



Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered via email

September 18, 2025

Administrator  
North Shore Health  
515 5th Ave West  
Grand Marais, MN 55604

RE: Survey Results  
CCN: 241317  
Cycle Start Date: September 11, 2025

Dear Administrator:

On September 11, 2025, a survey was completed by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Critical Access Hospitals and Swing Beds.

We are pleased to inform you that this survey resulted in no deficiencies being issued. Attached is your copy of the Federal Form CMS-2567 indicating your compliance with the Federal regulations.

Thank you for your cooperation.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

September 18, 2025

Administrator  
North Shore Health  
515 5th Ave West  
Grand Marais, MN 55604

Re: Licensing Orders  
CCN: 241317  
Cycle Start Date: September 11, 2025

Dear Administrator:

On September 11, 2025, a survey was completed by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for Critical Access Hospitals. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the licensing requirements.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

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

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

PRINTED: 09/18/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>241317</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTH SHORE HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 5TH AVE WEST</b> <b>GRAND MARAIS, MN 55604</b>		
(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	
C 000	<p><b>INITIAL COMMENTS</b></p> <p>On 9/9/25, thru 9/11/25, a substantial allegation investigation was conducted at North Shore Health to investigate an alleged violation of Hospitals participating in Medicare, specifically the Condition of Participation 42 CFR 485.645 Swing Bed and Condition of Participation 42 CFR 485.635 Nursing Services. North Shore Health was found to be IN compliance.</p> <p>The following complaints were investigated: HZ3171186C (MN00114706) HZ3173961C (MN00108600)</p>	C 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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00080A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/11/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NORTH SHORE HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 5TH AVE WEST GRAND MARAIS, MN 55604</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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6 000	<p><b>INITIAL COMMENTS</b></p> <p>In accordance with MN State Statute 144.55 Subd 3., for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations. North Shore Health was surveyed on 9/9/25 thru 9/11/25, to determine compliance with Minnesota State Licensing Requirements. Your facility was found to be IN compliance. Please refer to CMS 2567.</p>	6 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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