly Monday Administrative Staff meetings. If the Staff meeting is cancelled for any reason, the Administrative Person On-Call will complete the review. In addition to a general review, the incidents will continue	

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{F 225}	Continued From page 3 state all incidents are reviewed by the interdisciplinary team (IDT), and a determination is made after that meeting regarding if incident is reportable. The DON completed the report to the SA on 8/27/15, at 3:15 p.m., nearly 21 hours after R23 eloped. The report to the SA indicated R23 exited the building through the main entrance, witnessed by another resident who alerted staff. Three staff looked for R23, found her a block away, and brought her back to the facility after about 10 minutes. R23's Wanderguard was working, so it was unclear how she had gotten out. The Wanderguard bracelet was changed. The facility reviewed their surveillance camera system video which showed R23 leave the building, the staff going to look for her, and the staff and R23 returning to the building. On 8/28/15, at 1:02 p.m., the administrator stated the facility first determines if an event should be reported to the SA. The administrator stated that once an incident is determined reportable, the facility then reports immediately to the SA. The administrator stated that this decision-making process had not occurred at the time of the incident, but the next day. The administrator stated that the facility defines immediate reporting to the SA as within 24 hours. The administrator felt R23's elopement was not a reportable event, because it was witnessed. The following day the administrator learned it was witnessed by another resident, not by staff, and at that time deemed it a reportable event. R41 and R32 had a physical altercation and the facility did not immediately report to the SA. R41's Physician Order Sheet identified diagnoses	{F 225}	to be reviewed to verify that if in the opinion of the Administrative Staff an incident is deemed to be reportable to the State Agency, it was appropriately reported and to review submission timing to verify immediate reporting. The monitor worksheet has been modified to include the time from the incident report to submission of the Report to the State Agency. This review will be completed for one year, through October 31, 2016. The Administrator will compile the monitor information and will submit the Report to Quality Improvement/Peer Review Committee on a monthly basis. Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¿s allegation of compliance.	

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{F 225}	Continued From page 4	{F 225}		

that included dementia. The significant change MDS dated 8/9/15, indicated R41 had severe cognitive impairment, exhibited physical and verbal behavioral symptoms towards others 1-3 days, wandered 4-6 days and was able to walk independently. R41's care plan dated 8/14/15, identified her as vulnerable due to advanced early dementia, at risk of retaliation by other residents, and that she could become resistant or combative with resident and staff when being redirected. R41's care plan indicated behavior problems that included wandering at times into other resident rooms, providing other residents hugs, pats and stares that may not be welcome. Interventions included keeping track of where she was at and intervening and redirecting when wandering.

R32's Physician Order Sheet identified diagnoses that included dementia and persistent mental disorders. The quarterly MDS dated 8/13/15, indicated R32 had severe cognitive impairment, was independent with transfers and walking, and did not exhibit behaviors. R32's care plan dated 8/23/15, identified R32 as vulnerable for abuse from others related to the diagnosis of dementia. The care plan also identified R32 needed frequent re-orientation and no arguments but gentle distraction.

INCIDENT REPORT
On 8/18/15, at 9:15 p.m., R32 was heard yelling, "Get out! Get out!" Nursing Assistant (NA)-O arrived and saw R41 lightly punch R32 and grab R32's right arm. NA-O intervened and immediately reported the event to her charge nurse.

The incident was not reported to the SA until

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{F 225}	Continued From page 5 8/19/15, at 12:15 p.m. (15 hours after the incident occurred). In an interview on 8/28/15, at 10:16 a.m. the social services director (SSD) stated the event was reported because a nurse went back to evaluate R32 on 8/19/15, and R32 said she had pain in her wrist. Then the IDT recommended to submit the incident to the SA at that time. Review of the facility's Mandated Reporter Checklist revealed the DON submitted the Incident Report and the Investigative Report to the SA. The Investigative Report was submitted on 8/26/15. In an interview on 8/28/15, at 10:16 a.m. the SSD stated that the facility is to report "immediately or within 24 hours." When asked to clarify, the SSD stated that immediate is "at your earliest possible ability, not to exceed 24 hours." The SSD stated that maybe they would wait if there was a snowstorm or it was financial abuse. In an interview on 8/28/15, at 11:06 a.m. the DON stated that R41 and R32 were safe and there were no injuries. Since the nurse said R32 was not harmed, she chose to report the next morning. In a follow-up interview with the SSD on 8/28/15, at 11:31 a.m. the SSD stated that the staff are to report to their charge nurse immediately. For reports to the SA, they review the incident and then report within 24 hours. On 8/28/15, at 1:02 p.m., the administrator stated the facility first determines if an event should be reported to the SA. The administrator stated that once an incident is determined reportable, the facility then reports to the SA. The administrator stated that this decision-making process had not occurred at the time of the incident, but the next	{F 225}		

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{F 225}	Continued From page 6 day. The administrator stated that the facility defines immediate reporting to the SA as within 24 hours. The facility Abuse Prevention Policy dated 8/15, directed any suspicions of patient/resident maltreatment, injuries of unknown source or origin, resident to resident altercations with resulting harm, and unattended elopements shall immediately be reported to the State Agency. The facility Abuse Prevention Policy dated 8/15, directed any suspicions of patient/resident maltreatment, injuries of unknown source or origin, resident to resident altercations with resulting harm, and unattended elopements shall immediately be reported to the State Agency.	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prevention policy which required immediate notification to the State Agency (SA) episodes of elopement and allegations of mistreatment prior to conducting investigations for 2 of 2 (R23, R41, R32) reportable incidents reviewed. Findings include:	{F 226}	F226 During the earlier meetings held with employees, the Social Worker emphasized the importance to report incidents immediately to a Charge Nurse, Department Manger, Social Worker, Director of Nursing, Administration On-Call or the Administrator. A checklist to be used in conjunction with the Abuse	9/28/15

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{F 226}	Continued From page 7 R23 eloped from the facility on 8/26/15, and the facility did not immediately report to the SA. The facility Abuse Prevention Policy dated 8/15, directed any suspicions of patient/resident maltreatment, injuries of unknown source or origin, resident to resident altercations with resulting harm, and unattended elopements shall immediately be reported to the State Agency. R23's Physician Order Sheet identified diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 8/16/15, indicated R23 had severe cognitive deficit, wandered 1-3 days, and was able to ambulate with supervision. R23's care plan dated 5/31/15, identified R23 was at risk for self-neglect and wandering away, and directed staff to monitor her whereabouts, and distract and redirect when she is insistent on leaving the facility. The care plan further identified R23 as being confused regarding where she is and her perceived need to get out of the facility and go home can result in increased agitation when frustrated by the Wanderguard door system (a system that has a sensor that will alarm when a resident attempts to leave the facility). The care plan also identified R23 as wearing a Wanderguard bracelet. INCIDENT REPORT: On 8/26/15, at 6:21 p.m. R23 exited the facility by the main entrance in the dining room. Another resident observed this, and alerted staff. R23 was found a block away from the facility, and returned with staff. The staff replaced her Wanderguard bracelet, as it may have malfunctioned. On 8/27/15, at 2:15 p.m. the administrator was	{F 226}	Prevention Policy, B-1 was created to provide support in the immediate reporting process the State Agency. The checklist was updated to eliminate confusion and further refine the process. The revised checklist was reviewed at the Charge Nurse meeting by the Director of Nursing, Social Worker and Administrator on September 22, 2015. Nurses unable to attend the Charge Nurse Meeting will meet individually with the Director of Nursing by September 28, 2015. Initial reporting, investigation and follow up were specifically reviewed and the use of the checklist was demonstrated with various examples. To identify incidents that may not have been reported, the Director of Nursing will continue to review every submitted Clarity incident to determine if an event is reportable to the State Agency and verify that appropriate reports have been submitted. The Interdisciplinary Team (IDT) will also continue to review chart documentation and INTERACT documents for events that may be reportable to the State Agency and verify that appropriate reports have been submitted. Completion date of September 28, 2015. As an additional compliance monitor, the Administrative Staff (Administrator, Director of Nursing ¿ Care Center, Director of Nursing ¿ Hospital and Director of Finance) will continue to review all Clarity incident submissions at the weekly Monday Administrative Staff	

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{F 226} Continued From page 8
interviewed, and stated the main door Wanderguard system did not lock and alarm when R23 exited the facility. The administrator stated the facility maintenance department had checked R23's Wanderguard once she was returned to the facility, and it had worked at all doors. The administrator stated the facility had not reported the incident immediately to the SA, and the director of nursing (DON) was in the process of reporting.

On 8/27/15, at 3:05 p.m. the DON was interviewed and stated she had not yet completed the reporting to the SA. The DON continued to state all incidents are reviewed by the interdisciplinary team (IDT), and a determination is made after that meeting regarding if incident is reportable. The DON completed the report to the SA on 8/27/15, at 3:15 p.m., nearly 21 hours after R23 eloped. The report to the SA indicated R23 exited the building through the main entrance, witnessed by another resident who alerted staff. Three staff looked for R23, found her a block away, and brought her back to the facility after about 10 minutes. R23's Wanderguard was working, so it was unclear how she had gotten out. The Wanderguard bracelet was changed. The facility reviewed their surveillance camera system video which showed R23 leave the building, the staff going to look for her, and the staff and R23 returning to the building.

On 8/28/15, at 1:02 p.m., the administrator stated the facility first determines if an event should be reported to the SA. The administrator stated that once an incident is determined reportable, the facility then reports immediately to the SA. The administrator stated that this decision-making process had not occurred at the time of the

{F 226}
meetings. If the Staff meeting is cancelled for any reason, the Administrative Person On-Call will complete the review. In addition to a general review, the incidents will continue to be reviewed to verify that if in the opinion of the Administrative Staff an incident is deemed to be reportable to the State Agency, it was appropriately reported and to review submission timing to verify immediate reporting. The monitor worksheet has been modified to include the time from the incident report to submission of the Report to the State Agency. This review will be completed for one year, through October 31, 2016. The Administrator will compile the monitor information and will submit the Report to Quality Improvement/Peer Review Committee on a monthly basis.

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¿s allegation of compliance.

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{F 226}	Continued From page 9 incident, but the next day. The administrator stated that the facility defines immediate reporting to the SA as within 24 hours. The administrator felt R23's elopement was not a reportable event, because it was witnessed. The following day the administrator learned it was witnessed by another resident, not by staff, and at that time deemed it a reportable event. R41 and R32 had a physical altercation and the facility did not immediately report to the SA. The facility Abuse Prevention Policy dated 8/15, directed any suspicions of patient/resident maltreatment, injuries of unknown source or origin, resident to resident altercations with resulting harm, and unattended elopements shall immediately be reported to the State Agency. R41's Physician Order Sheet identified diagnoses that included dementia. The significant change MDS dated 8/9/15, indicated R41 had severe cognitive impairment, exhibited physical and verbal behavioral symptoms towards others 1-3 days, wandered 4-6 days and was able to walk independently. R41's care plan dated 8/14/15, identified her as vulnerable due to advanced early dementia, at risk of retaliation by other residents, and that she could become resistant or combative with resident and staff when being redirected. R41's care plan indicated behavior problems that included wandering at times into other resident rooms, providing other residents hugs, pats and stares that may not be welcome. Interventions included keeping track of where she was at and intervening and redirecting when wandering. R32's Physician Order Sheet identified diagnoses	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	R 08/28/2015

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

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{F 226}	Continued From page 10 that included dementia and persistent mental disorders. The quarterly MDS dated 8/13/15, indicated R32 had severe cognitive impairment, was independent with transfers and walking, and did not exhibit behaviors. R32's care plan dated 8/23/15, identified R32 as vulnerable for abuse from others related to the diagnosis of dementia. The care plan also identified R32 needed frequent re-orientation and no arguments but gentle distraction. INCIDENT REPORT On 8/18/15, at 9:15 p.m., R32 was heard yelling, "Get out! Get out!" Nursing Assistant (NA)-O arrived and saw R41 lightly punch R32 and grab R32's right arm. NA-O intervened and immediately reported the event to her charge nurse. The incident was not reported to the SA until 8/19/15, at 12:15 p.m. (15 hours after the incident occurred). In an interview on 8/28/15, at 10:16 a.m. the social services director (SSD) stated the event was reported because a nurse went back to evaluate R32 on 8/19/15, and R32 said she had pain in her wrist. Then the IDT recommended to submit the incident to the SA at that time. Review of the facility's Mandated Reporter Checklist revealed the DON submitted the Incident Report and the Investigative Report to the SA. The Investigative Report was submitted on 8/26/15. In an interview on 8/28/15, at 10:16 a.m. the SSD stated that the facility is to report "immediately or within 24 hours." When asked to clarify, the SSD stated that immediate is "at your earliest possible ability, not to exceed 24 hours." The SSD stated that maybe they would wait if there was a snowstorm or it was financial abuse.	{F 226}		

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{F 226}	Continued From page 11 In an interview on 8/28/15, at 11:06 a.m. the DON stated that R41 and R32 were safe and there were no injuries. Since the nurse said R32 was not harmed, she chose to report the next morning. In a follow-up interview with the SSD on 8/28/15, at 11:31 a.m. the SSD stated that the staff are to report to their charge nurse immediately. For reports to the SA, they review the incident and then report within 24 hours. On 8/28/15, at 1:02 p.m., the administrator stated the facility first determines if an event should be reported to the SA. The administrator stated that once an incident is determined reportable, the facility then reports to the SA. The administrator stated that this decision-making process had not occurred at the time of the incident, but the next day. The administrator stated that the facility defines immediate reporting to the SA as within 24 hours.	{F 226}		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 323	F323	9/28/15

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F 323 Continued From page 12
review, the facility failed to assess interventions implemented to prevent elopement for 1 of 1 resident (R23) who eloped from the facility. This had the potential to affect any residents who utilized a Wanderguard bracelet.

Findings include:

R23's Physician Order Sheet identified diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 8/16/15, indicated R23 had severe cognitive deficit, wandered 1-3 days, and was able to ambulate with supervision. R23's care plan dated 5/31/15, identified R23 was at risk for self-neglect and wandering away, and directed staff to monitor her whereabouts, and distract and redirect when she is insistent on leaving the facility. The care plan further identified R23 as being confused regarding where she is and her perceived need to get out of the facility and go home can result in increased agitation when frustrated by the Wanderguard door system (a system that has a sensor that will alarm when a resident attempts to leave the facility). The care plan also identified R23 as wearing a Wanderguard bracelet.

INCIDENT REPORT:
On 8/26/15, at 6:21 p.m. R23 exited the facility by the main entrance in the dining room. Another resident observed this, and alerted staff. R23 was found a block away from the facility, and returned with staff. The staff replaced her Wanderguard bracelet, as it may have malfunctioned. However, there was no futher investigation into the cause for the malfunctioning alarm.

On 8/27/15, at 2:15 p.m. the administrator was interviewed and stated the main door

F 323

R23¿s wanderguard was immediately changed on Wednesday, August 26, 2015, following her elopement from the facility. This was completed even though the door locked and alarmed appropriately upon her re-entry into the facility. The Maintenance Director contacted Accutech at 16:08 on August 26 for 14 minutes to discuss the incident and inquire about the steps that should be taken and what should be reviewed to identify why the system seemed not to work and determine why it did not work. Another Accutech representative called and spoke with the Maintenance Director at 16:31 on August 26 for 10 minutes. The Maintenance Director asked about the length of the battery life inside the resident tag. The code system was explained and as directed the Maintenance Director tested the field of the door in question to determine if there were any dead spots and none were identified. During this testing, other residents came by the Front door and it function correctly with them as well. Each door has its own control box and work independently from each other. The Maintenance Director checked each door equipped with a wanderguard. On August 31, 2015, the Maintenance Director again spoke with Accutech and with their assistance he recalibrated the antennas on the door in question to make sure that everything is working at its best. An adjustment was made to one of the antennas to make the locking zone of the door a little larger and more sensitive.

The investigation was unable to determine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CO NORTHSHORE HOSP & C&NC	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

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F 323	Continued From page 13 Wanderguard system did not lock and alarm when R23 exited the facility. The administrator stated the facility maintenance department had checked R23's Wanderguard once she was returned to the facility, and it had worked at all doors. On 8/27/15, at 3:05 p.m. the director of nursing (DON) was interviewed and stated the facility had replaced R23's Wanderguard bracelet, but had not checked the other residents who were at risk for elopement and wore Wanderguard bracelets to see if theirs were working. On 8/27/15, at 3:30 p.m. R23 was observed ambulating independently in her room and in the hallway. R23 had a Wanderguard bracelet on her left ankle. On 8/28/15, at 11:15 a.m. the administrator stated the facility had not checked Wanderguard bracelets of other residents who were at risk for elopement. The administrator also verified the facility had not contacted the Wanderguard company when R23 exited the facility when they could not determine why the alarm did not function. On 8/28/15, at 2:18 p.m. the DON stated she had viewed the surveillance tape that showed when R23 left the facility. The DON stated no other staff or visitors were around when R23 exited the building, and the Wanderguard alarm on the door did not lock or alarm. The DON stated R23 was out of the facility for about 10 minutes when the staff brought her back in. The DON also stated R23 had gotten outside previously when a visitor let her out, but the visitor was educated, and the	F 323	how R23 was able to open the door. Based upon a review of the surveillance camera, the code access at the door in question had not been entered for at least 10 minutes, well outside the 40 second reset time. Using the resident tag R23 wore at the time of the incident, the Maintenance Director was unable to replicate the incident at the door in question and all other doors locked and alarmed appropriately. The wanderguard tag was replaced on R23 immediately following the incident. The doors have locked and/or alarmed appropriately when R23 is near the alarmed doors. No incident of a similar nature involving R23 or any other resident wearing a wanderguard has occurred since August 26, 2015. The policy and procedure regarding the wanderguard will be updated. It will include the verification of the system operability with all Resident wanderguards for a door if a Resident elopes without a known reason. The revisions to the policy will be reviewed at the Charge Nurse meeting by the Director of Nursing on September 22, 2015. Nurses unable to attend the Charge Nurse Meeting will meet individually with the Director of Nursing by September 28, 2015 to review the policy. Completion date of September 28, 2015. Elopements will be reviewed for cause and verification of the wanderguard system operability on a monthly basis for six months. The information will be	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	R 08/28/2015

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

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F 323	Continued From page 14 facility put signage by the doors to alert visitors to check with staff before letting residents outside. The DON was unsure of when the previous elopement had occurred, but it was in the last few months. The facility policy and procedure on Wander Guard Accutech System dated 9/14, directed the Accutech Exit Seeker\TM (ES) Prevention System is used to help prevent special care residents suffering from wandering malady and tendencies, from straying into unauthorized areas or leaving the facility, the residents monitor is checked weekly.	F 323	reported to Quality Improvement/Peer Review Committee on a monthly basis.	

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

ID: Y1IU
Facility ID: 00080

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

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK CO NORTHSHORE HOSP & C&NC**
(L4) **515 - 5TH AVENUE WEST**
(L5) **GRAND MARAIS, MN** (L6) **55604**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **07/10/2015** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 07/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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 woudl 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Substandard Quality of Care - 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;

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

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

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

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

DEPARTMENT CONTACT

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

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. <u>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.</u>

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 <u>https://dab.efile.hhs.gov</u> 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 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.

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

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

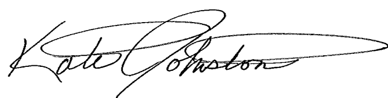
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 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 extended survey was conducted by the Minnesota Department of Health on 7/9/15 and 7/10/15.	F 000		
F 153 SS=F	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures to ensure timely access to medical records for	F 153	Our ¿Patient Access to Records¿ policy will be updated to the current Federal Guidelines for the Care Center to include	8/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 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.

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

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F 153	Continued From page 1 residents/responsible person. The facility also required a written request for medical records. This has the ability to affect all 29 residents residing in the facility. Findings include: Review of the facility's policy "Patient Access to Records" specified patients must make requests to access or obtain copies of their records in writing. The policy further identified the facility had 10 days to provide the opportunity to review or copy medical records. Although the policy referenced to Minnesota statutes and Health Insurance Portability and Accountability Act (HIPPA) the policy failed to comply with Center for Medicare/Medicaid Services (CMS) regulations. Review of the facility's Resident and Family Handbook specified the facility had 10 days to provide access to, or copies of, medical records based on written request. During an interview on 7/10/15, at 11:48 a.m. with the facility administrator and health information management (HIM) coordinator, the HIM coordinator stated the policy provided, was the current policy and practice of the facility.	F 153	allowing both oral and written requests for viewing of resident¿s records within 24 hours and a photocopy of record within 2 working days if requested. Our Resident and Family Handbook will also be updated with the current policy for distribution. These actions are currently being worked on and will be completed and in place by August 17. Completion date of August 17, 2015. Any record requests, oral or written, made to the Care Center staff by residents or their legal representatives will be completed by the Health Unit Coordinator at the Care Center. This request will be sent to the HIM Department immediately via email and will be entered into the Release of Information function within the Meditech system by the HIM Coordinator or their designee in a Logged status. Once the request is completed another email will be sent to the HIM Department and will be changed to a complete status. The HIM Coordinator will review all Care Center requests monthly for three months and then quarterly to ensure that the Patient Access to Records is being followed. The information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		8/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 2 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to immediately report allegations of abuse/neglect/mistreatment to the State Agency	F 225	F225 The Abuse Prevention Policy, B-1, will be updated and enhanced to include a	

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	245384		07/10/2015

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F 225 Continued From page 3

(SA) and thoroughly investigate allegations for 4 of 9 residents (R37, R22, R7, R34) reviewed for abuse. In addition, the facility failed to ensure reference checks were completed for 2 of 2 newly hired dietary aides. (DA-A, DA-B)

Findings include:

R37 alleged verbal abuse that was not reported or thoroughly investigated. The Minimum Data Set (MDS) admission assessment dated 5/31/15 indicated the resident was cognitively intact. There were no incident reports or investigations recorded from the time of admission through 7/8/15.

Interview with R37 on 7/7/15, at 11:30 a.m., the resident indicated LPN-B had verbally abused him shortly after his admission to the facility. He indicated she had become "pissy" with him when he requested an evening snack. Further interview with R37 on 7/8/15, at 1:08 p.m., the resident indicated he asked for a snack, and LPN-B had told him the snacks were for everyone. He thought that implied he was eating more than his share and he shouldn't have them because of his diabetes. R37 stated he spoke with the director of nursing (DON) about this event the following day, and has had no further concerns.

Telephone interview with LPN-B on 7/8/15, at 2:31 p.m. indicated she recalled the event R37 reported. LPN-B stated she was following the residents care plan that said to encourage better food choices, decrease carbohydrates and promote self care. LPN-B "confronted" the resident about eating ice cream, and R37 said he was going to eat what he wanted and that was

F 225

checklist. The revised policy will be reviewed and education will be provided to all employees by the Social Worker by August 18, 2015. Reporting, investigation and follow up will be specifically reviewed. The Director of Nursing will review every submitted Clarity incident to determine if an event is reportable to the State Agency and that appropriate reports have been submitted. The Interdisciplinary Team (IDT) will review chart documentation and INTERACT documents for events that may be reportable to the State Agency and that appropriate reports have been submitted. Completion date of August 18, 2015.

The Administrative Staff (Administrator, Director of Nursing ¿ Care Center, Director of Nursing ¿ Hospital and Director of Finance) will review all Clarity incident submissions at the weekly Monday Administrative Staff meetings. If the Staff meeting is cancelled for any reason, the Administrative Person On-Call will completed the review. In addition to a general review, the incidents will be reviewed to determine if they are reportable to the State Agency and verify that the reports have been completed as required. This review will be completed for one year. The Administrator will compile the monitor information and will submit the Report to Quality Improvement/Peer Review Committee on a monthly basis.

The Dietary Manager will recheck the references of the two recently hired

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225

Continued From page 4

between him and his doctor. LPN-B told R37 she did not believe the doctor was aware of what he was eating, but she would notify him. The next morning when the LPN went into the residents room, he alleged she had been verbally abusive to him during the night. LPN-B reported she immediately went to the DON and reported the allegation.

Interview with the DON on 7/9/15, at 9:30 a.m. identified she initially heard about the event from LPN-B. The LPN indicated she was attempting to discourage food choices, but the resident called it verbal abuse. She spoke with R37 who inferred the LPN had a "regimented attitude." The DON determined it was not verbal abuse through and did not report the event to the administrator, state agency or complete a thorough investigation.

The Abuse Prevention Policy dated 12/00 indicated, "Reports of alleged abuse, mistreatment, neglect, misappropriation of property or injuries of unknown origin will be promptly and thoroughly investigated."

R22 reported an allegation of verbal abuse by a staff member and it was not reported to the SA. According to the OBRA quarterly Minimum Data Set (MDS) dated 6/14/15, R22 was cognitively intact.

R22's nursing assistant care sheet indicated R22 could use the grab bar in bathroom to transfer independently, not able to use urinal reliably, and assist of one for perineal care and continent of bowel and bladder. Regarding behavior and cognition, the care sheet indicated R22 was alert and oriented and could get anxious about falling

F 225

employees. A reference check documentation form has been developed and will be utilized for every new hire. The Human Resources Coordinator will not complete the Offer letter to a new employee until all required documentation; including the references checks have been completed. The revised process will be reviewed at the Leadership Council meeting on August 11, 2015. Completion date of August 11, 2015.

The Human Resource Coordinator or her designee will review the employee files of all new employees at the end of each month to verify that documentation of reference checks is included in the file. This monitor will be completed monthly for six months and the information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis.

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¿s allegation of compliance.

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F 225	Continued From page 5 during transfers. The care sheet indicated "provide encouragement and assure him you are here to help him." According to a progress note on 5/12/15, R22 was very upset with a specific nursing assistant (NA-M) who provided cares. He did not want that NA to provide cares to him anymore. R22 reported the NAR said, "Wash your own damn ass." R22 reported that he nearly fell while wiping and that he was planning on turning her in. The facility removed NA-M from work until the event was thoroughly investigated. According to investigation/documentation dated 5/13/15 and 5/14/15 reports by the director of nursing (DON), NA-C assisted R22 to the toilet shortly after lunch on 5/11/15. NA-M and NA-N answered R22's bathroom call light later to assist with personal cares after a bowel movement. In addition to the information in the progress note, R22 also felt he was not offered the proper supplies to assist with his care after toileting as the washcloth was not warm enough nor did it have enough peri-wash on it. R22 told the DON that he did not want NA-M providing him care anymore. R22 stated that he was scared and upset to the point he lost his appetite for the evening meal and music program because of this incident. According to other undated investigation documentation provided by the facility with interviews dated 5/13/15 and 5/14/15, the DON interviewed involved staff and co-workers. Based on information gathered in the investigation, the facility determined that NA-M did not swear at R22. On 5/21/15, NA-M was allowed back to work and R22 was informed that NA-M would no	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 6	F 225		

longer be providing care to him.

In an interview on 7/10/15, at 10:44 a.m., the DON confirmed that the incident did get investigated, but was not reported to the SA. Notes from the investigation provided by the DON were dated 5/13/15 and 5/14/15. The DON also stated that the facility did inform the administrator right away, and did so in this incident. However, they may not always document when and who informed the administrator. In this case, it was "probably" the DON or the facility social worker (SW)-A. The DON stated that the process to notify the administrator is not formalized, but they "just know" they need to tell the administrator. Review of the facility ' s Healthcare Safety Zone Portal does not assist in determining if the administrator was notified or when.

In the interview on 7/10/15, the DON explained the decision to not report the incident to the SA was based on differing stories from those interviewed (staff and resident) and R22 has a "tendency to embellish."

R7 reported verbal abuse to the facility. The facility did not report the incident to the SA.

According to the physician order sheet, R7 had diagnoses including persistent mental disorder, personality disorder, hemiplegia, depression and anxiety. An OBRA quarterly MDS dated 5/21/15 indicated R7 was cognitively intact.

R7's vulnerability care plan dated 4/3/15 indicated she was vulnerable for abuse from others related to Cerebral Vascular Accident (CVA), mental illness and the need to total assistance. Interventions directed staff to allow time for

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F 225	Continued From page 7 decision making, attentive listening, and continue to encourage resident to interact with others, and to get out of her room. R7's mood care plan directed staff to encourage expression of feelings, establish a trusting relationship, listen attentively, use a calm reassuring approach, explain all procedures, acknowledge her feelings, provide reassurance and comfort, and encourage the use of relaxation techniques. R7's toileting care plan directed staff to check and change as needed every 2 to 2.5 hours while awake and during rounds at night. Staff were to use a Hoyer lift in bed to position R7 over bedpan and provide total assist of 1 to 2 staff for peri-cares. R7's quarterly MDS dated 5/21/15 indicated she was always incontinent of both bladder and bowel. According to an undated "VA Report Social Worker Summary", nursing assistant (NA)-O and NA-N approached Social Worker (SW)-A on 9/23/14, with concerns about statements R7 was making about NA-M. According to the report and a progress note dated 9/23/14, at 5:32 p.m. SW-A met with R7 who was "visually upset, sobbing, very tearful and initially unable to talk due to being upset." During this interview, R7 told SW-A when she is in the dining room and felt the need for a bowel movement, NA-M will tell her to go in her pants or wait. In addition, R7 reported having numerous bowel movements daily, NA-M would tell her "no one goes to the bathroom that many times a day." The report further identified R7 was concerned about NA-M finding out about the interview and being mad at her and causing her trouble. Handwritten notes from NA-O and NA-N were dated 9/25/14 and 9/24/15 respectively describing their knowledge og the incident.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 8 In the report, SW-A indicated that she consulted with the director of nursing (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	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 9 cognitively impaired residents and redirect. R34 was to wear a wander guard (a device worn by the resident that secures the door and alerts staff when the resident gets near the door). On 7/10/15, at 11:15 a.m. the director of nursing (DON) verified the elopement was not reported. The DON stated R34 removed the wander guard herself, the family member that gave her a ride was a high school classmate and R34 was never alone while away from the facility. The DON was unable to provide any written information regarding the investigation. On 7/10/15, at 11:30 a.m. the AD stated she believed R34 left around 4:00 p.m. with the classmate. The classmates's family called the facility when R34 arrived at the bar. The AD immediately went to the bar. The AD checked R34 for the wander guard and it was not on. The AD was able to get R34 into her car but when she attempted to put the seat belt on R34, R34 pushed her away and got out of the car. R34 and the AD walked to a local cafe. The social worker (SW) arrived at approximately 4:30 p.m. The SW called the police and R34 went willingly with the police officer and was returned to the facility. On 7/10/15, at 11:50 a.m. the SW stated she returned to the facility from the cafe at approximately 5:45 p.m. The SW stated the classmate entered the code to open the door in order to exit the facility with R34. The door alarm sounded because another resident with a wander guard on was sitting near the door. A new wander guard was placed on R34 upon returning to the facility. The SW stated she reported the elopement to the nurse on duty and the administrator on call.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 225	Continued From page 10	F 225		

On 7/10/15, at 12:40 p.m. the administrator on 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 AC's were able to start an investigation, answer questions and "actually act as my surrogate." If something needed to be reported to the SA all ACs have the ability to report allegations to the SA. The administrator stated she had instructions in a folder for the ACs to reference.

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.

On 7/9/15, at 10:45 a.m. the dietary manager (DM), verified the record did not contain evidence of reference checks. The DM stated she does

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 225	Continued From page 11 reference checks by notifying the last employer but does not document it anywhere. On 7/9/15, at 12:17 p.m. human resources (HR) stated there was not a system to ensure reference checks were done. It was the responsibility of the department supervisor to complete the reference checks. The HR did not have any systems in place to monitor the completion of reference checks. The facility's Abuse Prevention Policy revised 10/11, indicated prior to hiring the department head would request employment references from all potential employees. The department head would attempt to contact current and past employers to verify employment and request information about the potential employee's performance. All attempts and contacts would be documented on the job application.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an Abuse Prevention Policy that required immediate reporting to the administrator and State Agency (SA). The policy directed staff to thoroughly investigate allegations before reporting to the SA.	F 226	F226 The Abuse Prevention Policy, B-1, will be updated and enhanced to include a checklist. The revised policy will be reviewed and education will be provided to all employees by the Social Worker by	8/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 226	Continued From page 12 The facility failed to immediately report allegations of abuse/neglect/mistreatment to the SA and thoroughly investigate allegations for 4 of 9 residents (R37, R22, R7, R34) reviewed for abuse. In addition, the facility failed to ensure reference checks were completed for 2 of 2 newly hired dietary aides. (DA-A, DA-B). This deficient practice had the potential to effect all 29 residents in the facility. Findings include: The facility Abuse Prevention policy and procedure dated 10/11, indicated reports of alleged abuse, mistreatment, neglect, misappropriation of property or injuries of unknown origin would be promptly and thoroughly investigated. The administrator or the designee would be responsible for appointing an investigation team and conducting the investigation. At the conclusion of the investigation, a written report of the findings and the plan of correction would be prepared and filed with the appropriate agencies. However, the policy incorrectly directed staff to conduct an investigation of the allegation BEFORE any reports were made to the State agency. The policy also directed mandated reporters to immediately make an oral report to the county or report internally to the charge nurse, social worker, director of nursing (DON) or the administrator. For incidents after business hours the administrative person on call (AC) would be contacted. Internal reporting procedures directed the person receiving the report to immediately contact the administrator or the AC. Reporting to the administrator "immediately" shall mean "as soon as possible but no longer than 24 hours of	F 226	August 18, 2015. Reporting, investigation and follow up will be specifically reviewed. The Director of Nursing will review every submitted Clarity incident to determine if an event is reportable to the State Agency and that appropriate reports have been submitted. The Interdisciplinary Team (IDT) will review chart documentation and INTERACT documents for events that may be reportable to the State Agency and that appropriate reports have been submitted. Completion date of August 18, 2015. The Administrative Staff (Administrator, Director of Nursing ¿ Care Center, Director of Nursing ¿ Hospital and Director of Finance) will review all Clarity incident submissions at the weekly Monday Administrative Staff meetings. If the Staff meeting is cancelled for any reason, the Administrative Person On-Call will completed the review. In addition to a general review, the incidents will be reviewed to determine if they are reportable to the State Agency and verify that the reports have been completed as required. This review will be completed for one year. The Administrator will compile the monitor information and will submit the Report to Quality Improvement/Peer Review Committee on a monthly basis. The Dietary Manager will recheck the references of the two recently hired employees. A reference check documentation form has been developed and will be utilized for every new hire.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 226 Continued From page 13

the discovery of the incident." If the incident was reportable the administrator or the designee would report the incident to the county then to the SA. Both reports must be made "within 24 hours of discovery of the incident." The facility Abuse Prevention policy also lacked the definition of resident to resident altercation.

On 7/9/15, at 2:23 p.m. the DON verified the policy lacked the definition of resident to resident altercations. The DON stated the process for reporting an allegation of abuse was the nursing assistant (NA) was to report to the charge nurse, the charge nurse was then to report to the administrator, the social worker (SW) or the DON. If the allegation occurred after hours they were to contact the AC. The DON stated the staff appointed to be the AC were the DON, the DON in the hospital, the administrator and the financial director. Each of them take a week at a time. The DON described the AC as a designee who could go to the facility and find out "what's going on" if an allegation were to be identified. All ACs were trained on what incidents are reportable. The DON stated if an allegation was received "If it's a front line worker, bring them in, then send them home and ask them not to come in during the investigation." The DON further described the completion of internal interviews and the administrator files the report. If the administrator was not there, the DON stated she is able to report to the SA. The DON stated the alleged abuse should be reported within 24 hours following an investigation to determine if it was reportable.

On 7/09/15, at 2:51 p.m. the administrator verified the facility had not reported any allegations to the SA since the previous survey in 8/14. The

F 226

The Human Resources Coordinator will not complete the Offer letter to a new employee until all required documentation; including the references checks have been completed. The revised process will be reviewed at the Leadership Council meeting on August 11, 2015. Completion date of August 11, 2015.

The Human Resource Coordinator or her designee will review the employee files of all new employees at the end of each month to verify that documentation of reference checks is included in the file. This monitor will be completed monthly for six months and the information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis.

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¿s allegation of compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14 administrator stated the AC was able to start an investigation, answer questions and "actually act as my surrogate." If something needed to be reported to the SA the AC had the ability to report allegations to the SA. The administrator stated she had instructions in a folder for the AC to reference. The administrator verified the policy lacked the definition of resident to resident altercations. The administrator stated she determined if incidents were reportable based on the investigation. If the allegation met "the definition of reportable" it would be reportable. R37 alleged verbal abuse that was not reported or thoroughly investigated. The Minimum Data Set (MDS) admission assessment dated 5/31/15, indicated the resident was cognitively intact. There were no incident reports or investigations recorded from the time of admission through 7/8/15. Interview with R37 on 7/7/15, at 11:30 a.m. the resident indicated licensed practical nurse (LPN)-B had verbally abused him shortly after his admission to the facility. He indicated she had become "pissy" with him when he requested an evening snack. Further interview with R37 on 7/8/15, at 1:08 p.m. the resident indicated he asked for a snack, and LPN-B had told him the snacks were for everyone. He thought that implied he was eating more than his share and he shouldn't have them because of his diabetes. R37 stated he spoke with the DON about this event the following day, and has had no further concerns. Telephone interview with LPN-B on 7/8/15, at 2:31 p.m. indicated she recalled the event R37 reported. LPN-B stated she was following the	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ____ B. WING ____	07/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 15	F 226		

resident's care plan that said to encourage better food choices, decrease carbohydrates and promote self care. LPN-B "confronted" the resident about eating ice cream, and R37 said he was going to eat what he wanted and that was between him and his doctor. LPN-B told R37 she did not believe the doctor was aware of what he was eating, but she would notify him. The next morning when the LPN went into the resident's room, he alleged she had been verbally abusive to him during the night. LPN-B stated she immediately went to the DON and reported the allegation.

Interview with the DON on 7/9/15, at 9:30 a.m. identified she initially heard about the event from LPN-B. The LPN indicated she was attempting to discourage food choices, but the resident called it verbal abuse. She spoke with R37 who inferred the LPN had a "regimented attitude." The DON determined it was not verbal abuse and did not report the event to the administrator, State agency or complete a thorough investigation.

The Abuse Prevention Policy dated 10/11 identified mental abuse included humiliation and threats of punishment or deprivation. It further identified verbal abuse to include disparaging and derogatory terms.
R22 reported an allegation of verbal abuse by a staff member and it was not reported to the SA. According to the OBRA quarterly MDS dated 6/14/15, R22 was cognitively intact.

R22's nursing assistant care sheet indicated R22 could use the grab bar in bathroom to transfer independently, not able to use urinal reliably, and assist of one for perineal care and continent of bowel and bladder. Regarding behavior and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 226	Continued From page 16	F 226		

cognition, the care sheet indicated R22 was alert and oriented and could get anxious about falling during transfers. The care sheet indicated "provide encouragement and assure him you are here to help him."

According to a progress note on 5/12/15, R22 was very upset with a specific nursing assistant (NA-M) who provided cares. He did not want that NA to provide cares to him anymore. R22 reported the NAR said, "Wash your own damn ass." R22 reported that he nearly fell while wiping and that he was planning on turning her in. The facility removed NA-M from work until the event was thoroughly investigated.

According to investigation/documentation reports dated 5/13/15 and 5/14/15 by the DON, NA-C assisted R22 to the toilet shortly after lunch on 5/11/15. NA-M and NA-N answered R22's bathroom call light later to assist with personal cares after a bowel movement. In addition to the information in the progress note, R22 also felt he was not offered the proper supplies to assist with his care after toileting as the washcloth was not warm enough nor did it have enough peri-wash on it. R22 told the DON that he did not want NA-M providing him care anymore. R22 stated that he was scared and upset to the point he lost his appetite for the evening meal and music program because of this incident.

According to other investigation undated documentation provided by the facility with interviews dated 5/13/15 and 5/14/15 , the DON interviewed involved staff and co-workers. Based on information gathered in the investigation, the facility determined that NA-M did not swear at R22. On 5/21/15, NA-M was allowed back to work

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17 and R22 was informed that NA-M would no longer be providing care to him. In an interview on 7/10/15, at 10:44 a.m., the DON confirmed that the incident did get investigated, but was not reported to the SA. The DON also stated that the facility did inform the administrator right away, and did so in this incident. However, they may not always document when and who informed the administrator. In this case, it was "probably" the DON or the facility social worker (SW)-A. The DON stated that the process to notify the administrator is not formalized, but they "just know" they need to tell the administrator. Review of the facility's Healthcare Safety Zone Portal does not assist in determining if the administrator was notified or when. In the interview on 7/10/15, the DON explained the decision to not report the incident to the SA was based on differing stories from those interviewed (staff and resident) and R22 has a "tendency to embellish." R7 reported verbal abuse to the facility. The facility did not report the incident to the SA. According to the physician order sheet, R7 had diagnoses including persistent mental disorder, personality disorder, hemiplegia, depression and anxiety. An OBRA quarterly MDS dated 5/21/15, indicated R7 was cognitively intact. R7's vulnerability care plan dated 4/3/15, indicated she was vulnerable for abuse from others related to cerebral vascular accident (CVA), mental illness and the need to total assistance. Interventions directed staff to allow	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 18 time for decision making, attentive listening, and continue to encourage resident to interact with others, and to get out of her room. R7's mood care plan directed staff to encourage expression of feelings, establish a trusting relationship, listen attentively, use a calm reassuring approach, explain all procedures, acknowledge her feelings, provide reassurance and comfort, and encourage the use of relaxation techniques. R7's toileting care plan directed staff to check and change as needed every 2 to 2.5 hours while awake and during rounds at night. Staff were to use a Hoyer lift in bed to position R7 over bedpan and provide total assist of 1 to 2 staff for peri-cares. R7's quarterly MDS dated 5/21/15, indicated she was always incontinent of both bladder and bowel. According to an undated VA Report Social Worker Summary, NA-O and NA-N approached SW-A on 9/23/14, with concerns about statements R7 was making about NA-M. According to the report and a progress note dated 9/23/14, at 5:32 p.m. SW-A met with R7 who was "visually upset, sobbing, very tearful and initially unable to talk due to being upset." During this interview, R7 told SW-A when she is in the dining room and felt the need for a bowel movement, NA-M will tell her to go in her pants or wait. In addition, R7 reported having numerous bowel movements daily, NA-M would tell her "no one goes to the bathroom that many times a day." The report further identified R7 was concerned about NA-M finding out about the interview and being mad at her and causing her trouble. Handwritten notes from NA-O and NA-N were dated 9/25/14 and 9/24/15 respectively describing their knowledge og the incident.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 19	F 226		

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 cognitively impaired residents and redirect. R34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 20	F 226		

was to wear a wander guard (a device worn by the resident that secures the door and alerts staff when the resident gets near the door).

On 7/10/15, at 11:15 a.m. the DON verified the elopement was not reported. The DON stated R34 removed the wander guard herself, the family member that gave her a ride was a high school classmate and R34 was never alone while away from the facility. The DON was unable to provide any written information regarding the investigation.

On 7/10/15, at 11:30 a.m. the AD stated she believed R34 left around 4:00 p.m. with the classmate. The classmates's family called the facility when R34 arrived at the bar. The AD immediately went to the bar. The AD checked R34 for the wander guard and it was not on. The AD was able to get R34 into her car but when she attempted to put the seat belt on R34, R34 pushed her away and got out of the car. R34 and the AD walked to a local cafe. The SW-A arrived at approximately 4:30 p.m. The SW called the police and R34 went willingly with the police officer and was returned to the facility.

On 7/10/15, at 11:50 a.m. the SW-A stated she returned to the facility from the cafe at approximately 5:45 p.m.. SW-A stated the classmate entered the code to open the door in order to exit the facility with R34. The door alarm sounded because another resident with a wander guard on was sitting near the door. A new wander guard was placed on R34 upon returning to the facility. SW-A stated she reported the elopement to the nurse on duty and the administrator on call.

On 7/10/15, at 12:40 p.m. the administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ________ B. WING ________	07/10/2015

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

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F 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 reported to the SA all ACs have the ability to report allegations to the SA. 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. On 7/9/15, at 10:45 a.m. the dietary manager	F 226		

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	245384	A. BUILDING ______ B. WING ______	07/10/2015

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

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F 226	Continued From page 22 (DM), verified the record did not contain evidence of reference checks. The DM stated she does reference checks by notifying the last employer but does not document it anywhere. On 7/9/15, at 12:17 p.m. human resources (HR) stated there was not a system to ensure reference checks were done. It was the responsibility of the department supervisor to complete the reference checks. The HR did not have any systems in place to monitor the completion of reference checks. The facility's Abuse Prevention Policy revised 10/11, indicated prior to hiring the department head would request employment references from all potential employees. The department head would attempt to contact current and past employers to verify employment and request information about the potential employee's performance. All attempts and contacts would be documented on the job application. The facility Abuse Prevention Policy dated 10/11 failed to identify when resident to resident altercations would be considered abuse.	F 226		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		8/11/15

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COOK CO NORTHSHORE HOSP & C&NC	**515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604**

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F 315	Continued From page 23 function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a comprehensive bladder assessment that included risk benefit education for a resident entering the facility with a Foley catheter for 1 of 2 residents (R42) reviewed for urinary catheter use. Findings include: R42 was admitted to the facility on 6/23/15 for end of life care. The resident was admitted with an indwelling catheter in place. There was no medical diagnosis for the Foley catheter. A physicians note dated 7/8/15 indicated, "She has an indwelling Foley catheter to manage urine per her choice because she only has pain when trying to get up." A bladder assessment and risk benefit education related to the catheter use was requested from the director of nursing on 7/8/15. The Comprehensive Bladder Assessment dated 6/24/15 indicated the resident was continent of bladder, but had impaired mobility, history of falls and cancer. There was no evidence the resident or family had been explained the risks associated with an indwelling catheter or what the alternatives were. On 7/8/15 at 8:56 AM interview with licensed practical nurse (LPN)-C identified R42 was admitted with the indwelling catheter. LPN-C did not know why the catheter in place and stated	F 315	F315 R42 was admitted to the facility for end of life care on 06/23/15. On 07/08/15 she was seen by her PMD for routine rounds and his notes stated: ¿The patient remains on end of the life cares for metastatic lung cancer. She is too weak to ambulate, remains bed bound. She has an indwelling Foley catheter to mange urine per her choice because she only has pain when trying to get up. Continue with indwelling catheter to avoid the discomfort of transfer or using a bedpan.¿ On 07/23/15, her husband attended her care conference and he was presented with the risk/benefit education of an indwelling catheter. Resident passed away on July 24, 2015. Newly admitted residents with a Foley catheter in place and any other resident of the facility who may need a Foley catheter placed will have a comprehensive bladder assessment completed that will include a medical diagnosis and risk/benefit education. The document to gather this information will be revised to include a medical diagnosis and risk/benefit education. Completion date of August 11, 2015. The Comprehensive Bowel/bladder policy will be revised to include documentation of educating the resident on the risk/benefit	

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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".	F 315	of an indwelling catheter. The revisions to the policy will be reviewed with the RN Resident Care Managers. Completion date of August 11, 2015. The next five residents who may need a Foley catheter will be audited for evidence of a medical diagnosis and risk/benefit education. The information will be reported to Quality Improvement/Peer Review Committee on a monthly basis.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		7/29/15

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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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that clean linens and supplies were stored separately from soiled linens and waste in two soiled linen rooms. The facility also failed to ensure that housekeeping staff perform hand hygiene between soiled and clean tasks in the laundry. This had the potential to effect all 29 residents in the facility. Findings include: On 7/8/15, at 10:28 a.m., the Soiled Linen Room by the laundry area was observed to contain a red biohazard container, a bin of bagged garbage, a box of clean rugs, recycling containers, clean chair cushions, clean mop heads, containers of washer chemicals, clean curtains and a carpet cleaner machine. During an interview on 7/8/15 at 10:46 a.m. and in a follow-up interview on 7/9/15 at 8:17 a.m., housekeeper (H)-A confirmed that they have been storing the clean rugs and chair cushions in the same room as the garbage and the	F 441	On July 9, 2015, the Housekeeping/Laundry Supervisor made changes to the soiled utility room by removing anything that is considered dirty. The room was labeled at ¿Clean HSKP Storage¿. The Dirty Utility Rooms were inspected on July 28, 2015; any items considered ¿clean¿ were removed. Completion date of July 28, 2015. The Housekeeping/Laundry Supervisor or her designee will monitor the facility¿s Dirty Utility Rooms for ¿clean¿ items weekly for the next three months and the monthly for an additional three months. The information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis. Two Infection Control Classes were presented by the Hospital Director of Nursing/Infection Control Nurse, Bridget Sobieck. The classes were held on July 27, 2015 and July 29, 2015. All	

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F 441	Continued From page 26 hazardous waste. During observations on 7/8/15, at 10:46 a.m., and again on 7/9/15, at 8:17 a.m., the soiled utility room in the facility's blue hallway was observed to contain an open bin with bags of soiled linens, recycling containers, a commode, and a hopper. The shelves in the room contained cleaning supplies used by Activities, several buckets and commode/bucket lids, and containers of disinfectant that is used for bathtubs. During an interview on 7/8/15, at 10:46 a.m. H-A confirmed that this room is used to store bags of soiled linens and clothes and clean supplies including the containers of disinfectant that are used to clean bathtubs. On 7/8/15 at 10:28 a.m., H-B was observed to take a broom from the wall by the washing machines and sweep up lint from a boxed area under each facility dryer; this space was not on the floor, but an area surrounded by metal that held up the dryers. H-B then went to the garbage can and using bare hands, pulled the lint from the bottom of the broom into the garbage can. H-B then returned the broom to its wall holder and, without washing her hands or using hand sanitizer, pushed clean white laundry back into the dryer, shut the dryer and started the dryer cycle. During an interview with H-A and H-B on 7/9/15, at 8:17 a.m., H-A stated they do not have policy that addresses the policy of lint removal or washing hands after this task. H-B stated that she had not thought about the need for hand between these tasks. H-B stated she should have washed her hands between the tasks.	F 441	Housekeeping and Laundry staff were in attendance. Discussion included the importance of washing hands between touching dirty and clean linens and general infection control practices. Completion date of July 29, 2015. The Housekeeping/Laundry Supervisor or her designee will monitor each Housekeeping/Laundry employee regarding appropriate handwashing weekly for the next five weeks and then monthly for an additional five months. Depending upon the results of the monitor, additional monitoring may continue. The information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis.	

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

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F 465	Continued From page 27	F 465		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the ventilation hood above the stove in the kitchen was cleaned and free of grease and dust for the prevention of combustion. This had the potential to affect all 29 residents in the facility. Findings include: During a tour of the kitchen on 7/6/15, at 5:40 p.m. with the cook (C)-A, the left side of the oven/stove hood and the tops of the pipes/spigots above the left side of the stove had a covering of dust adhering to them. The side of the hood and the top of the pipe/spigot were greasy to touch. C-A stated it was a little greasy. C-A stated the back wall was cleaned weekly and the hood was cleaned monthly. During a tour of the kitchen on 7/8/15, at 11:15 a.m. with the dietary manager (DM), the left side of the oven/stove hood and the tops of the pipes/spigots above the left side of the stove continued to have the same covering of dust adhering to them. The DM stated the hood filters are cleaned quarterly and the wall behind the stove is cleaned weekly. There was no schedule for routine cleaning of the hood. The DM stated	F 465	F465 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 monthly for six months and quarterly thereafter. During the monitoring process if it is seen that the hood area including the pipes/spigots needs to be cleaned more frequently the policy will be changed and updated. The information will be reported to Quality Improvement/Peer Review Committee on a quarterly basis.	7/18/15

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F 465	Continued From page 28 they often cleaned it when the filters were cleaned. The DM verified the left side of the hood and the pipes/spigots over the left side of the stove were dusty and had grease on them. The DM stated she needed to talk to maintenance about developing a routine schedule for cleaning the hood. The facility policy and procedure for Cleaning of Exhaust Hoods and Filters dated 6/20/14, indicated the hood and ancillary spigots would be cleaned as needed. The policy and procedure directed the DM or assistant to email maintenance with a work order to clean the exhaust hood and ancillary spigots as needed. The policy indicated the dietary staff may also clean the area.	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F5384023

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/07/2015

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K 000	INITIAL COMMENTS 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	K 000		

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

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K 000	Continued From page 1 Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		