DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 12, 2021

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

RE: CCN: 245483
Cycle Start Date: June 4, 2021

Dear Administrator:

On June 11, 2021, we notified you a remedy was imposed. On June 24, 2021 the Minnesota Department of Health 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 June 17, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 26, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 11, 2021, 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 June 26, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 17, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Electronically delivered

July 12, 2021

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

Re: Reinspection Results
Event ID: Z1M212

Dear Administrator:

On June 24, 2021 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 June 24, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
June 11, 2021

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

RE: CCN: 245483
Cycle Start Date: June 4, 2021

Dear Administrator:

On June 4, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 4, 2021, the situation of immediate jeopardy to potential health and safety cited at F 880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 26, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 26, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 26, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 4, 2021. This prohibition is not subject to appeal. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 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 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 December 4, 2021 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245483	A. BUILDING _____ B. WING _____	C 06/04/2021

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 6/2/21, through 6/4/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety (F880). The IJ began on 5/25/21, when the failed to ensure staff were wearing N95s when caring for residents with COVID-19 or those under quarantine. The director of nursing (DON) and administrator were notified of the IJ on 6/3/21, 5:05 p.m. The IJ was removed on 6/4/21, at 2:30 p.m. The following complaint was SUBSTANTIATED, however no deficiencies were cited due to actions taken by the facility. H5483053C (MN73125) The following complaints wwere found to be UNSUBSTANTIATED: H5483054C (MN73359) H5483055C (MN73304) . 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 06/19/2021

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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		6/17/21

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F 880	Continued From page 2 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) for 4 of 4 residents (R1, R2, R3, and R4) reviewed for infection	F 880	• R1 was COVID positive. Please note, as of 6/3/2021, it had been 10 days since R1 tested positive for Covid-19. R1 was assessed and was determined to be clear of any signs and symptoms. Precautions were removed from R1 as of 6/4/2021. R2, R3, and R4 have all been removed	

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F 880	Continued From page 3 control practices. This resulted in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19. The IJ began on 5/25/21, when the facility failed to implement transmission-based precautions (TBP) utilizing all necessary personal protective equipment (PPE) including N95 respirators, for R1 who was newly diagnosed with COVID-19. The facility administrator and director of nursing (DON) were notified of the IJ on 6/3/21, at 5:05 p.m. The IJ was removed on 6/4/21, at 2:30 p.m. but noncompliance remained at the lower scope and severity level of E, pattern, no actual harm with potential for more than minimal harm that is not IJ. Current CDC guidance dated 2/10/21, directed health care workers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. CMS memo COVID-19 Long Term Care Facility Guidance, dated 4/2/20, directed nursing homes to immediately ensure they were complying with all CMS and CDC guidance related to infection control which included the use of standard, contact and droplet precautions. Findings include: R1 was diagnosed with COVID-19 on 5/25/21. R1's isolation period had been identified as ending 6/4/21. Signage on R1's door indicated R1 was on TBP. A white plastic PPE bin was set up outside of R1's room.	F 880	from precautions. • N95 respirators were placed outside rooms that are on a 14-day quarantine, or with the PPE carts. • Signage depicting donning and doffing posted on resident doors were updated to reflect the use of N95 respirators. • Staff were verbally educated on the need to wear N95 respirators, in addition to other PPE, when entering resident quarantine and COVID positive rooms prior to working their next shift. Staff education was completed in person and via telephone by 6/3/2021, for those staff that are unable to be reached, they will be educated prior to the start of their next shift. • Fit testing for N95's for all staff was conducted on 6/4/2021, 6/7/2021, 6/11/2021, and 6/14/2021. Any staff member that does not get fit tested for a N95 on 6/4/2021, whether due to being unable to attend or deemed medically unable to wear an N95, will not be allowed to work with a resident that is on a 14-day quarantine, or a resident that is suspected of Covid-19 or Covid-19 positive. The facility is recommending that all nursing staff that are medically able, get fit tested for a N95. The following are policy/procedure review and changes and related education/training. • The Respiratory Protection plan and COVID polices were reviewed and remain current. • Staff were educated on the respiratory protection plan and applicable COVID	

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F 880	Continued From page 4 R2 was placed under quarantine because she left the facility on 5/31/21, for the day. R2's quarantine period had been identified as ending 6/14/21. Signage on R1's door indicated R2 was on TBP. A white plastic PPE bin was set up outside of R2's room. R3 was readmitted to the facility after hospitalization on 5/25/21, with quarantine identified as ending 6/4/21. R3's quarantine period had been identified as ending 6/4/21. Signage on R3's door indicated R3 was on TBP. A white plastic PPE bin was set up outside of R3's. R4 was placed under quarantine when he admitted to the facility on 5/27/21. R4's quarantine period had been identified as ending 6/10/21. Signage on R4's door indicated R4 was on TBP. A white plastic PPE bin was set up outside of R4's room. On 6/2/21, at 11:45 a.m. nursing assistant (NA)-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. NA-A was wearing a surgical mask. Without donning an N95 respirator, NA-A entered R1's room and closed the door behind her. NA-A remained in R1's room for approximately 4 minutes. On 6/2/21, at 11:56 a.m. licensed practical nurse (LPN)-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. LPN-A was wearing a surgical mask. Without donning an N95 respirator, LPN-A entered R1's room. LPN-A closed the door behind her and remained in R1's	F 880	policies. The following describes the ongoing measures to sustain improvement needed to prevent further occurrences. • Audits have begun on all residents requiring quarantine or having a positive COVID infection four times a shift a week, until the facility reaches 100% compliance of the use of N95 masks in rooms requiring quarantine. The facility will then audit five times a week for four weeks and monthly for two months to ensure that staff are following the Respiratory Protection plan and utilizing N95s to prevent spread of infection. • Audits consist of observation of the use of N95s prior to entering resident room and removal when exiting. QAPI Committee will review for ongoing audits.	

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F 880	Continued From page 5	F 880		

room for approximately 2 minutes.

On 6/2/21, at 12:06 p.m. LPN-A and NA-A were both observed donning blue plastic isolation gowns, clean gloves, and they placed eye goggles over eye protection. Without donning an N95 respirator, LPN-A and NA-A were both wearing surgical masks. Without donning N95 respirators, LPN-A and NA-A entered R1's room, where they remained for approximately 3 minutes.

On 6/2/21, at 12:12 p.m. therapeutic recreation aide (TRA)-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. TRA-A was wearing a surgical mask. Without donning an N95 respirator, TRA-A entered R2's room with a meal tray. TRA-A remained in the room for approximately 2 minutes.

On 6/2/21, at 12:14 p.m. NA-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. NA-A was wearing a surgical mask. Without donning an N95 respirator, NA-A entered R1's room. NA-A remained in R1's room for approximately 3 minutes.

On 6/2/21, at 1:21 NA-A was interviewed and stated staff do not wear N95 respirators when providing cares for those residents who are on TBP for either having COVID-19 or are on quarantine. NA-A stated she had worn a surgical mask when caring for R1, R2, R3 and R4. NA-A stated she has never seen staff wear an N95 respirator in the facility since the COVID-19 pandemic began.

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	245483	A. BUILDING _____ B. WING _____	C 06/04/2021

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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 880	Continued From page 6	F 880		

On 6/2/21, at 1:19 p.m. LPN-A was interviewed and stated staff wore surgical masks when caring for residents with COVID-19, or on quarantine. LPN-A stated she has never seen staff wear an N95 respirator. LPN-A stated the facility had sent out a text message a while back asking if staff wanted to be fit tested for the N95 respirator, but she had not been fitted.

On 6/2/21, at 1:22 p.m. NA-B stated she had never been fit tested for an N95 respirator, nor had she ever seen staff wearing a N95 respirator when caring for those residents with confirmed COVID-19 or those under quarantine.

On 6/2/21, at 1:32 p.m. the DON was interviewed and stated the facility had an adequate supply of N95 respirators for staff to wear when caring for residents with COVID-19 or those under quarantine. The DON stated the facility had offered staff to get fit tested for the N95 respirators through a meeting or a text. The DON stated staff had chosen not to wear the N95 respirators. The DON stated the facility had not enforced staff to wear N95 respirators when caring for residents with COVID-19 or those under quarantine. The DON stated staff had not worn N95 respirators throughout the COVID-19 outbreak. The DON stated the facility had their first positive COVID-19 case back in 9/2020. DON further stated she had believed the CDC guidance related to the use of N95 respirators was only a recommendation.

On 6/4/21, at 2:12 p.m. the administrator was interviewed and stated she believed the CDC guidance related to N95 respirators was only a recommendation and not a requirement. The administrator stated the facility had not enforced

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F 880	Continued From page 7	F 880		

staff to wear N95 respirators when caring for residents with COVID-19 or those under quarantine. The administrator stated staff had not worn N95 respirators throughout the COVID-19 outbreak.

The facility policy Coronavirus (COVID-19) last revised 2/25/21, directed all residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated implement CDC recommendations. The policy further directed the facility would implement CDC and Department of Health recommendations to prevent the spread of Coronavirus Disease-2019 (COVID-19).

The IJ was removed on 6/4/21, at 2:30 p.m. when it was verified through observation, staff interviews and document review the facility educated staff on the use of N95 respirators, and began fit-testing direct care staff who would be wearing N95 respirators, and the facility supplied N95 respirators for staff to use.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 11, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: Z1M211

Dear Administrator:

The above facility was surveyed on June 2, 2021 through June 4, 2021 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00593	A. BUILDING: _____ B. WING _____	C 06/04/2021

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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 6/2/21, through 6/4/21, a standard abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be OUT of compliance with the MN State Licensure. The following complaint was SUBSTANTIATED,	2 000		

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2 000	Continued From page 1 however no licensing orders were issued due to actions taken by the facility: H5483053C (MN73125) The following complaints were found to be UNSUBSTANTIATED: H5483054C (MN73359) H5483055C (MN73304) However, as a result of the investigation a licensing order was issued at S1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 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		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		6/17/21

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21390	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) for 4 of 4 residents (R1, R2, R3, and R4) reviewed for infection control practices. This resulted in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19. The IJ began on 5/25/21, when the facility failed to implement transmission-based precautions (TBP) utilizing all necessary personal protective equipment (PPE) including N95 respirators, for R1 who was newly diagnosed with COVID-19. The facility administrator and director of nursing (DON) were notified of the IJ on 6/3/21, at 5:05 p.m. The IJ was removed on 6/4/21, at 2:30 p.m. but noncompliance remained at the lower scope and severity level of E, pattern, no actual harm with potential for more than minimal harm that is not IJ. Current CDC guidance dated 2/10/21, directed health care workers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. CMS memo COVID-19 Long Term Care Facility Guidance, dated 4/2/20, directed nursing homes to immediately ensure they were complying with all CMS and CDC guidance related to infection control which included the use of standard,	21390	• R1 was COVID positive. Please note, as of 6/3/2021, it had been 10 days since R1 tested positive for Covid-19. R1 was assessed and was determined to be clear of any signs and symptoms. Precautions were removed from R1 as of 6/4/2021. R2, R3, and R4 have all been removed from precautions. • N95 respirators were placed outside rooms that are on a 14-day quarantine, or with the PPE carts. • Signage depicting donning and doffing posted on resident doors were updated to reflect the use of N95 respirators. • Staff were verbally educated on the need to wear N95 respirators, in addition to other PPE, when entering resident quarantine and COVID positive rooms prior to working their next shift. Staff education was completed in person and via telephone by 6/3/2021, for those staff that are unable to be reached, they will be educated prior to the start of their next shift. • Fit testing for N95's for all staff was conducted on 6/4/2021, 6/7/2021, 6/11/2021, and 6/14/2021. Any staff member that does not get fit tested for a N95 on 6/4/2021, whether due to being unable to attend or deemed medically unable to wear an N95, will not be allowed to work with a resident that is on a 14-day quarantine, or a resident that is suspected of Covid-19 or Covid-19 positive. The facility is recommending that all nursing staff that are medically able, get fit tested	

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21390	Continued From page 4 contact and droplet precautions. Findings include: R1 was diagnosed with COVID-19 on 5/25/21. R1's isolation period had been identified as ending 6/4/21. Signage on R1's door indicated R1 was on TBP. A white plastic PPE bin was set up outside of R1's room. R2 was placed under quarantine because she left the facility on 5/31/21, for the day. R2's quarantine period had been identified as ending 6/14/21. Signage on R1's door indicated R2 was on TBP. A white plastic PPE bin was set up outside of R2's room. R3 was readmitted to the facility after hospitalization on 5/25/21, with quarantine identified as ending 6/4/21. R3's quarantine period had been identified as ending 6/4/21. Signage on R3's door indicated R3 was on TBP. A white plastic PPE bin was set up outside of R3's. R4 was placed under quarantine when he admitted to the facility on 5/27/21. R4's quarantine period had been identified as ending 6/10/21. Signage on R4's door indicated R4 was on TBP. A white plastic PPE bin was set up outside of R4's room. On 6/2/21, at 11:45 a.m. nursing assistant (NA)-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. NA-A was wearing a surgical mask. Without donning an N95 respirator, NA-A entered R1's room and closed the door behind her. NA-A remained in R1's room for approximately 4 minutes.	21390	for a N95. The following are policy/procedure review and changes and related education/training. • The Respiratory Protection plan and COVID polices were reviewed and remain current. • Staff were educated on the respiratory protection plan and applicable COVID policies. The following describes the ongoing measures to sustain improvement needed to prevent further occurrences. • Audits have begun on all residents requiring quarantine or having a positive COVID infection four times a shift a week, until the facility reaches 100% compliance of the use of N95 masks in rooms requiring quarantine. The facility will then audit five times a week for four weeks and monthly for two months to ensure that staff are following the Respiratory Protection plan and utilizing N95s to prevent spread of infection. • Audits consist of observation of the use of N95s prior to entering resident room and removal when exiting. QAPI Committee will review for ongoing audits.	

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21390	Continued From page 5 On 6/2/21, at 11:56 a.m. licensed practical nurse (LPN)-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. LPN-A was wearing a surgical mask. Without donning an N95 respirator, LPN-A entered R1's room. LPN-A closed the door behind her and remained in R1's room for approximately 2 minutes. On 6/2/21, at 12:06 p.m. LPN-A and NA-A were both observed donning blue plastic isolation gowns, clean gloves, and they placed eye goggles over eye protection. Without donning an N95 respirator, LPN-A and NA-A were both wearing surgical masks. Without donning N95 respirators, LPN-A and NA-A entered R1's room, where they remained for approximately 3 minutes. On 6/2/21, at 12:12 p.m. therapeutic recreation aide (TRA)-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. TRA-A was wearing a surgical mask. Without donning an N95 respirator, TRA-A entered R2's room with a meal tray. TRA-A remained in the room for approximately 2 minutes. On 6/2/21, at 12:14 p.m. NA-A was observed donning a blue plastic isolation gown, clean gloves, and placed eye goggles over her eye protection. NA-A was wearing a surgical mask. Without donning an N95 respirator, NA-A entered R1's room. NA-A remained in R1's room for approximately 3 minutes. On 6/2/21, at 1:21 NA-A was interviewed and stated staff do not wear N95 respirators when providing cares for those residents who are on	21390		

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21390	Continued From page 6 TBP for either having COVID-19 or are on quarantine. NA-A stated she had worn a surgical mask when caring for R1, R2, R3 and R4. NA-A stated she has never seen staff wear an N95 respirator in the facility since the COVID-19 pandemic began. On 6/2/21, at 1:19 p.m. LPN-A was interviewed and stated staff wore surgical masks when caring for residents with COVID-19, or on quarantine. LPN-A stated she has never seen staff wear an N95 respirator. LPN-A stated the facility had sent out a text message a while back asking if staff wanted to be fit tested for the N95 respirator, but she had not been fitted. On 6/2/21, at 1:22 p.m. NA-B stated she had never been fit tested for an N95 respirator, nor had she ever seen staff wearing a N95 respirator when caring for those residents with confirmed COVID-19 or those under quarantine. On 6/2/21, at 1:32 p.m. the DON was interviewed and stated the facility had an adequate supply of N95 respirators for staff to wear when caring for residents with COVID-19 or those under quarantine. The DON stated the facility had offered staff to get fit tested for the N95 respirators through a meeting or a text. The DON stated staff had chosen not to wear the N95 respirators. The DON stated the facility had not enforced staff to wear N95 respirators when caring for residents with COVID-19 or those under quarantine. The DON stated staff had not worn N95 respirators throughout the COVID-19 outbreak. The DON stated the facility had their first positive COVID-19 case back in 9/2020. DON further stated she had believed the CDC guidance related to the use of N95 respirators was only a recommendation.	21390		

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21390	Continued From page 7 On 6/4/21, at 2:12 p.m. the administrator was interviewed and stated she believed the CDC guidance related to N95 respirators was only a recommendation and not a requirement. The administrator stated the facility had not enforced staff to wear N95 respirators when caring for residents with COVID-19 or those under quarantine. The administrator stated staff had not worn N95 respirators throughout the COVID-19 outbreak. The facility policy Coronavirus (COVID-19) last revised 2/25/21, directed all residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated implement CDC recommendations. The policy further directed the facility would implement CDC and Department of Health recommendations to prevent the spread of Coronavirus Disease-2019 (COVID-19). The IJ was removed on 6/4/21, at 2:30 p.m. when it was verified through observation, staff interviews and document review the facility educated staff on the use of N95 respirators, and began fit-testing direct care staff who would be wearing N95 respirators, and the facility supplied N95 respirators for staff to use. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure infection control is followed during personal cares.	21390		

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21390	Continued From page 8 The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21390		