



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2026

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

RE: CCN: 245483
Cycle Start Date: July 8, 2026

Dear Administrator:

On August 3, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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



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July 14, 2026

Administrator
The North Shore Estates LLC
7700 GRAND AVENUE
DULUTH, MN 55807

RE: CCN:245483

Cycle Start Date: July 8, 2026

Dear Administrator:

On July 8, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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 October 8, 2026 (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 January 8, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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July 14, 2026

Administrator
The North Shore Estates LLC
7700 GRAND AVENUE
DULUTH, MN 55807

Re: Event ID: 25CE51-H1

Dear Administrator:

The above facility survey was completed on July 8, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Sarah Lane, Compliance Analyst
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P.O. Box 64900

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245483		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
NAME OF PROVIDER OR SUPPLIER THE NORTH SHORE ESTATES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7700 GRAND AVENUE , DULUTH, Minnesota, 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
F0000	INITIAL COMMENTS On 7/7/26 to 7/8/26, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaint was reviewed: H54833157C (3069193); with non-compliance cited at F609, F610, and F684. 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 that substantial compliance with the regulations has been attained.			F0000			07/24/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in			F0609	Allegation of suspicion of abuse was reported to OHFC via initial report. Vulnerable Adult Prevention and Reporting policy was reviewed and remains current. Investigation of allegation was completed and submitted to OHFC within 5 days of initial report. Education related to Vulnerable Adult Prevention and Reporting policy was provided to all staff. Audits of all incidents of suspected abuse and neglect will be completed weekly x4 then monthly x2 months to ensure they were reported per policy. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.		07/24/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0609 SS = D	Continued from page 1 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential verbal abuse and rough handling were immediately reported to the administration and State agency (SA) for 1 of 4 residents (R2) reviewed. A nursing assistant (NA) roughly handled R2 and made demeaning comments to him on 6/20/26 which were observed by another staff member; however, these allegations were not reported to the administrator until several days later; nor were they ever reported to the SA. Findings include: R2's admission Minimum Data Set (MDS), dated 4/29/26, identified R2 was non-verbal, had cognitive impairment, and demonstrated behaviors which placed himself and others at significant risk of harm or injury. R2's care plan, dated 6/30/26, identified R2 as a categorically vulnerable adult (VA) due to residing in the care center. R2 had decreased cognition, reduced physical abilities, and was non-verbal using mostly sign language or photo boards to communicate. Further, the care plan outlined R2 had impaired mobility and used a Hoyer with assistance of two staff to complete transfers. During interview on 7/7/26 at 12:05 p.m., nursing assistant (NA)-A stated they had worked with R2 and described him as a resident who "repeatedly causes issues" with other residents due to his behaviors. R2 did not speak, liked to "pick at people," and at times would get "super upset" and strike at others or himself. NA-A stated they just recently had given a statement to the director of nursing (DON) about R2 and some concerning events during cares they had observed happen with NA-E present. NA-A explained they felt NA-E was "provoking the crap out him [R2]" on 6/20/26 as cares were completed. NA-A stated they both were in R2's room and needed to place the mechanical lift sling underneath			F0609	Continued from page 1 Corrections will be monitored by: Administrator or designee		07/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245483		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
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F0609 SS = D	Continued from page 2 R2, and R2 was resistive to it and not allowing it, but then NA-E suddenly grabbed R2's head and "pulled it down like super hard against his will." NA-A stated aloud, "I don't think you should do that." NA-E then proceeded with help with cares and transfer while making verbal comments to R2 like calling him "crazy" and telling R2 that NA-E "hopes he gets a brain aneurysm [due to his behavior]." NA-A stated they had never seen NA-E treat another resident like that before and felt it was abusive adding, "You never keep aggravating somebody." NA-A stated they did not immediately report these concerns to the nurse working or administration as they were reluctant to speak out against NA-E. NA-A stated they spoke about the situation with their family member and then decided to report it to the DON. NA-A stated they reported it they thought on the Friday after it happened (6/26). NA-A stated there had been no follow-up about it since then or any re-education about reporting provided adding, "I haven't heard anything since I've given my statement." During interview on 7/7/26 at 12:42 p.m., licensed practical nurse (LPN)-A stated they had worked with NA-E prior and tried to keep them out of R2's room whenever able as they seemed to "butt heads" with each other. LPN-A stated they were aware of "something recently" which happened between R2 and NA-E which involved "something inappropriate" being said to R2. LPN-A stated NA-E seemed to make comments which were "weird" often and gave an example of telling someone to run after something even though they (NA-E) knew the person was unable to physically run. LPN-A stated several residents had voiced concerns about NA-E and didn't want them to provide care for them. LPN-A had never seen NA-E be purposefully abusive to a resident, however, stated NA-E seemed to have "just one of those senses of humor." The staff were trying to always do a "cares in pairs" with R2 now. When told about comments potentially said to R2 by a staff member (as explained by NA-A), LPN-A stated those comments were "not OK" and would be considered verbally abusive. The Centers for Medicare and Medicaid (CMS) iQEIS system, used to track complaint investigations and facility-reported incident (FRI) reports, was reviewed on 7/7/26. It lacked evidence that the allegations witnessed and reported to DON by NA-A were submitted to the SA. Further, R2's medical record was reviewed and lacked evidence of these allegations or what, if any, actions were taken to address them (i.e., reported, investigated).			F0609			07/24/2026

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F0609 SS = D	Continued from page 3 On 7/7/26 at 3:35 p.m., a group interview was held with licensed practical nurse unit manager (LPN)-B, the DON, and the administrator. It was explained that NA-E was “awkward” at times but overall was never intending to harm a resident or someone to their knowledge. DON verified that NA-A had come and reported some concerns about NA-E and R2 but was unable to recall the exact date when. DON stated they were unable to remember exactly what had been reported but recalled it was during placement of a mechanical lift sling and NA-E had “pulled [R2] forward.” DON reiterated, “I don't recall exactly what was said to me [reported].” DON stated they had maybe written some notes and would look for them and provide, if located. The administrator stated they were made aware of the concerns right after the DON was and then called some of the other staff members who had worked on the same shift that day. None of the other staff saw or had anything reported to them about it. They called NA-E who denied the comments being said in that manner but rather in a manner like, “You're going to give yourself an aneurysm [if he kept doing the behaviors].” The team verified if an NA witnessed something potentially abusive it should be immediately reported to them which did not happen with this situation. The administrator stated, “That's the expectation.” The team also acknowledged that comments as reported by NA-A would be credible allegations of potential verbal abuse. The administrator stated they did not report the allegation to the SA as they were able to gather enough evidence to unsubstantiate the allegation before the window to report (i.e., two hours) was through after they were made aware. It was a “he said, she said” allegation and NA-E denied making the comments or being rough with care. Later, at 4:44 p.m., the administrator provided their investigation into the allegations (SEE F610) and the DON provided their notes about the allegation they had made. The administrator stated they had up to 24 hours to report an allegation if they suspected abuse had happened and had two hours to report if the allegations were “100% abuse [known to have occurred].” The administrator reiterated they did not report the allegations to the SA as they investigated it and felt they had enough evidence to determine that the allegations were not credible. A notebook sheet, dated 6/30/26, (provided by DON) identified handwritten items on it. Both NA-A and NA-E's name were on top along with writing which read, “[NA-E] – rude & aggressive [sic] to residents. Pulled [R2] head forward. I hope you get a brain aneurysm [sic] a brain bleed. [NA-E] was restricting him. [R2] stating – unable to make statement.”			F0609			07/24/2026

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F0609 SS = D	Continued from page 4 The facility Abuse Prohibition/Vulnerable Adult Policy, dated 11/2025, identified all staff were responsible for reporting any situation that would be considered abuse or neglect. The supervisor would evaluate the situation and take actions to protect residents. The administrator was to be immediately notified for any instances of abuse, both alleged and suspected. Further, the policy identified abuse (including verbal abuse) should be reported to the SA not later than two hours after the suspicion of abuse was identified.			F0609			07/24/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure allegations of physical and verbal abuse were thoroughly investigated and adequate follow up to prevent ongoing abuse for 1 of 4 residents (R2) reviewed. A nursing assistant (NA) had allegedly roughly handled R2 and made demeaning comments to him on 6/20/26 which were observed by another staff member; however, these allegations were not reported to the administrator until several days later nor thoroughly investigated to determine if abuse had occurred. Further, the delay in reporting allowed the alleged perpetrator (NA-E) to continue working unsupervised with other residents despite the allegations.			F0610	A skin check and interview was completed with R2 to gather any information related to allegation of abuse. All residents on the unit were interviewed to identify any concerns of abuse or neglect. All non-cognitive residents on the unit had skin checks completed to identify any concerns or abuse or neglect. All staff were interviewed to identify any concerns of abuse or neglect. Vulnerable Adult Prevention and Reporting policy was reviewed and remains current. Education related to Vulnerable Adult Prevention and Reporting policy was provided to all staff, including Administrator. Audits of all incidents of suspected abuse and neglect will be completed weekly x4 then monthly x2 months to ensure they were investigated per policy. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator or designee		07/24/2026

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F0610 SS = D	Continued from page 5 Findings include: R2's admission Minimum Data Set (MDS), dated 4/29/26, identified R2 was non-verbal, had cognitive impairment, and demonstrated behaviors which placed himself and others at significant risk of harm or injury. R2's care plan, dated 6/30/26, identified R2 as a categorically vulnerable adult (VA) due to residing in the care center. R2 had decreased cognition, reduced physical abilities, and was non-verbal using mostly sign language or photo boards to communicate. Further, the care plan outlined R2 had impaired mobility and used a Hoyer with assistance of two staff to complete transfers. During interview on 7/7/26 at 12:05 p.m., nursing assistant (NA)-A stated they had worked with R2 and described him as a resident who "repeatedly causes issues" with other residents due to his behaviors. R2 did not speak, liked to "pick at people," and at times would get "super upset" and strike at others or himself. NA-A stated they just recently had given a statement to the director of nursing (DON) about R2 and some concerning events during cares they had observed happen with NA-E present. NA-A explained they felt NA-E was "provoking the crap out him [R2]" on 6/20/26 as cares were completed. NA-A stated they both were in R2's room and needed to place the mechanical lift sling underneath R2, and R2 was resistive to it and not allowing it, but then NA-E suddenly grabbed R2's head and "pulled it down like super hard against his will." NA-A stated aloud, "I don't think you should do that." NA-E then proceeded with help with cares and transfer while making verbal comments to R2 like calling him "crazy" and telling R2 that NA-E "hopes he gets a brain aneurysm [due to his behavior]." NA-A stated they had never seen NA-E treat another resident like that before and felt it was abusive adding, "You never keep aggravating somebody." NA-A stated they did not immediately report these concerns to the nurse working or administration as they were reluctant to speak out against NA-E. NA-A stated they spoke about the situation with their family member and then decided to report it to the DON. NA-A stated they reported it they thought on the Friday after it happened (6/26). NA-A stated there had been no follow-up about it since then or any re-education about reporting provided adding, "I haven't heard anything since I've given my statement." During interview on 7/7/26 at 12:42 p.m., licensed practical nurse (LPN)-A stated they had worked with			F0610			07/24/2026

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F0610 SS = D	Continued from page 6 NA-E prior and tried to keep them out of R2's room whenever able as they seemed to "butt heads" with each other. LPN-A stated they were aware of "something recently" which happened between R2 and NA-E which involved "something inappropriate" being said to R2. LPN-A stated NA-E seemed to make comments which were "weird" often and gave an example of telling someone to run after something even though they (NA-E) knew the person was unable to physically run. LPN-A stated several residents had voiced concerns about NA-E and didn't want them to provide care for them. LPN-A had never seen NA-E be purposefully abusive to a resident, however, stated NA-E seemed to have "just one of those senses of humor." The staff were trying to always do a "cares in pairs" with R2 now. When told about comments potentially said to R2 by a staff member (as explained by NA-A), LPN-A stated those comments were "not OK" and would be considered verbally abusive. R3's quarterly MDS, dated 4/22/26, identified R3 had intact cognition and demonstrated no delusional thinking or hallucinations. On 7/7/26 at 1:05 p.m., R3 was interviewed after they yelled into the hallway for the surveyor to come into their room. R3 stated there was a NA who worked on the evening shifts which they heard was "rough" with cares from other residents. R3 identified NA-E by name and stated they seem to "get rough" with residents more who "aren't normal [cognitively impaired]." R3 stated NA-E will help others and she could hear audible screams and yells from the closed door to their rooms which was very concerning. R3 stated NA-E had never abused her, but R3 reiterated a concern for other residents about NA-E adding, "It needs to be dealt with though." R4's quarterly MDS, dated 5/20/26, identified R4 had intact cognition and demonstrated no delusional thinking. When interviewed on 7/7/26 at 1:25 p.m., R4 stated they had been cared for by NA-E and "[didn't] like the way he handled me." R4 explained she had been hospitalized and when returned, NA-E wouldn't physically help her but rather just stood there and kept saying, "You can do it." R4 stated she was exhausted and weak from being hospitalized and NA-E not helping her then made her upset adding, "I find [NA-E] to be pretty much heartless." R4 stated they had seen the same thing happen with other residents, too, where NA-E would tell people who cannot stand up that they'd have to stand up to get help. R4 stated there had been an "96 year old" resident on the unit prior who would wait in the dining room and yell, "Help me," out loud but NA-E would just let the resident sit there and			F0610			07/24/2026

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F0610 SS = D	Continued from page 7 wait which R4 felt was rude and poor care. R4 added, "[NA-E] would help everyone else and just let her sit there [despite yelling for help]." R4 stated NA-E had never been verbally or physically abusive to her, however, had heard other residents voice they felt NA-E was "abusing to people." R4 added, "I hear that [NA-E] is mean to some people." On 7/7/26 at 1:49 p.m., a telephone call was placed the LPN-D who was listed as the nurse for the shift NA-E worked on 6/20/26. However, a return call was not received. R2's medical record was reviewed and lacked evidence the allegations of potential abuse were acted upon, investigated or what, if any, measures were taken to protect R2 from continued abuse since 6/20/26, when the allegations were witnessed by NA-A. No completed incident reports about the allegation were located. On 7/7/26 at 3:35 p.m., a group interview was held with licensed practical nurse unit manager (LPN)-B, the DON, and the administrator. It was explained that NA-E was "awkward" at times but overall was never intending to harm a resident or someone to their knowledge. DON verified that NA-A had come and reported some concerns about NA-E and R2 but was unable to recall the exact date when. DON stated they were unable to remember exactly what had been reported but recalled it was during placement of a mechanical lift sling and NA-E had "pulled [R2] forward." DON reiterated, "I don't recall exactly what was said to me [reported]." DON stated they had maybe written some notes and would look for them and provide, if located. The administrator stated they were made aware of the concerns right after the DON and then called some of the other staff members who had worked on the same shift that day. None of the other staff saw or had anything reported to them about it. They called NA-E who denied the comments being said in that manner but rather in a manner like, "You're going to give yourself an aneurysm [if he kept doing the behaviors]." The team verified if an NA witnessed something potentially abusive it should be immediately reported to them which did not happen with this situation. The administrator stated, "That's the expectation." The team also acknowledged that comments as reported by NA-A would be credible allegations of potential verbal abuse. The administrator stated the allegation was a "he said, she said" situation and NA-E denied making the comments or being rough with care. The administrator stated they recalled taking some notes about their investigation and would provide those.			F0610			07/24/2026

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F0610 SS = D	Continued from page 8 DON and administrator verified NA-E was not removed from the schedule or assigned any direct supervision despite the allegations as they felt the allegation was not credible given their investigation immediately after being told of the allegations by NA-A. There had also been no corrective actions done for NA-E as there was “no proof” it happened. Later, at 4:44 p.m., the administrator provided their investigation into the allegations and the DON provided their notes about the allegation they had made. A notebook sheet, dated 6/30/26, (provided by DON) identified handwritten items on it. Both NA-A and NA-E’s name were on top along with writing which read, “[NA-E] – rude & aggressive [sic] to residents. Pulled [R2] head forward. I hope you get a brain aneurysm [sic] a brain bleed. [NA-E] was restricting him. [R2] stating – unable to make statement.” A printer sheet, undated, identified typed wording which recorded R2 had lived at the care center since 4/2026 and was primarily non-verbal but could nod yes-or-no for responses. The sheet had several statements typed which identified NA-A reported on 6/30/26, that on 6/20/26 they had been caring for R2 with NA-E. R2 did not want to move his upper body forward, so NA-E pulled R2’s head forward to place a sling underneath him. R2 was then hitting himself in the head which was not uncommon. NA-A reported NA-E made a comment to R2, “I hope you hurt yourself.” NA-E was interviewed at 12:43 p.m. (6/30) and denied pulling on R2’s head. NA-E told R2 to stop hitting himself or he would hurt himself. NA-E denied the comments reported by NA-A and stated R2 could be challenging to work with. LPN-B was interviewed at 1:15 p.m. and denied having concerns reported about NA-E by NA-A on the 6/20/26 shift. Two other NA(s) were interviewed and denied knowledge of the incident. The note recorded, “[R2] asked if [NA-E] hurt him. [R2] shook his head no.” The note concluded, “Please note, [DON], worked as CNA 6/21/2026, with [NA-E] and had no concerns. She assisted with taking care of [R2] and there were no concerns, or skin issues.” The investigation lacked any recorded interviews with other residents to help determine if concerns with NA-E’s care were present on the same shift or since; it lacked evidence of what corrective actions the facility had completed with NA-A or NA-E about this incident and the late reporting of it; and it further lacked evidence of what, if any, protections were placed for R2 while these items were being investigated or since the allegations. The interview continued, and administrator stated			F0610			07/24/2026

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F0610 SS = D	Continued from page 9 they had up to 24 hours to report an allegation if they suspected abuse had happened and had two hours to report if the allegations were “100% abuse.” The administrator reiterated they did not report the allegations to the SA as they first investigated it and felt they had enough evidence to determine that the allegations were not credible within those two hours after being notified of them. The administrator verified they interviewed no other residents who had received care from NA-E on 6/20/26 as part of their investigation. DON was asked how they determined R2 did not feel abused by the verbal comments made to him and responded by saying they had asked R2 if anyone "had hurt them" to which R2 did a head nod in a ‘no’ response. DON verified they did not use any sign language or other communication attempts to interview R2 (despite a potential misunderstanding being possible of ‘hurt’ [i.e., physically abused] versus told demeaning comments [i.e., verbal abuse]). When interviewed on 7/7/26 at 4:31 p.m., NA-E stated they had worked at the care center for several years and typically worked on the evening shift. NA-E was asked about the events from 6/20/26 while helping R2 and expressed they were unable to recall ever pulling R2 by his head or neck to place a sling underneath him. NA-E adamantly denied making comments such as calling R2 “crazy” and responded aloud, “I never said anything like that!” NA-E stated the administrator had called them about a week ago and asked about the comments made to which NA-E denied making them. NA-E stated they were never removed from the schedule or placed on supervised care since the allegation and remained working their assigned shifts. NA-E stated they were told by leadership to basically “steer clear” of R2 as much as able was all for follow-up. NA-E wondered why someone would wait for so long to report concerns like that to administration if they saw it happen and felt it was likely just someone who didn’t like NA-E at the care center making those accusations. NA-E verified they had been given training by the care center on abuse and reporting. NA-E was unable to recall when they had last completed it but felt it was discussed at a team meeting within the last month or so. NA-E stated allegations of abuse should be reported to leadership “within 24 hours” and reiterated their denial of treating R2 rough or verbally abusing him. The facility's daily schedules, dated 6/20/26 through 7/7/26, were provided and had no markings on the sheets to demonstrate any restrictions on NA-E's workload. NA-E was listed as working on the PM shift for the following dates: 6/21/26,			F0610			07/24/2026

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F0610 SS = D	Continued from page 10 6/24/26, 6/25/26, 6/29/26, 6/30/26, 7/1/26, 7/3/26, 7/4/26, and 7/5/26. The facility Abuse Prohibition/Vulnerable Adult Policy, dated 11/2025, identified all staff were responsible for reporting any situation that would be considered abuse or neglect. The supervisor would evaluate the situation and take actions to protect residents. If the suspected perpetrator was a staff member, they would be immediately suspended until the investigation was completed. The administrator was to be immediately notified for any instances of abuse, both alleged and suspected, and abuse (including verbal abuse) should be reported to the SA not later than two hours after the suspicion of abuse was identified. The policy section labeled, "Investigation/Protection," identified the investigation would begin immediately and staff would take action to prevent further abuse. Incident reports would be reviewed, and the investigation may include interviews with staff, other residents, and witnesses.			F0610			07/24/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure behaviors, including behaviors which were bothersome to other residents, were comprehensively assessed and interventions developed to ensure a consistent, therapeutic approach was done for 1 of 4 residents (R2) reviewed. R2 demonstrated physical and verbal behaviors with care and others which were not assessed to develop consistent interventions the staff could attempt or use while providing care. Findings include: R1's quarterly MDS, dated 5/15/26, identified R1 had intact cognition and demonstrated no delusional thinking. On 7/7/26 at 11:07 a.m., R1 was			F0684	R2's care plan was updated to include additional behavioral documentation and interventions. A grievance was completed with R1 related to his concerns of R2's behavior and worked with staff to resolve grievance, stating satisfaction. All current resident care plans were reviewed to ensure identified behaviors and interventions are documented. Floor staff were interviewed related to resident behaviors and to identify any additional interventions that should be added to the care plan. Education related to Behavior Monitoring and Care Planning was provided to the Interdisciplinary Team. Audits of 5 residents' care plans will be audited weekly x4 then monthly x2 months to ensure behaviors and interventions are documented. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator or designee		07/24/2026

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F0684 SS = D	Continued from page 11 interviewed outside the nursing home main entrance. R1 stated he had lived at the care center for several years and liked the place except for “some issues” with another resident. R1 stated he was being bothered by another resident, R2, and had even been hit by him a few times describing the hitting as both with a closed fist but also a slapping motion. R1 stated they were not sure if R2 was intending or hurt him with the repeated slaps and hits but expressed the repeated altercations with R2 were “a real strainer” mentally, and R1 was fearful he was going to strike R2 back if they continued. R1 stated he felt always “on guard” when out of his room due to R2 being around and his behaviors. R2’s admission Minimum Data Set (MDS), dated 4/29/26, identified R2 as non-verbal and demonstrated no delusional thinking or hallucinations during the review period. R2 had multiple medical conditions including aphasia (neurological brain disorder which impairs speaking) and cerebral palsy (permanent movement disorder). R2 demonstrated behaviors which placed himself and others at risk of harm and interfered with care. R2’s corresponding Behavioral Symptoms Care Area Assessment (CAA), dated 4/30/26, identified an actual problem existing for behavior as R2 had multiple documented episodes of hitting/kicking during the look-back period. R2 was non-verbal and staff reported deficits in both short and long-term memory. A PHQ-9 was completed which identified mild depression. The CAA identified behavioral concerns would be care-planned with an objective to minimize decline and risk. The CAA added, “IDT will continue to follow resident care plan and refer additional services as needed.” However, the CAA lacked any further data or analysis of the behavioral incidents (i.e., time of day happened, events immediately prior which could have triggered it, staff working with him when happened, other residents involved, etc.). On 7/7/26 at 12:02 p.m., R1 was observed seated in an electric wheelchair next to the nurses’ station on the second floor. R2 wheeled out to the same area from the dining room and stopped right next to R1. Neither of them interacted with the other. No staff attempted to separate them. R1 then turned to the left and visited with nursing assistant (NA)-A who was standing at the desk. R1 then left the area. Following, on 7/7/26 at 12:05 p.m., NA-A stated R1 had voiced frustrations with R2 recently as R2 was a resident “who repeatedly causes issues” and at times would “bother people.” R2 liked to “pick at people” and go into others’ rooms and take things. R2 was non-verbal and R1 had reported that R2			F0684			07/24/2026

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F0684 SS = D	Continued from page 12 would “try to hit me [him].” NA-A stated they had never actually seen R2 physically hit R1 or any other resident, but R2 did strike out at staff with cares. NA-A stated the nurses were aware of R2's behavior and the NA staff to “try to keep an eye on [R2]” as best able. NA-A stated there were no formal safety checks or anything for R2, rather it was just trying to make sure staff know his location and check on him when able adding, “It's when I have time.” NA-A stated there was not really any direction to do that from the nurses rather it was just “a more personal thing I started on my own.” When interviewed on 7/7/26 at 12:23 p.m., NA-D stated they worked with R2 and were aware R1 was bothered by R2. R1 had reported being able to “only put up with so much” before he took action himself with R2. NA-D stated R2 did, at times, strike staff members during cares and NA-D felt it was all about the approach with R2 as they'd never really had issues with him like the other staff report. NA-D stated R2 was, at times, on “cares in pairs” and felt that might be causing some behavior as it was too stimulating for R2. R2 seemed to accept care better from certain staff members than others but there were no consistent staffing attempts (i.e., just have same people work with him) with R2 to NA-D's knowledge. R2's progress notes, dated 4/29/26 to 7/7/26, identified multiple episodes of behaviors. These included: On 6/20/26, an eMAR note identified, “Was a behavior observed? YES.” The note lacked any further information on what the specific behavior was or what staff did to reduce/improve it. On 6/21/26, an eMAR note identified, “Was a behavior observed? YES.” However, again, the note lacked any further information on what the specific behavior was or what staff did to reduce/improve it. On 6/27/26, R2 was sent to the hospital for “having exacerbated behaviors ... hit one other resident and while trying to get him to bed he hit two staff members.” R1 returned the next morning from the ED with orders to adjust the psychotropic medications. On 6/29/26, R2's psychotropic medication was increased after consent was given by the guardian. When interviewed on 7/7/26 at 12:42 p.m., licensed practical nurse (LPN)-A stated R2 came to the nursing home from a smaller group home but was			F0684			07/24/2026

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F0684 SS = D	Continued from page 13 unable to return there due to his poor mobility status now. Management was aware of R2's behaviors and were trying to find him a better location to get care. LPN-A stated they had noticed R2 seemed to "purposely" go behind R1 and "target him a little more than others" for whatever reason. LPN-A stated they thought R2 was maybe just bored as it was hard to get him focused on activities. The staff attempted multiple things like using his tablet, calling his family and playing movies but the effectiveness was usually short-lived. LPN-A stated R2 did hit out at staff during cares and LPN-A reiterated a smaller setting for R2 was needed in their opinion. LPN-A stated any assessment or care planning for behavioral interventions would be done by the nurse manager team and reported there were no other interventions for R2 aside from the things mentioned adding, "Nothing that come to the top of my head." LPN-A stated they had noticed that R2 seemed to enjoy soda pop so staff would, at times, buy one and "reward him with pop" for good behavior or allowing cares. LPN-A stated it wasn't something told to them to try but rather something the staff had identified as "something that makes him happy." On 7/7/26 at 1:18 p.m., a call was placed to trained medication aide (TMA)-A for interview. A return call was received on 7/8/26 at 11:37 a.m., and TMA-A explained R2 was bothersome to R1 to the point R1 had asked them (TMA-A) to make a grievance and place it in the director of nursing (DON) mailbox on the outside of her office door. R1 was upset and felt management was acting on R2 to do anything about the situation. TMA-A stated they felt R2 was more aware of his actions than people believed as R2 seemed to circle R1 "like he's looking for a reaction." TMA-A added, "I do believe [R2] is culpable [with some of the issues]." TMA-A stated they had only ever been told observe R2 and report issues, if noticed. TMA-A stated they were unaware R2 enjoyed soda pop, and nobody had ever mentioned trying to use that to better get R2 to cooperate with cares. R2's behavior care plan, dated 6/2/26, identified R2 had an alteration in mood and behavior due to ongoing adjustment to placement at the care center. R2's medical conditions were listed and the plan identified R2 had a history of restlessness, agitation, withdrawing, and attempting to hit staff. R2 had a history of previously attempting to inappropriately touch staff during cares. R2 was noted to hit himself and bite himself at times and would holler out when brought to his room. A goal was listed which read, "Resident's mood/behavioral state will remain			F0684			07/24/2026

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F0684 SS = D	Continued from page 14 stable.” The plan listed several interventions which included communicating clearly with R2 on cares to be provided and giving him a fidget gadget during physical care, giving R2 reminders of upcoming care prior to starting them, offering to call family members or play music, and monitoring target behaviors per protocol. However, the plan lacked any evidence of the interventions the floor staff had identified as being effective with R2 including using soda pop as incentive or having the same, consistent staff providing direct care whenever able as they seemed to have more success with care than others. R2’s Treatment Administration Record (TAR), dated 7/2026, identified the current treatments being done for R2 by the nursing staff. These included, “Target Behavior Monitoring ... restless ... agitation ... withdrawn,” and listed non-pharmacological interventions to be attempted and recorded if behavior was witnessed. The interventions included re-direction, ambulation, activities, and repositioning. The effectiveness of the interventions would then be recorded in the progress notes. The TAR recorded no behaviors being displayed or interventions done for R2 for the period. R2’s medical record was reviewed and lacked evidence the IDT had comprehensively assessed R2 for his behaviors to determine what, if any, patterns were identified or how they arrived at the interventions listed on the care plan. The record lacked evidence that the IDT had reviewed or considered the interventions the floor staff determined to be helpful in getting R2 to show improved behavior or allow cares, such as soda pop or consistent staff members being assigned to him. The record also lacked evidence that the resident-to-resident interactions which were bothersome to others had been evaluated or had interventions assigned to address them. On 7/7/26 at 2:17 p.m., a call was placed to R2’s identified guardian. However, they were not reached. On 7/7/26 at 2:36 p.m., a group interview was held with the DON, licensed practical nurse unit manager (LPN)-B, and social services director (SSD). The administrator joined the interview at 2:40 p.m. SSD explained when someone admitted to the care center, that staff would try to learn behaviors and the IDT would adjust the care plan accordingly. The social workers reviewed progress notes and then a “target behavior monitoring form” would be completed in the medical record. SSD reviewed the record and stated R2 “might not have one yet” as it			F0684			07/24/2026

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F0684 SS = D	Continued from page 15 wasn't a full quarter since he had admitted. The TAR was reviewed, and the group verified only three items were being tracked for R2 including restlessness, agitation, and withdrawn behavior. The administrator stated they were actively seeking other placement options for R2 but had not secured anything so far due to family wanting to keep him in the Duluth area. The group expressed R2 was not always hitting people but rather would grab them or tap them to get attention due to being non-verbal. The staff could use the tablet to distract or occupy R2 if needed. They acknowledged being aware R1 did not like R2's presence and the corresponding issues between them. R1 was being addressed with a possible room change and seeing psychiatry to help with emotions. The administrator explained behaviors were discussed and tracked in the "morning meeting" using a spreadsheet which was not part of the medical record. SSD stated the completion of the assessment (i.e., target behavior form) was only done quarterly as that was policy, and if staff don't communicate with them (IDT) on interventions they see work, then the care plan wouldn't get updated with that information. The administrator stated they would review the medical record for the IDT assessment process of R2's behaviors and provide it, if located. SSD stated it was important to assess behaviors and care plan the interventions to show what actions had been taken, what worked or did not work, and that the center was not ignoring the issue. No further information was received. A facility policy on behavioral assessment was requested; however, none was received.			F0684			07/24/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
NAME OF PROVIDER OR SUPPLIER THE NORTH SHORE ESTATES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7700 GRAND AVENUE , DULUTH, Minnesota, 55807			
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20000	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 7/7/26 to 7/8/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H54833157C (3069193) Minnesota Department of Health (MDH) is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
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20000	Continued from page 1 ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			