STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Shore Health	515 - 5th Avenue West Grand Marais, MN 55604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide a written bed hold for 2 of 2 residents (R5, R30) reviewed for hospitalization. In addition, the facility failed to notify the Ombudsman of the transfers to the hospital.Findings include: R30 R30's quarterly Minimum Data Set (MDS) identified resident as cognitively intact with diagnoses of hemiplegia (paralysis affecting one side of the body) following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe), depression, anxiety, anemia, dysuria (pain or discomfort during urination), obstructive and reflux uropathy (condition affecting the urinary tract and the flow of urine), and a personal history of prostate cancer. Progress note, dated 5/24/25, indicated it is evident that resident is not feeling well. T (temperature) 99.2 R (respirations) 40, P (pulse) 81 BP (blood pressure) 97/53. Update left with SMC MD who advised for resident to be seen in the ED. Resident transferred to the ED at approx. 1430. Sister received update on current status and ED visit- reports that she has provided update to son as well. Progress note lacked evidence of a bed hold being discussed with resident or representative at the time of transfer on 5/24/25 or during hospitalization. During review of R30's entire electronic medical record (EMR), the EMR lacked a completed bed hold form relating to resident's transfer to the emergency department on 5/24/25. Email received from administrator on 7/31/25 at 7:33 a.m., stated I wish I could give you the notice but I can't. The notification process to the resident/family got lost in personnel change. R5R5's quarterly MDS dated [DATE] identified resident as cognitively intact with diagnoses that included age related decline, cerebral infarction, repeated falls, anxiety, irritable bowel syndrome, diabetes, gout, and anemia.During interview on 7/28/25 at 3:25 p.m., R5 indicated she went to the emergency room on 7/27/25. R5 stated she is not sure if she had to sign anything but understood why she was going to the emergency room.During interview on 7/30/25 at 9:48 a.m., registered nurse (RN)-A stated when sending a resident to the hospital the nurse would call the primary provider to give an update on the situation. RN-A also stated the resident's family would be called as well. RN-A explained the business office would complete the bed hold when residents stay overnight in the hospital but not if they only go to the emergency room.During interview on 7/30/25 at 12:34 p.m., assistant director of nursing (ADON) stated her understanding was anytime a resident goes to the emergency room they should get a bed hold. ADON confirmed she did not ask R5 about a bed hold.During interview on 7/30/25 at 1:03 p.m., licensed practical nurse (LPN)-A stated when a resident was admitted to the hospital they would get a bed hold. LPN-A verified she did not obtain a bed hold for R5 on 7/27/25.During interview on 7/31/25 at 10:45 a.m., social worker (SW)-A stated it was her understanding that the facility should send the ombudsman a list of residents who were sent to the hospital monthly. SW-A explained she became aware of this requirement three weeks ago, and had sent a notice to the ombudsman on 7/18/25 for the previous 30 days. SW-A stated being unaware of requirement and the notices were not being sent before that time.During interview on 7/31/25 at 11:30 a.m., director of nursing (DON) stated the bed hold should be given when the resident leaves for the emergency room. DON indicated the bed hold was important to make sure the resident had a bed upon their return.Email received from administrator on 7/31/25 at 11:53 a.m., stated attached is the ombudsman notification for the last month [July 2025]. We do not have notification from previous months.Bed Hold Notice Policy last approved 8/20/2024, stated all nursing home residents must receive a bed hold notice and copy of the bed hold policy if they are placed on a bed hold, for either a planned absence or emergency event, a notice regarding that bed hold must be issued to the resident and/or the resident's representative prior to or at the time of departure.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to incorporate provider orders as well as indications for use for aquathermia heating therapy pad (aqua-K pad) intervention in care plan for 1 of 3 residents (R19) reviewed for care planning.Findings include:R19's quarterly Minimum Data Set (MDS) dated [DATE], identified the resident was severely cognitively impaired with diagnoses that included Alzheimer's disease, depression, anxiety, varicose veins of lower extremity, hypocholesteremia, osteoarthritis, hypothyroidism, gastroesophageal reflux disease, and peripheral vascular disease.Review of R19's provider orders on 7/30/25, no order for use of aqua-K pad for back pain in resident's electronic medical record (EMR).During interview on 7/30/25 at 2:12 p.m., registered nurse (RN)-B stated R19 did use an aqua-K pad but was not sure how long the resident had been using it. RN-B identified the pump for the aqua-K pad was set to 100 degrees and on continuous mode, with an empty water reservoir. RN-B stated there was not an order for R19 to use the aqua-K pad. During joint interview on 7/30/25 at 3:03 p.m., director of nursing (DON) and assistant director of nursing (ADON) stated expectation that the provider would enter orders for the use of the aqua-k pad. DON and ADON explained the order would have the temperature settings, the frequency of use, and whether continuous use would have been allowed. DON and ADON stated being unsure if there was any danger in using the aqua-K pad without water or in using the pad continuously. DON and ADON confirmed that during the facility's switch from one EMR to another, the provider order for R19 to use the aqua-K pad did not transfer over. DON and ADON verified there was no order in the current EMR and staff did not have necessary directions on use and care of aqua-K pad.During interview on 7/31/25 at 1136, DON stated expectation of having a provider order for R19's use of aqua-K pad, and that information should have been in the resident's care plan.Aquathermia Pad policy, last revised on 1/27/2025, stated the use of an aquathermic pad is initiated by a physician's/advance practice provider's order that specifies duration and frequency. Policy continued on to state in preparation section review physician's/advance practice provider's order to determine treatment area, type of application, and temperature of treatment.

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Based on observation, interview, and record review the facility failed to ensure infection prevention measures were in place to ensure linen was properly handled and stored. These deficient practices had the potential to impact all residents who resided at the facility. In addition, the facility failed to ensure proper glucometer sanitization occurred. This deficient practice had the potential to impact all residents who received glucometer testing at the facility. Findings include:During a tour of the laundry area on 7/29/25 at 12:31 p.m., the lead housekeeping staff (HS-A) stated dirty laundry was brought to laundry in clear plastic bags from all areas. Their process was to remove the plastic bags and sort laundry in the dirty linen area of laundry. Staff were to always wear gloves when they sorted linen. Staff would also wear a gown or a jacket when they sorted linen that was obviously soiled. HS-A confirmed staff were not required to wear a gown/jacket over their clothing for routine linen sorting, it was their process to wear gloves for routine linen sorting and then gown up for laundry that was visibly soiled. During a tour of the clean linen storage area on 7/29/25 at 12:35 p.m., wooden shelves and metal carts lined the walls of the linen room. On the right wall, the bottom wooden shelves were less than an inch think and flush to the floor. The bottom shelves contained mattress pads and blankets, some directly touching the floor. During an interview on 7/29/25 at 12:49 p.m., HS-A stated laundry should not be stored so close to the floor because it could become contaminated. HS-A removed the linen from the bottom shelves and stated they would need to re-wash the linen before it could be used. During an interview on 7/30/25 1:50 p.m., the director of nursing (DON) stated they were not sure if it was an infection prevention requirement for staff to wear a gown and gloves or just gloves when sorting linen. They would have to look at the facility policy to know for sure. During an interview on 7/30/25 at 2:02 p.m., environmental services aide EVS-A stated they also got assigned to laundry. On laundry days they were responsible for sorting dirty linen, washing, drying, and folding linen. EVS-A stated they had to always wear gloves to sort dirty laundry. When they had yellow or red bags of linen that needed to be sorted, they also wore a gown or a jacket in addition to their gloves. EVS-A confirmed they were instructed they only needed to wear gloves to handle dirty linen unless it was from a yellow or red linen bag. During an interview on 7/31/25 at 9:51 a.m., the infection preventionist (IP) stated for infection prevention the laundry staff should be wearing gown and gloves at all times when sorting dirty laundry. The laundry policy should include direction to wear gown and glove at all times for laundry sorting. Gowning and gloving when sorting linen should be done to prevent cross contamination of the clean laundry. Laundry should not be stored where it can touch the floor and become contaminated. The facility policy Departmental (Environmental Services) - Laundry and Linen dated 11/2014, section: Sorting Linen, instructed employees sorting or washing linen must wear a gown and gloves. During an interview on 7/30/25 at 1:37 p.m., registered nurse (RN-B) stated blood sugars were normally done by the night staff at 5:30 a.m. so they hadn't had to clean the glucometer. RN-B picked up the oxiver wipes and stated if they had to clean the glucometer, they would wipe it down with oxiver wipes and make sure the glucometer remained wet for the dwell time of 1 minute. The ADON was present and stated they would use the oxiver wipes to sanitize the Accu-Chek inform II between residents. The ADON pulled the infection control manual to see how to clean the glucometer, then left, returned, and shared cleaning instructions for the Accu-check Inform (not the instructions for the current glucometer Accu-Chek Inform II) The instructions instructed not to use bleach.During an interview on 7/31/25 at 9:21 a.m., the IP stated they were not sure what the requirements were for cleaning the facility glucometer, as the nurse managers and the ADON did the glucometer training. The IP indicated the infection prevention program should include oversight of the training of staff to ensure staff were using the right products and processes to clean patient care for equipment for infection prevention and control. During an interview on 7/31/25 at 11:24 a.m. the DON stated the IP was responsible for setting the policies and procedures for equipment cleaning and then nursing was responsible for the training/teaching which took place in orientation. The DON indicated they would expect training to occur when new equipment was put into use, however they were not certain when the newer glucometer model was put into use. The DON stated they were not aware what wipes were being used by staff for the glucometer, but they would expect the IP would do periodic audits on equipment sanitization including the glucometer.The facility policy Cleaning of Non-Critical and Semi-Critical Reusable Resident Care Equipment in North Shore Living Care Center dated 8/23/24, identified the glucometer as equipment staff was to clean. The policy directed it was the responsibility of the person using the equipment to ensure it was properly cleaned before and after use. Alcohol wipes could be used on equipment with

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 5 of 6 residents (R7, R10, R12, R15, R60) reviewed for immunizations were offered or received timely administration of pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The Centers for Disease (CDC) document Pneumococcal Vaccine Timing for Adults dated March 2025, included the following recommendations for adults 50 years or older: --PCV15 only at any age: administer PPSV23 on or after one year.--PCV15 & PPSV23 or PCV20 or PCV21 at any age: no additional administrations recommended.--PPSV23 only at any age: administer PCV20 or PCV21 at or after 1 year. OR administer PCV15 at or after 1 year.--PCV13 at any age: administer PCV20 or PCV21 at or after 1 year.--PCV13 at any age and PPSV23 at or before age [AGE]: administer PCV20 or PCV21 at or after one year.--Together with the patient providers may choose to administer PCV20 or PCV21 to adults 65 years or older who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. The facility policy Pneumococcal Vaccination dated 1/16/25, directed vaccinations for the prevention of pneumococcal pneumonia were to be assessed and provide upon admission to those residents who had not previously had the vaccines. In addition, pneumococcal vaccine would be provided throughout the Calander year to residents based on their immunization status. Revaccination with pneumococcal vaccine will occur per CDC guidelines. The policy lacked evidence to support the most current CDC guidelines were being utilized for pneumococcal administration. R7 was admitted to the facility on [DATE]. R7's undated, Minnesota Immunization Information Connection (MIIC) report indicated R7 had received PCV13 on 7/16/15. Per CDC recommendations R10 qualified for shared decision making for an additional pneumococcal administration. R10 was admitted to the facility on [DATE]. The facility document titled Client information indicated R10 had last received the pneumococcal immunization PCV13 on 10/17/17. Per CDC recommendations R10 qualified for shared decision making for an additional pneumococcal administration. R12 was admitted to the facility on [DATE]. R12 received an unspecified pneumococcal immunization on 8/15/17, and a dose of PPSV23 on 11/5/08. CDC recommendations indicated R12 qualified for PCV20 or PCV21 at least one year after PPSV23. R15 was admitted to the facility on [DATE]. The facility provided document Client Information indicated R15 had received PCV13 on 10/2/13. CDC recommendations indicated R12 qualified for PCV20 or PCV21 administration. R60 was admitted to the facility on [DATE]. The facility document Client Information indicated R60 had received PCV13 on 1/30/18. Per CDC recommendations R60 qualified to receive PCV20 0r PCV21. During an interview on 7/30/25 at 2:23 p.m., the assistant director of nursing (ADON) stated the infection preventionist (IP) at the facility calculated when residents needed vaccinations such as pneumococcal and then documents for consent would go out to residents and or family. The ADON indicated a provider had informed them the CDC had decreased the screening age to 50 so they had been working to get the policy changed to 50 instead of 65. The ADON pulled up their policy and stated it currently didn't address screen residents between 50 and 64, but they policy was in process of being updated. During an interview on 7/31/25 at 8:59 a.m., the IP stated the infection prevention policies should reflect the most current and up to date CDC recommendations and confirmed their Pneumococcal Vaccination policy dated 1/16/25, did not reflect CDC recommendation changes made in October of 2024. The IP indicated the facility offered pneumococcal immunizations yearly and they were in the process of getting ready to offer pneumococcal immunizations to residents next month (August 2025). Nine residents had been identified. Once approved for administration, the facility would be sending out consents to residents/family. The IP indicated if there were a lot of residents that needed a pneumococcal vaccination at the end of the year they would not necessarily wait until August to administer the pneumococcal vaccine to those residents. They would try and do it sooner if four or more residents needed the vaccination. The IP provided a list of residents that had been identified for pneumococcal administration. In addition to R7, R10, R12, R15, and R60, R20 admitted on [DATE], R21 admitted on [DATE], and R26 admitted on [DATE], were also identified as needing pneumococcal administration. The facility guidelines for determining when to administer pneumococcal vaccinations to residents was requested but not received.