Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 17, 2023

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

RE: CCN: 245483
Cycle Start Date: February 24, 2023

Dear Administrator:

On February 24, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 24, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 24, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	02/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/21/23 to 2/24/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H5483064C (MN00080768) and H5483063C (MN00083011), H54838584C (MN00085317), H54838583C (MN00086364), H54838582C (MN00086365), H54838581C (MN00086482), and H54838969C (MN00086527). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	F 585		3/31/23

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

Electronically Signed | 03/24/2023

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 585	Continued From page 1 furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is	F 585		

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F 585	Continued From page 2 responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'	F 585		

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F 585	Continued From page 3 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to document and follow up on missing clothing for 1 of 1 (R49) investigated for missing clothing. findings include: R49 admission Minimum Data Set (MDS) indicated R49 was cognitively intact. On 2/23/23, at 2:12 pm. the grievance log was reviewed from 2/23/23, to 1/1/23, and lacked a missing item report from R49. During an interview on 2/21/23, at 5:10 p.m. R49 stated a missing black nightgown was reported to certified occupational therapy assistant (COTA)-C around three weeks ago. COTA-C told me she went down to the laundry room and looked around for the nightgown and then filled out a form about the missing item. After that there was no follow up. During an interview on 2/24/23, at 9:04 a.m. COTA-C stated R49 had told her about a missing nightgown around three weeks ago. She stated she was not aware of the color. She went down to the laundry room and looked for the clothing item. There were no laundry staff down there at that time to assist with looking. She then went to the social services designee (SSD)-A and asked for a missing item form. She then went back to R49's	F 585	F585 Grievances Immediate Corrective Action: A Lost/Missing Item form was filled out for R49. R49's nightgown was replaced. Corrective Action as it applies to others: The facility Lost, Missing, and Damaged Items Policy was reviewed and remains current. All residents were reviewed to ensure that no one is missing any personal items. Education will be provided to all staff regarding the Lost, Missing, and Damaged Items Policy specifically focusing on the process of filling out a grievance form for any resident/representative report of missing personal items. Date of Compliance: 3/31/2023 Recurrence will be prevented by: 5 residents will be interviewed weekly x4 weeks, and monthly x2 months to ensure that a grievance form was filled out if they are missing any personal items. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by:	

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F 585	Continued From page 4 room, wrote down information and returned it to SSD-A. During an interview on 2/24/23, at 9:33 a.m. SSD-A stated COTA-C had asked for a missing item form but never brought it back. She had not been told who the form was for. She stated she did not follow up with COTA-C about the form COTA-C had requested but should have. SSD-A stated she had not followed up with COTA-C to get the missing item form and follow up with resident. During an interview on 2/24/23, at 2:18 p.m. the administrator stated an expectation when staff found out a resident item was missing they would fill out a missing item form and report to SSD-A and administrator so it can be looked for. Facility policy Lost, Missing and Damaged Items last reviewed 5/17, indicated a grievance form would be completed. The facility employee who received the grievance was responsible to fill out the grievance form The grievance form would be returned to the social services office or administrator's office.	F 585	Administrator or Designee	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		3/31/23

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F 636	Continued From page 5 assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes	F 636		

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F 636	Continued From page 6 prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set(s) (MDS) assessments were completed for 1 of 22 residents (R1) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. "The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being."	F 636	F636 Comprehensive Assessments Immediate Corrective Action: Social Services Designee was immediately educated on need to fill out designated sections of MDS timely. Corrective Action as it applies to others: The Resident Assessment Instrument Policy was reviewed and remains current. All residents' MDS assessments will be reviewed from last 30 days to ensure that all sections are filled out completely. Education will be completed with all leadership that complete MDS sections regarding the Resident Assessment Instrument Policy with specific regards to completing entire section timely and completely. Date of Compliance: 3/31/2023 Recurrence will be prevented by: 5 resident MDS assessments will be reviewed weekly x4 weeks, and monthly	

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F 636	Continued From page 7 Further, the manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section C: Cognitive Patterns, Intent: "The items in this section are intended to determine the resident' attention, orientation and ability to register and recall new information. These items are crucial factors in many care planning decisions." Section D: Mood, Intent: "The items in this section address mood distress, a serious condition that is undiagnosed and untreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable." Section Q: Participation in assessment and goal setting, Intent: "The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals." R1's quarterly MDS dated 11/30/23, indicated diagnoses which included anemia, hypertension, Diabetes Mellitus, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), anxiety, depression, schizophrenia, post traumatic stress disorder, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). R1's quarterly MDS dated 11/30/23, for sections C0100-C0300 were all blank, section C0500 had a dash (no information). For section D0100 it was	F 636	x2 months to ensure that all sections have been completed timely and completely. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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F 636	Continued From page 8 blank, for sections D0200-D0600 dashes (no information was filled in). For sections F and Q all blank, no information. During an interview on 2/24/23, at 11:24 a.m. the director of nursing (DON) stated she would expect an MDS to be fill out completely as it drives the resident's care. During an interview on 2/24/23, at 11:57 a.m. RN-B reviewed R1's quarterly MDS dated 11/30/23, and verified sections C, D, Q were not assessed. RN-B stated social services typically filled out those sections. RN-B verified she was responsible to ensure completeness of the MDS and to submit the completed MDS. RN-B verified it was important to have the MDS filled out completely as it drives the residents cares. During an interview on 2/24/23, at 12:08 p.m. social service designee (SSD)-A verified sections C, D, Q, were not completed/assessed. SSD-A stated it would be important to complete those sections as it would identify a possible decline and the provider could be involved in making any needed changes. The facility policy titled Resident Assessment dated 11/2019, indicated the resident assessment coordinator was responsible for ensuring the interdisciplinary team conducted timely and appropriate reviews according to the requirements by CMS.	F 636		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		3/31/23

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F 677	Continued From page 9 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist with transfers who required assistance from staff for 1 of 1 (R170) resident reviewed for activities of daily living (ADL). Findings included R170's admission Minimum Data Set (MDS) assessment dated 2/20/23, indicated R170 was cognitively intact and was totally dependent on staff to transfer from bed to chair and needed the use of mechanical assistance device. R170's care plan dated 2/21/23, indicated an alteration in mobility and required assistance of two staff and mechanical lift when transferred out of bed. R170's care guide dated 2/23/23, indicated staff were to offer to get R170 up for meals and to document refusals under behaviors. During an interview on 2/21/23, at 4:16 p.m. R170 stated she would like to get out of bed and into the chair more but staff would not offer to assist her up, and she was unable to do it independently. During an observation on 2/22/23, at 11:16 a.m. nurse assistant (NA)-A entered R170's room to perform morning cares. A bed bath was performed along with linen change. NA-A elevated the head of bed up to a 90-degree angle and placed the bedside table across R170's lap to	F 677	F677 ADL Care Immediate Corrective Action: R170's care plan was updated to reflect preference to get up for meals. Corrective Action as it applies to others: The ADL Policy was reviewed and remains current. All dependent residents were reviewed regarding preferences on whether they want to get up for dining. Care plans will be updated to reflect this preference. Education will be completed with all nurses, TMAs, and CNAs on the ADL Policy with regards to offering to get all residents up for meals especially if it is per their identified preference and to notify nurse for any refusals so that refusals can be documented. Date of Compliance: 3/31/2023 Recurrence will be prevented by: 5 dependent residents will be reviewed weekly x4 weeks, and monthly x2 months to ensure that they are offered to get up for meals per their preference/request. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by:	

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	245483	A. BUILDING _____ B. WING _____	02/24/2023

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F 677	Continued From page 10 prepare for lunch. NA-A asked R170 if anything else was needed and then left the room. NA-A did not offer to get R170 into the chair for lunch. During an interview on 2/22/23, at 11:38 a.m. NA-A stated she did not offer to assist R170 into the chair but should have. She did not think about the offer to get out of bed. NA-A confirmed R170 was dependent on staff to get out of bed and into the chair for meals. During an interview on 2/22/23, certified occupational therapy assistant (COTA)-C stated therapy wanted R170 up into the chair for each meal. This was reported to staff and R170 a second time on 2/21/23, when the care conference occurred. COTA-C stated the nurse manager was in the meeting. Staff had not reported to therapy R170 had refused to get out of bed for meals. During observation on 2/23/23, at 8:12 a.m. NA-A entered R170's room with the breakfast tray. Tray was placed on the over bed table; head of bed was elevated to 90 degrees and over bed table placed in front of resident. NA-A asked if R170 needed anything else and then left room without an offer to get in chair for breakfast. During an interview on 2/24/23, at 12:38 p.m. the director of nursing (DON) stated an expectation staff would offer to get residents out of bed for meals per therapy recommendations and would document any resident refusals. If resident had a history of refusals the staff would still offer to get up with each meal. Facility policy Refusal of cares/Interventions, Risk and Benefits dated 9/11, indicated residents	F 677	Director of Nursing or Designee	

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F 677	Continued From page 11 would be informed of necessary cares, interventions and services that would include information related to risks and benefits. If refused, the refusal would be documented. A facility policy regarding therapy recommendations was requested but not received.	F 677		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility failed to ensure food stored in the facility kitchen and in the unit fridges was properly dated and discarded when expired. In addition, the facility failed to ensure food was stored under sanitary conditions in the unit fridges and kitchen storage areas were maintained in a sanitary manner. This deficient practice had the potential	F 812	F812 Food Procurement/Storage Immediate Corrective Action: The expired cereal was disposed of. All food/beverages in 1st and 2nd floor kitchen fridges were gone through and all items that were open and non-dated or	3/31/23

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F 812	Continued From page 12 to impact all residents who received food and drink in the facility. On 2/21/23, at 12:00 p.m. the facility had four large bins of cereal stored in the kitchen beverage and steam table area. The labels on the containers were: Flakes Open: 1/15 Expire 2/15/23; rice crispies open: 2/17/23 no expired date filled in; corn flakes: 1/15/23 expire 2/15/23; second Corn flakes open 1/15/23 expire 2/15/23. Culinary aide (CA)-A confirmed the dates on the container labels and stated the cereal was expired and should have been thrown away on 2/15/23. On 2/21/23, 12:17 p.m. the culinary Director (CD) stated the cereal bins should be labeled with a sticker containing the open date and date of expiration. CD stated the cereal was expired and instructed a nearby cook to immediately throw the expired cereal away. On 2/21/23, at 12:40 p.m. the second-floor kitchen fridge contained facility and resident food. The top fridge shelf had an unlabeled/undated box lunch from Ebert and Gerberts. The top shelf also had seven sandwich halves in plastic sandwich bags dated 2/19. The sandwiches were sitting on top of a large red sticky spot on the shelf surface. Behind pitchers of red and yellow beverage, in the very back of the top shelf, there were several undated/unlabeled facility containers of fruit bits. The top shelf surface had several additional areas with dried substances and food debris. The second shelf had a metal bin that held one yogurt and two unlabeled/undated sandwiches in baggies. The metal bin was visibly wet inside with a clear water like substance.	F 812	expired were disposed of. Fridges were deep cleaned. Kitchen was deep cleaned and all food/beverage items were gone through and all items that were open and non-dated or expired were disposed of. Corrective Action as it applies to others: The Food Receiving and Storage Policy was reviewed and remains current. All food/beverages in 1st and 2nd floor kitchen fridges were gone through and all items that were open and non-dated or expired were disposed of. Fridges were deep cleaned. Kitchen was deep cleaned and all food/beverage items were gone through and all items that were open and non-dated or expired were disposed of. Education will be completed with all staff on the Food Receiving and Storage Policy with regards to not keeping staff food in kitchen fridges, dating any open containers, dating/labeling any resident leftovers, and disposing of expired foods/open food or beverage items if discovered. Education will be completed with all culinary staff on the Food Receiving and Storage Policy with regards to keeping kitchen utensils, surfaces, and floors clean and sanitized and ensuring that all food/beverage items are dated when opened and disposed of when expired. Date of Compliance: 3/31/2023 Recurrence will be prevented by:	

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F 812	Continued From page 13 The left bottom drawer contained apples in an unlabeled/undated bag. The fridge door compartments held dated and labeled resident food. The bottoms and sides of the door compartments had dried clear, brown, and red substances on them. The freezer was full, and food was labeled and dated. On 2/21/23, at 12:59 p.m. at the second-floor fridge, nursing assistant (NA)-A stated none of the sandwiches are dated so they need to be thrown out, we can't give these to the residents without knowing the expiration date. On 02/21/23, at 12:50 p.m. the first-floor fridge contained resident, and facility provided food. The top shelf contained an undated/unlabeled bag with six individual unlabeled/undated bagged sandwich halves. The top shelf had dried clear substances on the surface, and the front surface area of the shelf was visibly wet with a clear sticky substance. The bottom shelf had a moist pink gelatinous substance approximately the size of two tablespoons sitting on the front left edge of the shelf. The surface area of the corner of the shelf was visibly wet and the color from the gelatinous substance was bleeding into the clear liquid. The top shelf had a large dark pink/red area of a dried substance. The top side door shelf contained an unlabeled/undated zip lock bag of salami and cheese. The second door compartment contained an unlabeled/undated grinch peppermint mocha coffee creamer. The fridge side compartment bottoms and sides had several areas that had spots or lines of a sticky dried clear pink substance. The fridge drawers contained multiple small sized unlabeled/undated containers of shredded cheese, an undated/unlabeled plastic container of	F 812	Common area refrigerators will be audited weekly x4 weeks and monthly x2 months to identify open food/beverage items are getting labeled/dated, expired foods are being disposed of, and that fridges are clean. Kitchen area will be audited weekly x 4 weeks, and monthly x 2 months to ensure kitchen utensils, surfaces, and floors are cleaned and sanitized and to ensure that all food/beverage items are dated when opened and disposed of when expired. Corrections will be monitored by: Culinary Director or Designee	

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F 812	Continued From page 14 food and an unlabeled/undated bag of apples. On 2/22/23, at 11:37 a.m. the second-floor fridge had a undated/unlabeled blue cloth lunch bag on bottom shelf of fridge. The shelves and side compartment surface areas of the fridge had been cleaned. On 2/23/23, at 7:11 a.m. the blue cloth lunch bag was in the second-floor unit fridge on the second shelf. On 2/23/23, at 11:59 a.m. registered nurse (RN)-B stated staff lunches should not be in the fridge, and if the bag belonged to a resident, the lunch bag should be dated and labeled. On 2/23/23, at 2:54 p.m. RN-B stated the lunch bag belonged to a staff member who had since been educated on the policy that staff food items could not be stored in the unit fridges. RN stated the inside of the fridge was wiped down after the bag was removed. 2/24/23, at 10:49 a.m. it was noted the first-floor fridge surface areas had been cleaned; however, the top glass shelf had beverage pitchers on it and the shelf was wet with a clear liquid. The fridge had a bin with two sandwich halves labeled 2/21/23, expire 2/23/23, and one unlabeled/undated brownie in a baggie in it. RN-A stated per policy the unlabeled brownie and the expired sandwiches needed to be thrown away. On 2/24/23, at 10:54 a.m. the second-floor freezer bottom was exposed. The bottom of the freezer was covered with food debris. There were also some partial and one full patient label stuck to the bottom of the freezer compartment. The	F 812		

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F 812	Continued From page 15 exposed side shelves were empty and had spots with food debris. On 2/23/23, at 8:38 a.m. the storage area under the prep table across from the main oven was found to have food residue on the bottom shelves and in the door track where the clean pots and pans were stored. In the open area to the right two large flower bins were on a wheeled cart. The cart surface area was covered in white and brownish debris. The flour lids were covered with white and flecks of brown debris. To the right of flour, the fronts of the table drawers were covered in spatters and streaks of dried debris. The food prep surface and insides of the drawers were clean. On 2/23/23, at 11:17 a.m. the CD confirmed one of the flour bins was not properly labeled with an open and expiration date and directed a team member to address immediately. The CD stated the pan storage area, flour cart and flour container lids, and the front of the drawers should be sanitized, clean, and free of any kind of debris, and indicated the items would get properly sanitized before the end of the day. The CD stated in the six weeks she had been in her role; she had started to have a staff member come in three days a week to catch up on surface cleaning. In addition, she was working on a daily cleaning and staff task schedule for the facility. The CD stated when she was informed of the poor state of the unit fridges, a staff member was sent to sanitize them right away. Everything was pulled out of the fridges and cleaned. The unit fridges are harder to keep up, but they will be on the daily cleaning schedule to ensure they are properly maintained. The dietary aids are responsible for cleaning the fridges, removing	F 812		

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F 812	Continued From page 16 outdated food, and ensuring food is labeled and dated. Culinary staff are responsible for managing food dates and cleaning in the kitchen areas. All food should be labeled per policy. Facility food should be dated when placed in the fridge/storage areas and removed when expired. Education on food storage and dating has been provided to the aide that stocked the fridge with undated sandwiches. On 2/24/23, at 10:29 a.m. the second-floor fridge had two sandwiches dated 2/21/23 with an expiration date of 2/23/23, one day past expiration. On 2/24/23, at 11:05 a.m. RN-B stated the second-floor unit freezer was not clean and sanitized to facility policy standards for resident food storage. RN-B also confirmed sandwich halves in the fridge were expired and needed to be throw away. RN-B indicated the dietary aids are responsible for sanitizing the fridges, ensuring that food is properly labeled and throwing away food that has expired. The resident food storage policy identified requirement for all food to be stored under sanitary conditions. The new daily cleaning scheduled instructed staff to perform surface cleaning and equipment cleaning daily. In addition, it addressed fridge and freezer cleaning daily. The schedule also included checking left over food for dates and ensuring disposal after three days or the expiration date of products in storage.	F 812		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 17, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 3GB011

Dear Administrator:

The above facility was surveyed on February 21, 2023 through February 24, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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	00593	A. BUILDING: _____ B. WING _____	C 02/24/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/21/23 to 2/24/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0540, 0920, 1015.	2 000		

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2 000	Continued From page 1 Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status;	2 540		3/31/23

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	00593	A. BUILDING: _____ B. WING _____	C 02/24/2023

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

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2 540	Continued From page 3 M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set(s) (MDS) assessments were completed for 1 of 22 residents (R1) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. "The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being." Further, the manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section C: Cognitive Patterns, Intent: "The items in this section are intended to determine the resident' attention, orientation and ability to register and recall new information. These items	2 540	Corrected	

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2 540	Continued From page 4 are crucial factors in many care planning decisions." Section D: Mood, Intent: "The items in this section address mood distress, a serious condition that is undiagnosed and untreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable." Section Q: Participation in assessment and goal setting, Intent: "The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals." R1's quarterly MDS dated 11/30/23, indicated diagnoses which included anemia, hypertension, Diabetes Mellitus, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), anxiety, depression, schizophrenia, post traumatic stress disorder, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). R1's quarterly MDS dated 11/30/23, for sections C0100-C0300 were all blank, section C0500 had a dash (no information). For section D0100 it was blank, for sections D0200-D0600 dashes (no information was filled in). For sections F and Q all blank, no information. During an interview on 2/24/23, at 11:24 a.m. the director of nursing (DON) stated she would expect an MDS to be fill out completely as it drives the resident's care.	2 540		

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2 540	Continued From page 5 During an interview on 2/24/23, at 11:57 a.m. RN-B reviewed R1's quarterly MDS dated 11/30/23, and verified sections C, D, Q were not assessed. RN-B stated social services typically filled out those sections. RN-B verified she was responsible to ensure completeness of the MDS and to submit the completed MDS. RN-B verified it was important to have the MDS filled out completely as it drives the residents cares. During an interview on 2/24/23, at 12:08 p.m. social service designee (SSD)-A verified sections C, D, Q, were not completed/assessed. SSD-A stated it would be important to complete those sections as it would identify a possible decline and the provider could be involved in making any needed changes. The facility policy titled Resident Assessment dated 11/2019, indicated the resident assessment coordinator was responsible for ensuring the interdisciplinary team conducted timely and appropriate reviews according to the requirements by CMS. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding completion of an individualized comprehensive resident assessment including care area assessments for admission, annual and significant changes. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 540		

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2 540	Continued From page 6 (21) days.	2 540		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist with transfers who required assistance from staff for 1 of 1 (R170) resident reviewed for activities of daily living (ADL). Findings included R170's admission Minimum Data Set (MDS) assessment dated 2/20/23, indicated R170 was cognitively intact and was totally dependent on staff to transfer from bed to chair and needed the use of mechanical assistance device. R170's care plan dated 2/21/23, indicated an alteration in mobility and required assistance of two staff and mechanical lift when transferred out of bed. R170's care guide dated 2/23/23, indicated staff were to offer to get R170 up for meals and to document refusals under behaviors. During an interview on 2/21/23, at 4:16 p.m. R170	2 920	Correct	3/31/23

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2 920	Continued From page 7 stated she would like to get out of bed and into the chair more but staff would not offer to assist her up, and she was unable to do it independently. During an observation on 2/22/23, at 11:16 a.m. nurse assistant (NA)-A entered R170's room to perform morning cares. A bed bath was performed along with linen change. NA-A elevated the head of bed up to a 90-degree angle and placed the bedside table across R170's lap to prepare for lunch. NA-A asked R170 if anything else was needed and then left the room. NA-A did not offer to get R170 into the chair for lunch. During an interview on 2/22/23, at 11:38 a.m. NA-A stated she did not offer to assist R170 into the chair but should have. She did not think about the offer to get out of bed. NA-A confirmed R170 was dependent on staff to get out of bed and into the chair for meals. During an interview on 2/22/23, certified occupational therapy assistant (COTA)-C stated therapy wanted R170 up into the chair for each meal. This was reported to staff and R170 a second time on 2/21/23, when the care conference occurred. COTA-C stated the nurse manager was in the meeting. Staff had not reported to therapy R170 had refused to get out of bed for meals. During observation on 2/23/23, at 8:12 a.m. NA-A entered R170's room with the breakfast tray. Tray was placed on the over bed table; head of bed was elevated to 90 degrees and over bed table placed in front of resident. NA-A asked if R170 needed anything else and then left room without an offer to get in chair for breakfast.	2 920		

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2 920	Continued From page 8 During an interview on 2/24/23, at 12:38 p.m. the director of nursing (DON) stated an expectation staff would offer to get residents out of bed for meals per therapy recommendations and would document any resident refusals. If resident had a history of refusals the staff would still offer to get up with each meal. Facility policy Refusal of cares/Interventions, Risk and Benefits dated 9/11, indicated residents would be informed of necessary cares, interventions and services that would include information related to risks and benefits. If refused, the refusal would be documented. A facility policy regarding therapy recommendations was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents personal preferences with activities of daily living are met. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in	21015		3/31/23

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21015	Continued From page 9 the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: The facility failed to ensure food stored in the facility kitchen and in the unit fridges was properly dated and discarded when expired. In addition, the facility failed to ensure food was stored under sanitary conditions in the unit fridges and kitchen storage areas were maintained in a sanitary manner. This deficient practice had the potential to impact all residents who received food and drink in the facility. On 2/21/23, at 12:00 p.m. the facility had four large bins of cereal stored in the kitchen beverage and steam table area. The labels on the containers were: Flakes Open: 1/15 Expire 2/15/23; rice crispies open: 2/17/23 no expired date filled in; corn flakes: 1/15/23 expire 2/15/23; second Corn flakes open 1/15/23 expire 2/15/23. Culinary aide (CA)-A confirmed the dates on the container labels and stated the cereal was expired and should have been thrown away on 2/15/23. On 2/21/23, 12:17 p.m. the culinary Director (CD) stated the cereal bins should be labeled with a sticker containing the open date and date of expiration. CD stated the cereal was expired and instructed a nearby cook to immediately throw the expired cereal away. On 2/21/23, at 12:40 p.m. the second-floor kitchen fridge contained facility and resident food. The top fridge shelf had an unlabeled/undated box lunch from Ebert and Gerberts. The top shelf also had seven sandwich halves in plastic	21015	Corrected	

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21015	Continued From page 10 sandwich bags dated 2/19. The sandwiches were sitting on top of a large red sticky spot on the shelf surface. Behind pitchers of red and yellow beverage, in the very back of the top shelf, there were several undated/unlabeled facility containers of fruit bits. The top shelf surface had several additional areas with dried substances and food debris. The second shelf had a metal bin that held one yogurt and two unlabeled/undated sandwiches in baggies. The metal bin was visibly wet inside with a clear water like substance. The left bottom drawer contained apples in an unlabeled/undated bag. The fridge door compartments held dated and labeled resident food. The bottoms and sides of the door compartments had dried clear, brown, and red substances on them. The freezer was full, and food was labeled and dated. On 2/21/23, at 12:59 p.m. at the second-floor fridge, nursing assistant (NA)-A stated none of the sandwiches are dated so they need to be thrown out, we can't give these to the residents without knowing the expiration date. On 02/21/23, at 12:50 p.m. the first-floor fridge contained resident, and facility provided food. The top shelf contained an undated/unlabeled bag with six individual unlabeled/undated bagged sandwich halves. The top shelf had dried clear substances on the surface, and the front surface area of the shelf was visibly wet with a clear sticky substance. The bottom shelf had a moist pink gelatinous substance approximately the size of two tablespoons sitting on the front left edge of the shelf. The surface area of the corner of the shelf was visibly wet and the color from the gelatinous substance was bleeding into the clear liquid. The top shelf had a large dark pink/red	21015		

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21015	Continued From page 11 area of a dried substance. The top side door shelf contained an unlabeled/undated zip lock bag of salami and cheese. The second door compartment contained an unlabeled/undated grinch peppermint mocha coffee creamer. The fridge side compartment bottoms and sides had several areas that had spots or lines of a sticky dried clear pink substance. The fridge drawers contained multiple small sized unlabeled/undated containers of shredded cheese, an undated/unlabeled plastic container of food and an unlabeled/undated bag of apples. On 2/22/23, at 11:37 a.m. the second-floor fridge had a undated/unlabeled blue cloth lunch bag on bottom shelf of fridge. The shelves and side compartment surface areas of the fridge had been cleaned. On 2/23/23, at 7:11 a.m. the blue cloth lunch bag was in the second-floor unit fridge on the second shelf. On 2/23/23, at 11:59 a.m. registered nurse (RN)-B stated staff lunches should not be in the fridge, and if the bag belonged to a resident, the lunch bag should be dated and labeled. On 2/23/23, at 2:54 p.m. RN-B stated the lunch bag belonged to a staff member who had since been educated on the policy that staff food items could not be stored in the unit fridges. RN stated the inside of the fridge was wiped down after the bag was removed. 2/24/23, at 10:49 a.m. it was noted the first-floor fridge surface areas had been cleaned; however, the top glass shelf had beverage pitchers on it and the shelf was wet with a clear liquid. The fridge had a bin with two sandwich halves labeled	21015		

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21015	Continued From page 12 2/21/23, expire 2/23/23, and one unlabeled/undated brownie in a baggie in it. RN-A stated per policy the unlabeled brownie and the expired sandwiches needed to be thrown away. On 2/24/23, at 10:54 a.m. the second-floor freezer bottom was exposed. The bottom of the freezer was covered with food debris. There were also some partial and one full patient label stuck to the bottom of the freezer compartment. The exposed side shelves were empty and had spots with food debris. On 2/23/23, at 8:38 a.m. the storage area under the prep table across from the main oven was found to have food residue on the bottom shelves and in the door track where the clean pots and pans were stored. In the open area to the right two large flower bins were on a wheeled cart. The cart surface area was covered in white and brownish debris. The flour lids were covered with white and flecks of brown debris. To the right of flour, the fronts of the table drawers were covered in spatters and streaks of dried debris. The food prep surface and insides of the drawers were clean. On 2/23/23, at 11:17 a.m. the CD confirmed one of the flour bins was not properly labeled with an open and expiration date and directed a team member to address immediately. The CD stated the pan storage area, flour cart and flour container lids, and the front of the drawers should be sanitized, clean, and free of any kind of debris, and indicated the items would get properly sanitized before the end of the day. The CD stated in the six weeks she had been in her role; she had started to have a staff member come in three days a week to catch up on surface cleaning. In addition, she was working on a daily	21015		

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21015	Continued From page 13 cleaning and staff task schedule for the facility. The CD stated when she was informed of the poor state of the unit fridges, a staff member was sent to sanitize them right away. Everything was pulled out of the fridges and cleaned. The unit fridges are harder to keep up, but they will be on the daily cleaning schedule to ensure they are properly maintained. The dietary aids are responsible for cleaning the fridges, removing outdated food, and ensuring food is labeled and dated. Culinary staff are responsible for managing food dates and cleaning in the kitchen areas. All food should be labeled per policy. Facility food should be dated when placed in the fridge/storage areas and removed when expired. Education on food storage and dating has been provided to the aide that stocked the fridge with undated sandwiches. On 2/24/23, at 10:29 a.m. the second-floor fridge had two sandwiches dated 2/21/23 with an expiration date of 2/23/23, one day past expiration. On 2/24/23, at 11:05 a.m. RN-B stated the second-floor unit freezer was not clean and sanitized to facility policy standards for resident food storage. RN-B also confirmed sandwich halves in the fridge were expired and needed to be throw away. RN-B indicated the dietary aids are responsible for sanitizing the fridges, ensuring that food is properly labeled and throwing away food that has expired. The resident food storage policy identified requirement for all food to be stored under sanitary conditions. The new daily cleaning scheduled instructed staff	21015		

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21015	Continued From page 14 to perform surface cleaning and equipment cleaning daily. In addition, it addressed fridge and freezer cleaning daily. The schedule also included checking left over food for dates and ensuring disposal after three days or the expiration date of products in storage. SUGGESTED METHOD OF CORRECTION: The registered dietician, or the administrator could review policies and educate staff in kitchen of proper cleaning techniques and monitoring of equipment. And follow up with competencies. Then audit for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days	21015		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.	21880		3/31/23

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21880	Continued From page 15 Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to document and follow up on missing clothing for 1 of 1 (R49) investigated for missing clothing. findings include: R49 admission Minimum Data Set (MDS) indicated R49 was cognitively intact. On 2/23/23, at 2:12 pm. the grievance log was	21880	Corrected	

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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
21880	Continued From page 16 reviewed from 2/23/23, to 1/1/23, and lacked a missing item report from R49. During an interview on 2/21/23, at 5:10 p.m. R49 stated a missing black nightgown was reported to certified occupational therapy assistant (COTA)-C around three weeks ago. COTA-C told me she went down to the laundry room and looked around for the nightgown and then filled out a form about the missing item. After that there was no follow up. During an interview on 2/24/23, at 9:04 a.m. COTA-C stated R49 had told her about a missing nightgown around three weeks ago. She stated she was not aware of the color. She went down to the laundry room and looked for the clothing item. There were no laundry staff down there at that time to assist with looking. She then went to the social services designee (SSD)-A and asked for a missing item form. She then went back to R49's room, wrote down information and returned it to SSD-A. During an interview on 2/24/23, at 9:33 a.m. SSD-A stated COTA-C had asked for a missing item form but never brought it back. She had not been told who the form was for. She stated she did not follow up with COTA-C about the form COTA-C had requested but should have. SSD-A stated she had not followed up with COTA-C to get the missing item form and follow up with resident. During an interview on 2/24/23, at 2:18 p.m. the administrator stated an expectation when staff found out a resident item was missing they would fill out a missing item form and report to SSD-A and administrator so it can be looked for.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21880	Continued From page 17 Facility policy Lost, Missing and Damaged Items last reviewed 5/17, indicated a grievance form would be completed. The facility employee who received the grievance was responsible to fill out the grievance form The grievance form would be returned to the social services office or administrator's office. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff on forwarding resident and/or family stated concerns to mangement for review. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/23/2023. At the time of this survey, The Northshore Estates was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2023**

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2023**

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

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K 000	Continued From page 2 also have a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The two resident sleeping floors are each divided into three separate smoke compartments. The facility has a capacity of 70 beds and had a census of 68 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.	K 541		3/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2023**

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K 541	Continued From page 3 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. On 02/23/2023, it was revealed by observation that the laundry chute door located on the second floor was missing the self-closer. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	K541 – Rubbish Chutes, Incinerators and Laundry Chutes The self-closer to the laundry chute door was installed. There were no other chutes without a self-closer installed. In order to protect all residents, the maintenance director or designee will audit the chute(s) weekly for 4 weeks and monthly for two months to ensure the self-closer is properly installed. Date of Compliance: 3/23/2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2023

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

RE: CCN: 245483
Cycle Start Date: February 24, 2023

Dear Administrator:

On March 17, 2023, we notified you a remedy was imposed. On April 13, 2023 the Minnesota Department(s) of Health and on June 2, 2023 Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 24, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 17, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 18, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.
Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 29, 2023

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

Re: Reinspection Results
Event ID: 3GB012

Dear Administrator:

On April 13, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 24, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File