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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: G6LP

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245183**

2.STATE VENDOR OR MEDICAID NO.
(L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

4. TYPE OF ACTION: **7** (L8)

**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2014**

6. DATE OF SURVEY **05/29/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **351** (L18)

13.Total Certified Beds **351** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 351 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 06/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/13/2014 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
**X** 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
**05/01/1972**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00000**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**05/30/2014**
(L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN: 24-5183

The facility was not in substantial compliance with Federal participation requirements at the time of the tandard survey completed on 04/18/14. On 05/29/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 06/09/14, the Department of Public Safety completed a PCR. Based on these PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 04/18/14, effective 06/06/14 Refer to the CMS-2567B for both health and life safety code.

Effective 06/06/14, the facility is certified for 351 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

CMS Certification Number (CCN): 24-5183

Electronically Delivered: June 10, 2014

Ms. Kristina Guindon, Administrator
North Ridge Health and Rehab
5430 Boone Avenue North
New Hope, Minnesota 55428

Dear Ms. Guindon:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 6, 2014, the above facility is certified for:

351 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 351 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

Electronically Delivered: June 10, 2014

Ms. Kristina Guindon, Administrator
North Ridge Health and Rehab
5430 Boone Avenue North
New Hope, Minnesota 55428

RE: Project Number S5183023

Dear Ms. Guindon:

On May 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 18, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 9, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 18, 2014, effective June 6, 2014 and therefore remedies outlined in our letter to you dated May 6, 2014, will not be imposed

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245183 | A. Building<br>B. Wing | 5/29/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH<br>NEW HOPE, MN 55428 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0176**<br>Reg. # **483.10(n)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0253**<br>Reg. # **483.15(h)(2)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0274**<br>Reg. # **483.20(b)(2)(ii)**<br>LSC | Correction Completed **05/23/2014** |
| ID Prefix **F0279**<br>Reg. # **483.20(d), 483.20(k)(1)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **05/23/2014** |
| ID Prefix **F0318**<br>Reg. # **483.25(e)(2)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0353**<br>Reg. # **483.30(a)**<br>LSC | Correction Completed **05/23/2014** |
| ID Prefix **F0356**<br>Reg. # **483.30(e)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0371**<br>Reg. # **483.35(i)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **05/23/2014** |
| ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | Correction Completed **05/23/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | GD/AK | 06/09/2014 | 18623 | 05/29/2014 |
| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
| CMS RO | | | | |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 4/18/2014 | | | |

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245183 | A. Building B. Wing **01 - MAIN BUILDING 01** | 6/9/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix | Correction Completed **05/09/2014** | ID Prefix | Correction Completed **05/23/2014** | ID Prefix | Correction Completed **05/14/2014** |
| Reg. # **NFPA 101** | | Reg. # **NFPA 101** | | Reg. # **NFPA 101** | |
| LSC K0018 | | LSC K0020 | | LSC K0029 | |
| ID Prefix | Correction Completed **06/06/2014** | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # **NFPA 101** | | Reg. # | | Reg. # | |
| LSC K0144 | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |

| | | | | |
|---|---|---|---|---|
| **Reviewed By** _____ **State Agency** | **Reviewed By** PS/AK | **Date:** 06/09/2014 | **Signature of Surveyor:** 28120 | **Date:** 06/09/2014 |
| **Reviewed By** _____ **CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

**Followup to Survey Completed on:** 4/18/2014

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: G6LP

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245183**
2.STATE VENDOR OR MEDICAID NO.
(L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

4. TYPE OF ACTION: **2** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2014**

6. DATE OF SURVEY **04/18/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **351** (L18)

13.Total Certified Beds **351** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 351 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR Dietary Specialist 05/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/29/2014 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**05/01/1972**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00000**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN: 24-5183

At the time of the standard survey completed 04/18/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically Delivered: May 6, 2014

Ms. Kristina Guindon, Administrator
North Ridge Health and Rehabilitation
5430 Boone Avenue North
New Hope, Minnesota 55428

RE: Project Number S5183023

Dear Ms. Guindon:

On April 18, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

**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.**

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

**Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**

**Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

**Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

**Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

**Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

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.

**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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 28, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 28, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the

facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

**Original deficiencies not corrected**

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

**Original deficiencies not corrected and new deficiencies found during the revisit**

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

**Original deficiencies corrected but new deficiencies found during the revisit**

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

**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 July 18, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 October 18, 2014 (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.

**INFORMAL DISPUTE RESOLUTION**

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
Division of Compliance Monitoring
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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH NEW HOPE, MN 55428** |

| (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<br><br>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. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to determine whether the practice of self-administration of nebulizer medication was safe for 1 of 1 resident (R54) observed self-administering medication.<br><br>Findings include:<br><br>R54 was observed on 4/17/14, from 7:09 a.m. to 7:16 a.m. while in her room and wearing a nebulizer via a mask around her face. R54's door was observed to be wide open and could be observed from the hallway. A licensed practical | F 176 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 176 | Continued From page 1 | F 176 | | |

nurse (LPN)-B was walking up and down the hallway carrying a tote of nutritional supplements as R54's nebulizer medication was being administered by the resident. LPN-B briefly entered several rooms and returned to the medication cart that was parked one door down from R54's room, however, did not return to R54's room during the observational period. At 7:16 a.m. LPN-B entered R54's room and turned off the nebulizer machine and removed the mask from the resident's face. Following the observation at 7:18 a.m. the surveyor attempted a conversation with R54, but the resident just mumbled and could not be understood.

R54's quarterly Minimum Data Set (MDS) dated 3/21/14, indicated R54 had dementia, with both short term and long term memory problems and Brief Interview for Mental Status (BIMS--used to determine cognition) had not been completed. The resident's physician orders dated 4/9/14, revealed two orders for Duoneb (breathing medication) as needed and scheduled twice daily for shortness of breath/wheezing. The orders did not include physician orders directing staff to allow R54 to self-administer the medication.

R54's Self-Med [Medication] Administration care plan dated 3/28/14, revealed the resident was unable to self-administer medication due to cognitive impairment and the care plan directed all medications be dispensed by nursing staff.

In an interview on 4/17/14, at 2:03 p.m. with LPN-B, she stated she thought all residents who had nebulizer treatments had orders to self-administer the medication after it was set up. She further stated she planned to verify R54's orders on the Medication Administration Record

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 176 | Continued From page 2<br>(MAR). LPN-B then returned and verified R54 did not have an order to self-administer the nebulizer after set-up and the resident's care plan indicated she was unable to self-administer medication. LPN-B acknowledged she should have stayed with the resident during the entire treatment.<br><br>On 4/17/14, at 3:03 a.m. a registered nurse (RN)-C stated her and RN-D both thought R54 had an order to self-administer the nebulizer treatment. The surveyor informed RN-C of LPN-B's findings in the resident's record to which she responded, "Then that is true I don't have to look. My expectation is if a resident does not have an order, then the nurse is supposed to stay with resident at least or have the medication cart parked outside the room as they watched." RN-C added that because she was responsible for 92 residents, she did not know each resident's physician orders.<br><br>On 4/18/14, at 1:11 p.m. the director of nursing (DON) verified the nurse did not follow the facility policy for self-administration of medications for R54.<br><br>The facility Bedside Medications-Self Administration of Medications policy dated 2/28/08, directed, "9. For inhalation therapy, a physician order is required if the resident self administers the nebulizer treatment after the medication is prepared by the nurse (If resident is capable of self administration of the treatment and choose to do so)...." | F 176 | | |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and | F 253 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 253 | Continued From page 3<br>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure resident wheelchairs, motorized scooter for 2 of 2 residents (R439, R309) were kept clean. In addition, the facility failed to ensure 1 of 1 shared bathroom (R483's) area was maintained in a clean and sanitary manner reviewed for environmental concerns.<br><br>Findings include:<br>On 4/18/14, at 10:37 a.m. an environmental tour was completed with the regional vice president (VP)/acting administrator, account manager, direct manager and maintenance staff. During the tour the concerns were identified:<br>R439's motorized scooter was observed on 4/14/14, at 7:32 p.m. with a thick coat of brown to gray, particularly underneath the seat. During interview on 4/14/14, at 7:36 p.m. R439 indicated to surveyor "I would like it cleaned" and thought staff should have been able to see the film of dust.<br><br>During the tour the VP, account manager and maintenance staff all verified the scooter had a layer of dust around the frame and other aspects of the motorized scooter. Maintenance staff indicated the scooter needed to be cleaned. In addition, the account manager indicated she would not have the wheelchair (w/c) log for that unit, and nursing staff would have been responsible for cleaning R439's scooter. | F 253 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 253 | Continued From page 4 | F 253 | | |

R309's w/c on 4/15/14, at 1:16 p.m. was observed stored along the wall outside R309's room. R309's w/c was observed to have many food spills on the edges and the front aspects of the seat with white and brown debris. In addition, the cushion was observed to have large dried white stains in the front and underneath it. When interviewed on 4/15/14, at 1:25 p.m. R309 was not able to state who was responsible to clean his w/c.

During the tour maintenance staff indicated the paper tape dated 2/4/14, located on the foot rest area would probably be the last time the w/c had been cleaned but account manager interjected and stated she had all w/c logs and would provide logs after the tour.

The facility Wheelchair-Motorized Vehicle Use Within The facility policy dated 7/13, directed "Nursing will wipe down the wheelchairs daily when charging batteries."

The w/c and equipment cleaning policy was requested on 4/18/14, at 11:04 a.m. but was not provided.

Toiletries cluttered, stored and unmarked in a shared bathroom.

On 4/14/14, at 6:30 p.m. surveyor observed toiletries sitting on the vanity on both sides in the shared bathroom that R483 used. On the vanity was an unmarked toothbrush and tooth paste in a small basin that was spotted with dried toothpaste. To the left side of the vanity was mouthwash, biotin oral rinse, shampoo, body

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 253 | Continued From page 5<br>wash, baby lotion, unmarked electric toothbrush in another small basin. In addition, a clean incontinent pad was observed on back of toilet, the front of vanity was spotted with dried toothpaste.<br><br>On 4/18/14, at 10:44 a.m. during tour to shared bathroom observed an unmarked electric tooth brush stored in an emesis basin and was covered with a sheet of paper towel to the left side of vanity and to the top right side of the vanity was a denture cup with a tube of tooth paste next to it. The regional vice president and account manager (O)-E verified the bathroom was shared and personal toilettes were not supposed to be stored at the vanity.<br>-At 10:46 a.m. as surveyor was still in the bathroom doing the tour, R483 stated, "I like the denture cup to be sitting here at my stand and not in there and I have told them." R483 thanked the regional vice president after getting the denture cup to her bedside stand. | F 253 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the | F 274 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 274 | Continued From page 6<br>care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to complete a significant change assessment for 1 of 1 resident (R355) reviewed for activities of daily living (ADLs).<br><br>Findings include:<br><br>R355 was interviewed regarding her level of assistance with ADLs on 4/17/14, at 8:10 a.m. She reported she only needed help from staff to put on her leg ace wrappings in the mornings, and sometimes staff took off her wheelchair leg rests. In the past, she needed assistance to the toilet, but said she was able to toilet herself independently.<br><br>Following the interview on 4/17/14, at 8:44 a.m. R355 was observed in her room sitting in her wheelchair. The resident independently lifted the foot pedals on her wheelchair, swung the leg rest to the left side and used a grab bar to independently stand and sit onto the bed. R355 then bent over and removed her shoes, lifted her legs, and laid down on the bed. A nursing assistant (NA)-K placed the resident's call light onto the grab bar, and encouraged the resident to use call light if she needed the bathroom. The resident was not observed after the 4/17/14, observation as the resident's behavior had escalated.<br><br>R355's quarterly Minimum Data Set (MDS) dated 9/6/13, indicated R355 was independent with bed mobility and transfers and required only set up | F 274 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 274 | Continued From page 7 | F 274 | | |

assistance for dressing and hygiene. A Brief Interview Mental Status (BIMS- a test to determine cognition level) was 13 out of 15 which depicted no cognitive loss. R355's annual MDS dated 11/29/13, indicated the resident was independent only needing supervision or cues for bed mobility, transferring, locomotion on the unit, dressing, and hygiene. A BIMS score was noted to be 13 out of 15 which depicted no cognitive loss.

A subsequent quarterly MDS dated 2/21/14, however, revealed the resident had experienced a decline in performance and required extensive assistance with bed mobility, transferring, locomotion on the unit, dressing, and hygiene. A BIMS score was noted to be 9 out of 15 which depicted moderate cognitive loss. R355 displayed a change in cognitive patterns as evidenced by a decrease in the BIMS.

The Care Area Assessment (CAA) dated 12/4/13, indicated R355 was requiring more assistance with activities of daily living (ADLs) due to poor hygiene and resident was at optimal functioning level and no therapy was indicated at that time. The CAAs did not depict R355 as having a well-established cyclical pattern with ADLs.

R355's Daily Performance Sheets were reviewed from 9/1/13, going forward and the following was noted:
Bed Mobility: Daily ADL Performance Sheets 9/1/13 thru 9/6/13, and 11/23/13 thru 11/29/13, for R355 were reviewed and indicated R355 needed no physical assist and independent with bed mobility, however, Daily ADL Performance Sheets dated 2/15/14 thru 2/21/14 for R355 indicated R355 needed physical assist with bed mobility 12

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 274 | Continued From page 8<br>times.<br><br>Transfers: Daily ADL Performance Sheets dated 9/1/13 thru 9/6/13, for R355 were reviewed and indicated R355 Independent with transfers and needed no physical assist. Daily ADL Performance Sheets dated 11/23/13 thru 11/29/13, indicated R355 required physical assist of one and supervision for transfers once. Daily ADL Performance Sheets dated 2/15/14 thru 2/21/14, indicated R355 required physical assist of one with transfers 13 times and physical assist of two once.<br><br>Dressing: Daily ADL Performance Sheets dated 9/1/13 thru 9/6/13, indicated R355 was independent with dressing. Daily ADL Performance Sheets dated 11/23/13 thru 11/29/13, indicated R355 required physical assist of one, one time for dressing. Daily ADL Performance Sheets dated 2/15/14 thru 2/21/14, indicated R355 required physical assist of one eight times, set up two times, and supervision one time for dressing.<br><br>Hygiene: Daily ADL Performance Sheets dated 9/1/13 thru 9/6/13, indicated R355 required physical assist of one, one time for hygiene. Daily ADL Performance Sheets dated 11/23/13 thru 11/29/13, for R355 indicated set up assistance twice. Daily ADL Performance Sheets dated 2/15/14 thru 2/21/14, for R355 indicated physical assist of one, seven times and set up assistance three times for hygiene.<br><br>Interdisciplinary Care Conference Summary dated 2/27/14, indicated the resident's need for assistance varied daily due to behavioral issues and/or confusion. | F 274 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 274 | Continued From page 9 | F 274 | | |

A nurse practitioner (NP)-L noted on 3/17/14, noted the resident had experienced a decline in behavior and cognition, and was needed more assistance from staff. The NP also noted that the addition of antipsychotic medication had been helpful for R355.

An interview conducted with a nursing assistant (NA)-K on 4/17/14, at 8:20 a.m. revealed R355 was already dressed that day and she "sometimes" helped the resident with that task. NA-K stated that R355 often refused to go to the bathroom when offered, but when she was assisted, pericare was performed.

On 4/17/14, at 2:14 p.m. NA-D reported she assisted R355 to change her incontinent pad and performed pericare, sometimes assisted the resident to stand if the resident allowed, helped her brush her teeth, removed ace wraps from her legs, and covered the resident once she was in bed.

The MDS Coordinator (RN)-D was interviewed on 4/18/14, at 7:58 a.m. and stated R355 displayed paranoia in 2/14, and had been started on antipsychotic medications. The resident was now a little better, but sometimes had refused care. The resident required extensive assistance depending on the day, and received maximum assistance three times weekly. RN-D thought R355 might have improved to baseline by the time survey, as it had been about six weeks, but R355 had not improved to baseline. She also stated the interdisciplinary team (IDT) had discussed R355's condition and requested therapy staff screen her for possible treatment because of the decline. RN-D said the resident's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 274 | Continued From page 10 | F 274 | | |

delusions and paranoia were causing the need for more assistance, and R355 had been looking more disheveled, with an increase in body odor and a little more urinary incontinence. In addition, the MDS coordinator stated R355's level of cognition had probably decreased. RN-D also explained R355 had experienced elevated blood sugars and now required Glucophage (for diabetic management). MDS coordinator stated a screening by occupational therapy staff had been completed, and the resident was "on the list" for a significant change assessment. At the time of the interview, however, RN-D was unable to show documentation of a therapy screen for R355. RN-D produced a form titled Therapy Communication Form dated that day (4/18/14) which indicated R355 had an increase in need for assistance with transferring and personal care.

The assistant rehabilitation director was interviewed on 4/18/14, at 8:38 a.m. and stated the therapy company was new to the facility as of 1/14, and they had not yet screened or seen R355 for physical or occupational therapy to the director's knowledge. "The last therapy notes in the resident's record were from 2010." RN-D referred R355 to therapy after surveyor intervention on 4/18/14.

The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual dated April 2012, defines a significant change as a decline or improvement in a resident's status that: 1. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" 2. impacts more than one area of the resident's health status; and 3. requires interdisciplinary review and/or revision

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 274 | Continued From page 11<br>of the care plan. A Significant Change in Status Assessment (SCSA) is appropriate when: the resident's condition is not expected to return to baseline within two weeks.<br><br>The facility's MDS Assessment policy dated 3/3/08, indicated significant change assessments would be completed per regulations and was the responsibility of the MDS coordinator. | F 274 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to develop a care plan to | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 279 | Continued From page 12<br>addressed dialysis dressing removal and the access site location for 1 of 1 resident (R153) reviewed for dialysis.<br><br>Findings include:<br><br>On 4/16/14, at 10:52 a.m. observed R153 sitting at the dining room (DR) table dressed in a long sleeved green sweater and on left arm area observed to be very bulky. Surveyor approached R153 who indicated "I am supposed to go to dialysis today but I just don't feel good and I had told the girl at the desk but don't know."<br>-At 10:53 a.m. surveyor approached R153 and requested licensed practical nurse (LPN)-B to bring R153 back to the room to check her arm if she had a dressing on her left arm.<br>-At 10:54 a.m. LPN-B when asked where R153's access site was indicated left arm. LPN-B pulled the left sleeve of sweater and underneath was observed several gauze pads secured with paper tape. LPN-B stated the bandages were supposed to be removed six to eight hours after dialysis. LPN-B then went back to the bathroom, washed her hands, applied gloves and removed the dressing. There was no blood on the gauze, area was dry and no signs and symptoms of infection observed.<br>-At 10:59 a.m. LPN-B was observed going through the April 2014 treatment book and verified the bandages on the access site had been signed off on 4/14/14, as being removed. LPN-B further stated "I guess it was signed off but was not removed." LPN-B verified both the temporary and care plan on the computer had not indicated the access site location but indicated there was a sign in the room that indicated "NO B/P [blood pressure] ON LEFT ARM." | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 279 | Continued From page 13 | F 279 | | |

The Resident Problem List/Temporary Care Plan dated 3/27/14, identified R153's other skin problems. In addition, the care plan dated 4/9/14, identified R153 needed hemodialysis related to renal failure. The care plan directed to check and change dressing at access site, document, not to draw blood or take blood pressure in arm with graft and monitor access site for signs and symptoms of infection both lacked the exact access site location.

The Dialysis Care Flow Sheet dated March 2014, and April 2014, both indicated to check Bruit every shift and upon return from dialysis to check for bleeding; pain; tenderness or drainage from shunt site but also lacked the exact location of the access site.

When interviewed on 4/18/14, at 10:16 a.m. registered nurse (RN)-C stated, "As far as I know everyone knows resident is on dialysis and if she was to be moved to another unit it would be communicated on report. The graft is big and there is no way anybody can miss it." When asked why the location of site was not specified in the care plan. RN-C further stated "For as long I know with going to Point Click Care [electronic health record program] we are not supposed to put all that personal information in the care plan. When asked if someone were to take a blood pressure somewhere else other than in the room where the sign was posted "NO B/P ON LEFT ARM" how the staff would know which arm and if R153 happened to wear a long sleeved shirt RN-C stated "Again the graft is huge nobody can miss it."

When interviewed on 4/18/14, at 1:22 p.m. the director of nursing (DON) stated the location of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 279 | Continued From page 14<br>the access site should be specified to make sure staff knows the exact arm location. In respect to the Point Click Care and the new company not wanting to have resident specific information as indicated by RN-C, DON stated "We are just getting to it and are working on getting used to it." DON further stated the care plan should have been updated with order to remove the dressing as directed by dialysis.<br><br>When interviewed on 4/18/14, at 1:40 p.m. RN-D stated acknowledged the access site location should be specified in the care plan. RN-D further stated "Again as I told you the other day this was the first care plan I did with the new system and there maybe problems" as she lifted her right hand up. | F 279 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure range of motion services were provided for 1 of 2 residents (R63) reviewed in the sample for range of motion. In addition, the facility failed to ensure resident-specific target-behavior monitoring and side effect monitoring was completed as directed by the care plan for 1 of 6 residents (R137).<br><br>Findings include: | F 282 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 282 | Continued From page 15 | F 282 | | |

R63 was admitted 4/1/02, and had diagnoses that included cerebral vascular accident (CVA) with right hemiplegia and aphasia (inability to speak) per the Admission Record.

During observation on 4/16/14, at 10:13 a.m. R63 was sitting in a wheelchair with her right hand and arm resting on a 1/2 laptray on the right side of her wheelchair. R63's right hand appeared contracted and no splint was observed in place.

During observation on 4/16/14, at 11:20 a.m. R63 was seated in wheelchair in front of TV blowing her nose with her left hand. R63 nodded her head up and down when asked how she was, her right arm was resting on the 1/2 laptray on right side of wheelchair, no splint on.

During observation on 4/16/14, at 12:18 a.m. R63 was in the dining room. Her right hand and arm were resting on the 1/2 laptray attached to her wheelchair. R63 was feeding herself with her left hand. At 1:05 p.m., R63 wheeled herself from the dining room to the hallway handrails using her left hand only.

The Care Area Assessment (CAA) dated 10/28/13, revealed R63 required extensive assistance with all ADLs with the exception of eating and ambulation due to cognitive and balance losses related to CVA with right hemiparesis and weakness, was non-verbal and does not make her needs known, but was able to make some gestures. The CAA did not address range of motion.

The quarterly Minimum Data Set (MDS) dated 1/23/14, identified R63 had functional limitations

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 282 | Continued From page 16 | F 282 | | |

of one side, for both upper and lower extremities and required extensive assistance for most activities of daily living (ADLs).

The plan of care dated 2/7/14, identified R63's mobility was impaired due to CVA with aphasia and right hemiparesis and that there was a contracture of elbow and shoulder region. Passive range of motion (PROM) was to be completed daily with cares on the 2:00 to 10:00 shift by the nursing assistants (NA).

Review of February, March and April 2014 Treatment Administration Record (TAR) indicated no PROM was completed until 4/16/14.

During an interview on 4/16/14, at 1:24 p.m. clinical manager (RN)-I stated R63 "has been here for over 10 years. I'm not aware she is on a ROM program and have not known her to wear a splint on her right arm or hand." RN-I further stated if R63 was on a ROM program, it would be done when the NAs were dressing her and it would have been documented on the therapy page in the Medication Administration Record (MAR) and that she was not sure why the care plan stated ROM for the 2:00 to 10:00 p.m. aide shift.

During an interview on 4/16/14, at 1:36 p.m. RN-I provided an updated care card which indicated "PROM right side UE [upper extremity] & LE [lower extremity] with cares 2-10 shift". RN-I stated "they said if it is on the care plan, then it should be done, so we added it, there has been no decline." RN-I verified ROM should have been done.

During an interview on 4/17/14, at 1:32 p.m. NA-A

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 282 | Continued From page 17 | F 282 | | |

stated she did not remember giving the resident ROM exercises, further stated it would be done "just when we get her dressed, we may move her arms." R63 was not provided ROM as directed by the care plan.

R137's target behaviors of paranoia such as believing the room was "bugged" and food was "poisoned;" R137 was not monitored for side effects for the use of Seroquel (an antipsychotic medication), such as orthostatic blood pressure monitoring as directed by the care plan

The admission MDS dated 2/16/14, noted R137 had severe cognitive impairment and had no mood or behavior problems; R137 was prescribed Seroquel, an antipsychotic medication.

The CAA for psychotropic drug use dated 2/17/14, indicated R137 received Seroquel for psychosis. The care plan considerations section of the CAA directed staff to monitor for complications related to medication use.

R137's care plan dated as initiated on 2/18/14, indicated R137 received Seroquel for Alzheimer's disease with psychosis and paranoid behaviors of her food being poisoned and her room being bugged. R137's care plan directed facility staff to monitor and document the occurrence of target behaviors, and specified the behaviors as "paranoid statements and refusing to eat." R137's care plan further directed facility staff to give the Seroquel as ordered and to monitor and document side effects.

On 4/17/14, at 2:30 p.m. licensed practical nurse (LPN)-C verified there was no baseline orthostatic blood pressure obtained for R137, and no target

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 282 | Continued From page 18<br>behavior monitoring or side -effect monitoring done on R137 for the use of Seroquel.<br><br>On 4/17/14, at 3:02 p.m. the mental health nurse (RN)-E verified R137 had no monitoring for target behaviors or side effects for the use of the Seroquel. RN-E acknowledged, "That is an error on our part."<br><br>On 4/18/14, at 12:20 p.m. the director of nursing (DON) verified target behaviors and side effects should be monitored with the use of anti-psychotic medications as directed by the care plan.<br><br>The facility's Anti-psychotic Medication Policy dated 10/8/13, directed to complete monthly monitoring of orthostatic blood pressure and directed target behavior monitoring "per the Scheduled Antipsychotic/Anxiolytic Med Monitoring Sheet." | F 282 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure dialysis site dressing was removed after dialysis to reduce the | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 309 | Continued From page 19<br>risk of access site infection or clotting for 1 of 1 resident (R153) reviewed for dialysis.<br><br>Findings include:<br><br>R153 was observed seated in the dining room on 4/16/14, at 10:52 a.m. The resident was wearing a long sleeved sweater, and the resident's left arm was very bulky. The resident stated, "I'm supposed to go to dialysis today but I just don't feel good and I told the girl at the desk but I don't know." Just after the observation at 10:53 a.m. a licensed practical nurse (LPN)-B was carrying a duffle bag, R153's jacket, and wheeling a wheelchair in the hallway. The surveyor intervened to request the LPN return R153 to her room and check her arm. When asked by LPN-B, the resident indicated her dialysis access site was in her left arm. When LPN-B pulled up the resident's sweater sleeve, several gauze pads were secured with paper tape covering the site. LPN-B explained that the bandages should have been removed six to eight hours after the resident had dialysis, and the dressing was removed without blood or signs of infection noted. At 10:59 a.m. LPN-B looked in the April 2014 treatment book and verified although someone had signed off that the bandages had been removed after the resident had dialysis two days prior on 4/14/14, they in fact had not been removed. LPN-B stated "I guess it was signed off but was not removed."<br><br>R153's Physician Orders signed 3/27/14, did not identify the location of the access site, nor specific instructions for care of the shunt site dressing.<br><br>R153's admission Minimum Data Set (MDS) dated 4/3/14, noted diagnoses including end | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 309 | Continued From page 20 | F 309 | | |

stage renal disease (ESRD) with dialysis, diabetes mellitus (DM), and chronic neuropathy. The resident's Brief Interview for Mental Status (BIMS-tool used to measure cognition) revealed a score of 12 indicating moderate impaired cognition, and the need for extensive assistance from one to two staff to perform all cares.

Additional document review revealed a Minnesota Masonic Home North Ridge Referral Form dated 4/4/14, that indicated the resident had arrived at dialysis with an "Oxygen [tank] empty! Bandages on access SHOULD be removed after 6-8 hours and not be left on overnight & definitely not...next dialysis day!"

The care plan dated 4/9/14, identified R153 needed hemodialysis related to renal failure. Staff were directed to "Check and change dressing at access site and document."

When interviewed on 4/16/14, at 11:26 a.m. a registered nurse (RN)-C stated her expectation was if the nurse had signed it off, "They better have taken it off, as it's a doctor's order."

A registered dietitian (RD)-A stated on 4/16/14, at 11:30 a.m. that R153 was being weighed at dialysis, and the dialysis RD reported the resident's weights were stable. The RD said facility staff was to check resident weights for persons receiving dialysis as directed.

A RN-C was interviewed on 4/17/14, at 3:07 p.m. regarding nurses ability to check bruit and thrill at the access site on 4/14/14, when the dressing had remained in place until 4/16/14. RN-C responded, "Last night I also thought about it. You will have to ask them [staff responsible]. I am not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 309 | Continued From page 21<br>able to talk for them. RN-C also acknowledged infection control concerns when the dressing had not been removed.<br><br>The dialysis center's RN was interviewed on 4/18/14, at 9:53 a.m. and reported an awareness the resident sometimes returned to dialysis with the old dressing in place on the access site. The RN explained that, "The dressing is supposed to be removed about after four hours after to prevent the pressure around the access site, as the longer the dressing stayed on it can cause the access site to clot." The RN added that the facility staff probably needed more education. | F 309 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services to minimize the risk of further decline in ROM for 1 of 2 residents (R63) reviewed for range of motion.<br><br>Findings include:<br><br>R63 was observed throughout the day on 4/16/14. | F 318 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 318 | Continued From page 22 | F 318 | | |

- At 10:13 and 11:20 a.m. the resident was seated in a wheelchair with her right hand and arm resting on a 1/2 arm tray on the right side of her wheelchair. The resident's hand appeared contracted (joint is bent and will not move) and without a splint (to minimize or improve ROM).
- At 12:28 p.m. R63 was in the dining room with her hand and arm in the 1/2 arm tray and was eating with her left hand. After the meal the resident pulled herself down the hallway using her left hand and the hand rails.

A Care Area Assessment (CAAs) dated 10/28/13, revealed R63 required extensive assistance with all activities of daily living (ADLs) with the exception of eating and ambulation due to cognitive and balance losses related to Stoke (CVA) with right hemiparesis and weakness, was non-verbal but able to make some gestures. ROM was not addressed on the CAA.

R63's physical therapy daily flow sheet dated 11/19/13, noted the resident had been seen one time for an evaluation. During the evaluation passive range of motion (PROM) was performed on the resident's right extremity. "See eval [evaluation]. Pt. [patient] not very interested in activity, but cooperated." The resident's tolerance to therapy was marked, "fair." A Physician's Telephone Order also dated 11/19/13 was to discontinue "OT [occupational therapy]" evaluation. "Resident is at baseline with ADLs. No intervention indicated."

A quarterly Minimum Data Set (MDS) dated 1/23/14, showed R63 had functional limitations on one side of the body on both the upper and lower extremities and required extensive assistance for most ADLs. R63 had diagnoses including a CVA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 318 | Continued From page 23 | F 318 | | |

with hemiplegia (paralysis on one side of the body).

R63's care plan dated 2/7/14, revealed the resident had contractures at the elbow and shoulder. Staff was directed to perform PROM daily on the 2:00 to 11:00 p.m. shift by the nursing assistants (NAs). The care card inside R63's closet and the NA assignment sheet, however, did not direct the NAs to perform PROM for the resident during evening cares.

Treatment Administration Records (TAR) for R63 for 2/14, 3/14, and 4/14, showed PROM was not recorded as being completed until 4/16/14.

A registered nurse (RN)-I was interviewed on 4/16/14, at 1:24 p.m. and reported R63 "has been here for over 10 years. I'm not aware she is on a ROM program and have not known her to wear a splint on her right arm or hand." RN-I further stated if R63 was to receive ROM, it would have been performed when the NAs assisted the resident to dress. ROM would have been documented on the "therapy page" in the Medication Administration Record (MAR). RN-I was unsure why the care plan directed staff to perform ROM on the 2:00 to 11:00 p.m. shift. At 1:36 p.m. RN-I provided an updated care card that indicated, "PROM right side UE & LE [upper extremity and lower extremity] with cares 2-10 shift." RN-I explained, "They said if it is on the care plan, then it should be done, so we added it." RN-I added that it should have been performed, and the resident had not declined in her ROM.

The occupational therapist (OT/R) stated on 4/17/14, at 1:08 p.m. that R63 knew exactly what

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 318 | Continued From page 24 | F 318 | | |

she wanted, and did not like participating in ROM exercises. Typically OT staff would have taken baseline measurements when R63 was admitted, but the OT/R stated, "I don't know what was set up in the beginning."

The director of nursing (DON) was interviewed on 4/17/14, at 1:26 p.m. and stated, "I don't know why it wasn't on the care sheet in the room. I don't know if therapy measured the contracture. There hasn't been any change since between the last two MDS's. The aides would report if she was in pain." At 4:05 p.m. the DON explained that R63 was hospitalized in 11/13 and a physician had ordered physical and occupational therapists to treat the resident. A physical therapist saw R63 once and an OT/R had discharged her from therapy. The DON further stated "Staff is providing ROM because they are dressing her and have to move her limbs."

NA-A reported in an interview on 4/17/14, at 1:32 p.m. she did not remember performing ROM exercises for R63 and said, "Just when we get her dressed we may move her arms."

The OT/R explained in an interview on 4/18/14, at 9:55 a.m. that she performed a verbal assessment 1:1 with the resident to determine if the need for an evaluation, but found R63 to be at baseline with no intervention from therapy needed. The OT/R stated, "I don't know what nursing does for range of motion."

The facility Range of Motion policy dated 7/11/11, indicated, "Range of motion will be done as indicated to maintain and/or increase flexibility and mobility to help prevent deformities and contractures." The facility Care of Residents

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 318 | Continued From page 25<br>dated 6/18/12, noted "Each resident will receive nursing care and supervision based on individual needs addressed on resident Care Plans and Care Cards." R63 was not provided with ROM as directed by the care plan and the facility to maintain flexibility. | F 318 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 26 | F 329 | | |

review, the facility failed to ensure resident specific target behavior monitoring and side effect monitoring were implemented with antipsychotic use for 1 of 6 residents (R137) reviewed for unnecessary medications.

Findings include:

R137 was not monitored for resident-specific target behaviors for the use of Seroquel (antipsychotic medication); in addition, R137 was not monitored for side effects associated with use of Seroquel, such as monitoring orthostatic blood pressures.

On 4/16/14, from 11:59 a.m. to 12:15 p.m. R137 was observed at the Bridgeway South (BWS) front dining room eating lunch. R137 was observed to be calm, eating independently.
- At 12:58 p.m. R137 was observed to be seated calmly in a wheelchair at the baking activity in the Therapeutic Recreation room. R137 was observed in a word game activity, with other residents in the BWS front area dining room. R137 remained quiet and calm during the activity, alternately glancing at the other residents and the activity director.

On 4/17/14, at 10:22 a.m. R137 was observed at the BWS front area dining room with other residents at the music activity. R137 appeared calm and attentive.

R137's nursing clinical notes from 2/6/14 to 3/22/14, indicated R137 was cooperative with cares, pleasantly confused, had no behavior issues, and was "adjusting well to the unit." A note on 2/8/14, indicated R137 was "cooperative with cares, resisitive [sic] with medicationss [sic]

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 27 | F 329 | | |

but did not talk about wanting to leave or get out of here. Was not looking for way out." Review of the nursing clinical notes from 3/13/14 to survey date 4/17/14, noted R137 was resistive to cares at time and R137 was redirectable. No entries indicated R137 was monitored for resident specific target behaviors and side effects for the use of Seroquel.

R137's Minimum Effective Dose Committee Quarterly Audit (MEDCQA) form dated 2/6/14, indicated R137 had diagnoses to include Alzheimer's dementia, psychosis, paranoia and anxiety. MEDCQA noted R137's daughter reported R137 had a history of psychosis which improved with the use of Seroquel. The plan section of the form noted the facility would "evaluate response to medications." Although the form indicated potential target behaviors were identified by R137's family, the form did not identify monitoring for the identified target behaviors and did not identify how the facility would evaluate R137's response to the Seroquel.

R137's Root Cause Analysis of Behavioral and Psychological Symptoms of Dementia (BPSD) form dated 2/11/14, noted R137's daughter (O)-G had reported R137's history of acute paranoia symptoms of the room being "bugged" and the food being "poisoned." BPSD indicated R137 had stopped eating, lost weight and had been enrolled in Hospice. The form further indicated Seroquel was initiated and R137 "started to clear, gained weight and graduated from Hospice." BPSD from directed to give R137 Seroquel as needed (PRN)"if paranoid" and directed facility staff to assess for "side effects." Although the form identified potential target behaviors for R137, the clinical record lacked evidence potential side

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 28 | F 329 | | |

effects, which included orthostatic hypotension, which was identified and supposed to be monitored for according to the facility policy dated 10/8/13. In addition, the clinical record lacked evidence the target behaviors identified by the family were monitored.

R137's admission Minimum Data Set (MDS) dated 2/16/14, noted R137 had severe cognitive impairment and required extensive to total physical assistance with most activities of daily living (ADLs); R137 was prescribed an antipsychotic medication. The MDS indicated R137 had no mood or behavior problems noted during the assessment period. The Care Area Assessment (CAAs) for psychotropic drug use also dated 2/17/14, indicated R137 received Seroquel. The analysis of findings in the cognitive loss/dementia section of the CAA indicated R137 was on Seroquel for psychosis; the care plan considerations section of the CAA directed staff to monitor for complications related to medication use. Although the CAAs identified R137 received an antipsychotic medication, the CAA lacked identification of target behaviors associated with the use of Seroquel, how long R137 was on the medication, monitoring for the efficacy of the drug and monitoring for side effects, including orthostatic blood pressures.

R137's care plan dated as initiated on 2/18/14, identified R137 received Seroquel for Alzheimer's disease with psychosis and paranoid behaviors of her food being poisoned and her room being bugged. R137 ' s care plan directed facility staff to give the Seroquel as ordered and to monitor and document side effects. The care plan further directed facility staff to monitor and document the occurrence of target behaviors, and specified the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 29 | F 329 | | |

behaviors as "paranoid statements and refusing to eat." R137's care plan for "mood/behavior" identified R137 had a history of paranoia and resistiveness with eating and medications. The care plan goal identified R137 would cooperate with care. The interventions section directed to give Seroquel as ordered and to monitor the effect. The care plan lacked identification of and monitoring for orthostatic hypotension.

R137's Family Conference form dated 2/19/14, noted R137's family wanted "psyche [psychotropic] meds [medications] taper if resident continues to be stable."

The Consultation Report form dated 2/24/14, indicated the consultant pharmacist, (CP) identified R137's use of Seroquel and recommended the facility identify R137's specific target behaviors to be monitored and documented. An undated hand written response from a nurse practitioner (NP)-H was written at the bottom of the form. The response indicated, "Resident displays paranoid behavior secondary to dementia. Currently, refuses medications at times, specifically the afternoon, and is exit seeking. This paranoid behavior is distressing to the patient and a reduction in medication would not be appropriate at this time " Although the note indicated a clinical rational for not reducing the dosage of Seroquel, the clinical record lacked evidence R137 had paranoid behaviors, that the behaviors were distressing or R137 was exit seeking.

On 4/17/14, at 2:47 p.m. a nursing assistant (NA)-B stated R137 was resistive with transfers at times, but would cooperate after re-assurance. At 2:48 p. m. NA-C stated she usually took care of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 30 | F 329 | | |

R137 and "[R137] is what you see now, not much behavior, quiet." NA-C stated R137 was "never" observed to have any behaviors.

On 4/17/14, at 10:34 a.m. when the licensed practical nurse (LPN)-C was asked about R137's specific target behavior monitoring for the use of Seroquel, LPN-C stated target behavior documentation was usually found in a "form." LPN-C showed surveyor a binder with Scheduled Antipsychotic/Anxiolytic Med [medication] Monitoring (SAAMM) forms, checked the monitoring forms and verified there was no form in the binder for R137. LPN-C then stated the SAAMM form could be on "somebody's desk." LPN-C further stated behaviors could also be documented in the nurses' notes. At 2:30 p.m. LPN-C verified there was no baseline orthostatic blood pressure obtained for R137, and no target behavior monitoring or side-effect monitoring done on R137 for the use of Seroquel.

On 4/17/14, at 2:15 p.m. O-G was contacted via telephone. O-G verified facility staff talked with her about a potential gradual dose reduction (GDR) of the Seroquel, but was not sure if GDR had been attempted. O-G stated she agreed to a GDR of Seroquel if R137's paranoid behaviors no longer existed.

On 4/17/14, at 3:02 p.m. the mental health nurse (RN)-E verified R137 had no monitoring for target behaviors or side effects for the Seroquel. RN-E acknowledged, "That is an error on our part." RN-E stated CP recommended a GDR, and referred to NP-H's undated hand written note indicating R137 needed the medication. RN-E further stated she thought R137 "is a good candidate for GDR because she has been calm."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 31<br><br>On 4/18/14, at 8:28 a.m. the care coordinator (RN)-F stated recommendations from CP's monthly reviews were called in to the doctor, or sometimes the reviews were placed on the chart to be reviewed and signed by the nurse practitioner on their next visit.<br><br>On 4/18/14, at 8:34 a.m. NP-H stated the information identified the undated note on consultation Report form dated 2/24/14, was obtained from O-G's report of R137's history of delusions and hallucinations. NP-G further stated R137 was also on Seroquel for a long time. NP-H stated review and recommendations made by the pharmacist were made too close from the admission date and were "too soon" to do a GDR. NP-H stated R137 was still on the transition stage at that time. When NP-H was asked if she expected to review documentation and monitoring of specific target behaviors, NP-H stated she would just ask the staff for "reports of behaviors, they are pretty good about that." NP-H added GDR would certainly be considered if there are no behaviors reported. When asked about what behaviors were expected, NP-H mentioned R137 was "exit-seeking and resistive with cares" when she first got to facility.<br><br>On 4/18/14, at 12:20 p. m. the director of nursing (DON) verified target behaviors and side effects should be monitored with use of anti-psychotic medications.<br><br>On 4/18/14, at 1:43 p.m. the Omni Care manager stated they had been changing the consultant pharmacist at the facility; she would not be able to answer questions but would have the specific pharmacist return the call. At 2:37 p.m. a | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 329 | Continued From page 32<br>voicemail was not able to be retrieved. A return call was not answered.<br><br>The facility's Anti-psychotic Medication Policy dated 10/8/13, directed to complete monthly monitoring of orthostatic blood pressure and directed target behavior monitoring "per the Scheduled Antipsychotic/Anxiolytic Med Monitoring Sheet." | F 329 | | |
| F 353 SS=F | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 33 | F 353 | | |

review, the facility failed to provide adequate staff to complete resident cares in a timely manner for 8 of 12 residents for (R479, R267, R333, R231, R161, R152, R192, R450). This had the ability to impact 300 of 316 residents in the facility who dependent for cares and on resided 5 of 5 units.

Findings include:

Complaints of inadequate staffing were received from residents, family members, staff, from people who asked to speak with the surveyors (who wanted to remain anonymous), and from a review of the grievance logs. Residents voiced concerns that staff either do not answer the call lights, or turn off the call lights, but do not meet their needs for R479, R267, R333, R231, R161, R152, R192, and R450.

R479:
On 4/14/14, at approximately 12:00 p.m. an observation during the initial tour of the facility revealed a R479 resided on the BWS (Bridgeway South) hallway. R479 had a mechanical bell ringer that was repeatedly going off, and the resident was yelling for help (RING, RING, RING, HELP, RING, RING, RING, and HELP). No staff was observed to be in the hallway, and when the surveyors proceeded to the desk to look for help, the mechanical bell could not be heard at the nursing station desk.

R479 ' s Minimum Data Set (MDS) dated 3/26/14, indicated R479 needed extensive assist with activities of daily living (ADLs) with the exception of ambulation as R479 did not ambulate, was occasionally incontinent of urine, and had limited function on one side of the body. R479 had a Brief Interview Mental Status (BIMS - a test for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 34 | F 353 | | |

cognition) completed and received a score of 15/15. The score indicated R479 was cognitively intact.

On 4/14/14, at 5:00 p.m. an Open Weekend Shifts (undated) posting was noted by the employee time clock on each unit, which revealed that on 4/19/14, four shifts were not filled; and on 4/20/14, 15 shifts were not filled.

On 4/14/14, at 6:20 p.m. an anonymous (requested not to be identified) family member stated the family made sure they were present most of the day to ensure cares where done, they were actively seeking another placement for their resident and only knew four of the staff on the unit that night (out of the nine who were present during the evening meal to assist with dinner).

R267:
On 4/14/14, at 6:42 p.m. the family of R267 stated the facility needed more aides, she had seen call lights on for 45 to 60 minutes, and it happened again just last week.

R267 had a Minimum Data Set (MDS) dated 4/8/14, which indicated R267, was cognitively impaired and was totally dependent on staff for transfers and locomotion on and off the unit. R267 required extensive physical assist of two staff for bed mobility and toileting and extensive physical assist of one staff for dressing and personal hygiene.

R333:
An observation at a nursing station on 4/17/14, from 1:30 to 2:00 p.m. R333 was taken the activities room and returned to the nursing station three times. When interviewed licensed practical

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 35 | F 353 | | |

nurse (LPN)-F stated that activities was short on that day, and R333 could not be left in activity room because he always jumped up when not in sight. LPN-F stated staffing was not short on 4/17/14, and felt that staff was usually enough, unless patients had events, or if someone called in sick, nursing was replaced, but aides may not be replaced if there were empty beds.

R333 ' s MDS dated 2/5/14, noted R333 needed extensive assist to total dependence for all areas of ADLs with the exception of ambulation. R333 did not ambulate. R333 ' s BIMS score was 9/15 which indicated R333 was moderately cognitively impaired.

On 4/17/14, at 2:05 p.m. LPN-G stated that they cannot get the medications passed, because they have to keep stopping to help provide resident cares.

On 4/17/14, at 2:10 p.m. NA-E stated "we are not supposed to talk to you", when assured that names are kept confidential NA-E stated the unit he was working on was "missing one aide today."

On 4/17/14, at 2:12 p.m. NA-F stated, "Not enough help today, short one aide."

On 4/18/14, at 8:58 a.m. LPN-D, stated racing around on the shift, "more (work) than I can get done in an 8 hour day. I do not take a lunch break, I do not take bathroom breaks, and work was pretty much this way all the time. "

On 4/18/14, at 9:34 a.m. LPN-I stated "for the most part it's okay. Sometimes when people give their two weeks' notice, they can't always get them replaced in that time, and recently people

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 36 | F 353 | | |

have changed jobs, so they need to replace them."

On 4/18/14, at 9:37 a.m. registered nurse (RN)-M stated "staffing is okay today, everyone showed up." RN-M verified the open shift posting by the time clock was notification to the staff that shifts remain open, and announcements were made by walkie-talkie.

On 4/18/14, at 9:45 a.m. NA-H stated staffing was okay. NA-I responded "tell the truth, we are two short this afternoon, and work is heavy when we work short." NA-H stated that she could not name a specific time when someone was hurt because staff was short; "sometimes people do fall, because you can't reach everywhere at once."

On 4/18/14, at 10:12 a.m. an announcement over the walkie-talkie, "attention NAR's there are shifts open this evening, days on Saturday, and days and p.m.'s on Sunday."

On 4/18/14, at 10:16 a.m. RN-I stated the usual staffing on the unit was four aides, and would rarely have three, but added "sometimes I'm the second nurse."

On 4/18/14, at 10:20 a.m. the staffing coordinator (SC) stated, the facility staffing was done by a grid according to regulations by the government, and by census. The SC stated the open shift posting was only put out for employees to see that there are shifts open. Staff come down to the staffing office and sign up for the open shifts. At that point (on Friday) Saturday day shift had only one open shift on the North unit 6:00 to 10:00 a.m. Sunday was down to six open shifts (less than 48 hours from the start of the shift). SC

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 37<br>stated people who only work every other weekend days and evenings would stop in and pick them up. The SC stated when staff calls in sick, the SC's make numerous phone calls and ask staff who are working if they will stay, and just keep working until the shift gets filled. SC further stated that it was not very often the facility was minus two (NA's), but that they may minus one, and even the staffing out based on the unit. A unit that cannot be minus one was 1 SW (Southwest) which had 32 residents. Supplemental agency staffing was not used by the facility. SC stated on the weekends, the North building gets a charge nurse to do paperwork, otherwise everything was the same. The SC stated the philosophy was to staff to full census, because it was easier to ask people to go home, then to call and get them in. The SC stated the facility rarely did some half shifts on 3W or transitional care unit (TCU). If the TCU needed an aide, an aide was pulled from restorative to do a half shift NA in the morning in TCU, and then went back to 2W to do restorative in the afternoon.<br><br>R231:<br>On 4/18/14, at 10:52 a.m. R231 stated she had filed a grievance about staffing concern, and felt retaliated against. R231 stated the care got worse after the grievance was filed, aides look at the lit call light and walk right by. Four or five would be holding up the wall standing there with lights on and no one was answering them.<br><br>The MDS dated 2/14/14, indicated R231 had a BIMS score of 15/15, indicating intact cognition. R231 required extensive physical assistance of one staff with bed mobility, transferring, toileting, personal hygiene, dressing and locomotion on and off the unit. | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 38 | F 353 | | |

R161:
On 4/18/14, at 11:03 a.m. R161 stated she had recently had her call light on and had asked to be turned over on side, but was told by the nursing assistant (NA) " No, it was too soon to turn. " R161 stated the NA was almost mean in his chatter and took off. Another aide had sat on a chair, did not do a thing, and then took off. NA's tell them [resident's] too busy, and NA's are sometimes too rough, and in a hurry. Sometimes give me big spoonful's of food, which I can ' t handle. " A sign was observed on the wall over bed in resident's room which stated, " Please remember small bites at meals. "

R161 had an MDS dated 2/7/14, with a BIMS score 15/15, indicating intact cognition. R161 was totally dependent on staff for transfers and locomotion on and off the unit. R161 Required extensive physical assist of two staff for bed mobility, toilet use and personal hygiene; and extensive physical assist of one staff for dressing and eating.

On 4/18/14, at 11:10 a.m. anonymous (requested not to be identified) F-B stated they had witnessed people crying for liquids and had brought them coffee and water, when they were no staff to be found. The family tried to be at the facility as often as possible and was actively looking for placement at another facility for better care.

R152:
On 4/18/14, at 11:30 a.m. R152 stated she had been tempted to file a staffing complaint, " I don't know if I want to file one, I would be afraid it would be held against me, they would say I am

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 39 | F 353 | | |

too picky, or crabby. I seem to have wait a long time with call light, just last night I waited for an hour. " R152 stated it was frustrating to her that she waits so long.

An MDS dated 2/4/14, had a BIMS score of 15/15, which indicated R152 was cognitively intact. R152 was totally dependent on staff for locomotion off unit, and required extensive physical assist of two staff for bed mobility, transfer, toilet use, personal hygiene, dressing, and locomotion on the unit.

R192:
On 4/18/14, at 2:00 p.m. facility grievances were reviewed with the director of nursing (DON), and revealed a concern expressed by a daughter whose father (R192) told her that his NA the past few days had been rushed with his cares and rough with him. The facility response was to tag the chart to monitor accusations, have the nurse manager (NM) follow up with the resident, and directs the NA to "trade" residents with another NA. When the NM followed up with the resident he felt the NA had to go too fast with cares, and when dressed the NA would sit him on the edge of the bed and want him to transfer into the chair right away. Resident stated he gets dizzy and needs a moment to sit.

R192's Minimum Data Set (MDS) dated 2/27/14, revealed R192 was alert and oriented as the Brief Interview Mental Status (BIMS) was 15 out of 15 which depicted no cognitive disability. R192 needed extensive assist for all areas of activities of daily living (ADLs) with the exception of ambulation. R192 did not ambulate.

R470:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 40 | F 353 | | |

A second grievance reviewed with the DON expressed concern from a R470's visitor regarding the length of time staff took to respond to a resident call light, range of motion, toileting schedule and staff attitude when approached. The facility followed up with R470 who expressed concern with call light response times and lack of range of motion. The DON verified that staff had been terminated when their behavior could not be corrected.

R470's MDS dated 4/4/14, revealed R470 was alert and oriented as the BIMS was 13 out of 15 which depicted no cognitive disability. R470 needed extensive assist to total dependence for all areas of ADLs with the exception of ambulation. R470 did not ambulate.

On 4/18/14, at 2:30 p.m. a copy of the Daily Staffing Guide sheets 3/31/14 through 4/18/14, and call light logs were provided, when asked about the unit staffing assignment sheets the SC stated that the Daily Staffing Guide was the only assignment sheet. The Daily staffing guide lists the names of the staff working and hand written in (behind the name) were hallway assignments (100, 300, etc) and job duties (pass water, intakes, etc). The SC verified staff names were not paired with resident names on an assignment sheet. The assignment sheets lacked evidence a way to document any "traded" patient assignments.

A review of the Daily Staffing Guide sheets revealed:
- On 3/31/14, on the first shift a nurse was sent from 3 West (3W) to Bridgeway South (BWS); On the second shift a nurse was sent from 2 West (2W) to South (S), a nurse was sent from 3W to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 41 | F 353 | | |

BWS, and a NA was sent from 2W to BWS; On the third shift an LPN and a NA were replaced.
- On 4/1/14, on the first shift the nurse manager of 1 Southwest (1SW) worked as a floor nurse, a NA from 3W was sent to 2W, an NA was sent from N to 2W; on the second shift a nurse from 3W was sent to North (N), an NA was absent on 3W; on the third shift a NA was sent from N to BWS and a NA from S was sent to N.
- On 4/2/14, on first shift two NA's from 3W were sent to 2W, an NA from N was sent to BWS, an NA from N was sent to S; on the second shift a nurse was sent from 3W to BWS.
- On 4/3/14, on the first shift the nurse manager of 1 Southwest (1SW) worked as a floor nurse, two NA's from 2W were sent to 3W; on the second shift an NA from 3W was sent to 2W and one assignment group was split. a nurse from 3W was sent to S, an NA from 3W was sent to 2W, a NA from 3W was sent to BWS, an NA from 3W was sent S; on the third shift a nurse from 3W was sent to 2W.
- On 4/4/14, on the first shift a NA was sent from 2W to 3W and group 8 was split and on 3W group 2 was split, an NA from N was sent to 2W, a NA assignment was split on S; on the second shift a nurse from 2W was sent to S, an NA from 3W was sent to 2W, a nurse from 2W was sent to 3W and an NA from 3W was sent to 2W, an NA from BWS was sent to N, an NA from S was sent to N; on the third shift an NA from N was sent to 2W.
- On 4/5/14, on the second shift a nurse from 3W was sent to N.
- On 4/7/14, on the second shift a NA from 2W was sent to 3W.
- On 4/8/14, on the first shift the nurse manager of 1 Southwest (1SW) worked as a floor nurse, on 3W group 11 was split (an LPN and a NA were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 42<br>absent); on the second shift a NA from 3W was sent to 2W; on the third shift an NA was sent to TCU.<br>- On 4/9/14, on the first shift a nurse from 2W was sent to S.<br>- On 4/10/14, on the first shift a nurse from 2W was sent to 1SW; on the second shift a NA was sent to BWS, a NA from 3W was sent to S.<br>- On 4/11/14, on the first shift a 2W NA was sent to S and an assignment was split, a 3W NA was sent to N; on the second shift an NA from 3W was sent to 2W and a NA from S was sent to 2W.<br>- On 4/12/14, on the first shift, a 3W NA was sent to 2W; on the second shift a 3W NA was sent to N.<br>- On 4/13/14, on the first shift a 2W NA was sent to 3W, a 3W NA was sent to N, and S split group F5 assignment; on the second shift a 3W nurse was sent to 1SW, a 3W NA was sent to N, a S NA was sent to N; on the third shift a NA was sent to BWS.<br>- On 4/14/14, on the first shift, a 3W NA was sent to 2W and group 8 was split; on the second shift on 2W group 5 was split.<br>- On 4/15/14, on the first shift a NA from 2W was planned to float to N (but was a no call, no show), on 3W group 11 was split after 10:00 a.m.; on the second shift a 1SW NA was sent to 3W for a 1:1, on 2W group 8 was split, an 3W NA was sent to 1SW.<br>- On 4/16/14, on the first shift group 11 was split; on the second shift a NA from BWS was sent to 2W and group 8 was split, a S NA was sent to 2W.<br>- On 4/17/14, on the first shift the nurse manager of 1 Southwest (1SW) worked as a floor nurse so a nurse could be sent to BWS, a 3W NA was sent to 2W, A N NA was sent to 2W; on the second shift a 2W NA was sent to 3W. | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 353 | Continued From page 43<br>- On 4/18/14, on the first shift a N NA was sent to 1SW; on the second shift a 2W NA was sent to 1SW; on the third shift a 1SW nurse was sent to N (and another nurse worked in 1SW).<br>During the nineteen days reviewed 34 day shifts, 28 evening shifts, and nine night shifts were left unfilled (5 of 71 shifts were replaced by management working the floor). An additional 59 shift openings were filled (21 on days, 28 on evenings and 10 on nights).<br><br>A review of the Call Light Study revealed 31 call light logs with between 2:00 to 10:00 p.m. observations on each page were completed (a total of 160 call light observations), 27 logs were completed on the day shift, 2 on the evening shift and 2 on the night shift. Of the 160 observations, 146 were marked yes to indicate needs were meet and response was timely, eight were not documented, six were marked not applicable because the resident was not in their room (it was unclear how the call light was initiated if the resident was not in their room). Three different versions of the call light study form were used. The sheets contained an average time to answer lights, but lacked a longest length of time until the call light was answered or meaningful analysis of the data, for example the longest length of time recorded until a call light was answered was 16 minutes on 12/27/13, at 5:10 a.m., the average was recorded at 3.9 minutes, there was no staffing data included on that day, in that unit, to see if there were correlations between staffing and call lights. | F 353 | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on | F 356 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 356 | Continued From page 44<br>a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the Report of Nursing Staff Directly Responsible for Resident Care (nurse staff posting) included the actual hours worked for unlicensed and licensed nursing staff. This practice had the potential to affect all 316 residents residing in the facility, families, and | F 356 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 356 | Continued From page 45<br>visitors from the public.<br><br>Findings include:<br><br>On 4/14/14, at 11:30 a.m. upon entrance to facility, the nurse staff posting was observed to be posted on a clip board, in the front lobby and hung on the wall at wheelchair level directly to the left of the reception desk. The nurse staff posting was noted to have the number of registered nurses (RNs) and licensed practical nurses (LPNs) scheduled and the full time equivalents (FTEs, a ratio comparing the number of staff worked in a pay period) worked by the licensed staff and unlicensed staff (such as a nursing assistant, NA) for the day, evening and night shifts. Although the posting contained other required information such as the date and census of the facility, the posting lacked the actual hours worked by the licensed staff (such as the start and end times of shift). The posting lacked the total number and actual hours worked by the licensed and unlicensed staff.<br><br>On 4/15/14, at 8:44 a.m.; 4/16/14, at 9:00 a.m.; and 4/17/14, at 8:15 a.m. the nurse staff posting was observed to lack the total and actual hours worked for the licensed and unlicensed nursing staff.<br><br>Review of the previous weeks nurse staff postings from 4/7/14, thru 4/13/14, indicated the postings lacked the total number and actual hours worked by the facility's licensed and unlicensed nursing staff.<br><br>On 4/18/14, at 9:16 a.m. the receptionist (O)-L stated LPN-J was in charge for making and posting assignments. LPN-J approached the | F 356 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 356 | Continued From page 46 | F 356 | | |

reception area, verified she was in-charge of the nurse staff posting and stated the posting would be updated as staffing changed throughout the day. LPN-J verified the posting hours were written in FTEs and the general public may not understand FTEs. LPN-J stated visitors and/or family members could "ask" facility staff if they needed to understand more details about the posting. LPN-J also verified the hours were written in FTEs, and NAs were listed under the "unlicensed nursing staff" column of the posting. LPN-J stated the facility short shifts were identified as ".5" and again stated residents, visitors and/or family members had to ask what the number in the posting would mean. LPN-J verified nursing shift start and end times varied at times.

On 4/18/14, at approximately 9:30 a.m. the administrator and the director of nursing (DON) requested to speak to the surveyor regarding the nursing staff posting. The regulation and nurse staff posting were reviewed by the administrator, the DON and the surveyor. DON confirmed the nurse staff posting was written in FTEs, shift times varied, and the total number and actual hours worked were not included in the nurse staff posting for licensed and unlicensed staff.

The Report of Nursing Staff Directly Responsible for Resident Care policy dated 7/7/11, identified a "daily report" would be posted indicating the number of nursing staff working daily that are directly responsible for resident care. The policy directed the "Staffing Office" would post the nurse staff posting, include the number of RNs, LPNs and NAs scheduled for the day and "this report will also include the number of hours worked that day." The policy directed to include the resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 356 | Continued From page 47<br>census, and to adjust the numbers of census and staff working based on resident census changes and employee attendance. The policy lacked direction to include the total and actual number of hours worked by licensed and unlicensed staff. In addition, the policy lacked direction for location of the posting. Although the policy identified the facility would adjust census and employee numbers "as necessary," the policy lacked the regulatory language to include: posting the nurse staffing data on a daily basis at the beginning of each shift, posting in a prominent place readily accessible to residents and visitors, and maintenance of daily nurse staffing posting for a minimum of 18 months. | F 356 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to maintain clean appliances in 3 of 3 activity rooms, (Bridgeway South - (BWS), 3W, 2W) having the potential to affect 256 of 316 residents who participated in activities. In addition, the facility failed to ensure a sanitary dining experience in the BWS kitchenette having | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 371 | Continued From page 48<br>the potential to affect 56 residents who ate out of the BWS kitchenette.<br><br>Findings include:<br><br>The activity rooms on 2W, 3W, and BWS were toured on 4/17/14, at 9:45 a.m. with the recreational therapist (RT)-A. During the tour the activity room on 2W had a popcorn machine that had greasy inner side walls, baked on black debris on the bottom of the oven, and the top of the stove had dried on food particles and greasy areas. On 3W the activity room had a 4-slice toaster that had a large buildup of bread crumbs on inside bottom of the toaster and the oven had baked on black food debris. On BWS the oven had baked on food debris.<br><br>RT-A was interviewed on 4/17/14, at 10:00 a.m. during the tour of the activity rooms and confirmed approximately 100 residents each used 2W and 3W. There were 56 residents on BWS during the month that used the activity room. RT-A confirmed the findings listed during the tour. RT-A also stated that the ovens were self-cleaning and they were cleaned every three months. RT-A confirmed recreational activities was responsible for cleaning of the appliances in the activity rooms and that there was no policy available. | F 371 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to | F 428 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 428 | Continued From page 49<br>the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure recommendations made by the consultant pharmacist for resident-specific target behavior monitoring were implemented for 1 of 6 residents (R137) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R137's undated Minnesota Masonic Home North Ridge Diagnostic List identified R137 had diagnoses to include dementia, history of acute paranoia and anxiety. R137's admission Minimum Data Set (MDS) dated 2/16/14, identified R137 had severe cognitive impairment and had no mood or behavior problems. R137's Care Area Assessment (CAA) for psychotropic drug use dated 2/17/14, indicated R137 received Seroquel for psychosis. The care plan considerations section of the CAA directed staff to monitor complications, but lacked directions for monitoring and documentation of resident specific target behaviors.<br><br>R137's care plan dated as initiated on 2/18/14, identified R137 received Seroquel for Alzheimer's disease with psychosis and paranoid behaviors of her food being poisoned and her room being bugged. R137's care plan directed facility staff to give the Seroquel as ordered and to monitor and | F 428 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 428 | Continued From page 50 | F 428 | | |

document side effects. The care plan further directed facility staff to monitor and document the occurrence of target behaviors, and specified the behaviors as "paranoid statements and refusing to eat." R137's care plan for "mood/behavior" identified R137 had a history of paranoia and resistiveness with eating and medications. The care plan goal identified R137 would cooperate with care. The interventions section directed to give Seroquel as ordered and to monitor the effect. The care plan lacked identification of and monitoring for orthostatic hypotension.

R137's clinical record lacked evidence R137 was monitored for target behaviors such as believing the food was poisoned or the room was "bugged," and the clinical record lacked evidence R137 was monitored for side effects such as orthostatic blood pressures (orthostatic hypotension, a severe drop in blood pressure) as identified by the facility policy 10/8/13.

The Consultation Report form dated 2/24/14, indicated the consultant pharmacist (CP) identified R137's use of Seroquel and recommended the facility identify R137's specific target behaviors to be monitored and documented. The form did not identify the lack of side effect monitoring for orthostatic hypotension.

On 4/17/14, at 2:30 p.m. the licensed practical nurse (LPN)-C verified there was no baseline orthostatic blood pressure obtained from R137 and no target behavior monitoring or side-effect monitoring done on R137 for the use of Seroquel.

On 4/17/14, at 3:02 p.m. the mental health nurse (RN)-E verified R137 had no monitoring for target behaviors and side effects for Seroquel. RN-E

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 428 | Continued From page 51<br>acknowledged, "That is an error on our part."<br><br>On 4/18/14, at 8:34 a.m. when nurse practitioner (NP)-H was asked if she expected to review documentation and monitoring of resident specific target behavior, NP-H stated she would just ask the staff for "reports of behaviors, they are pretty good about that."<br><br>On 4/18/14, at 12:20 p.m. the director of nursing (DON) verified target behaviors and side effects have to be monitored for the use of anti-psychotic medications. DON verified CP should have identified the irregularity.<br><br>On 4/18/14, at 1:43 p.m. the Omni Care manager stated they had been "changing the consultant pharmacist" at the facility, she would not be able to answer questions, but would have the specific pharmacist return the call. At 2:37 p.m. a voicemail from CP was not able to be retrieved. A return call was not answered.<br><br>The Anti-psychotic Medication Policy dated 10/8/13, indicated monthly monitoring of orthostatic blood pressure, target behavior monitoring "per the Scheduled Antipsychotic/Anxiolytic Med Monitoring Sheet." | F 428 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 431 | Continued From page 52<br>reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure expired medications was removed, discarded and not administered to 1 of 1 resident (R700); the facility failed to properly date an opened vial of Tuberculin Skin Test (TST) reviewed for medication storage. This had the potential to affect 122 residents who resided on the 500 wing, 800 wing and 3SW and 3NW wings. In addition, the facility failed to secure and store medications | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 431 | Continued From page 53<br>as required. This had the potential to affect 35 residents who had medications on the 2W near North cart.<br><br>Findings include:<br><br>500 Wing Cart:<br>On 4/14/14, at 2:15 p.m. a toured of medication cart was completed with registered nurse (RN)-A. During the tour a bottle of Aspirin 325 milligrams (mg) one hundred quantity bottle marked with a House Stock label was observed stored on the top right drawer with manufacturer expiration date of 2/14. RN-A verified the medication was expired and stated she believed someone was receiving the medication. After looking RN-A indicated R700 who had just been admitted to the facility two days before had gotten one dose from the bottle for the morning scheduled dose on 4/14/14. RN-A further stated she was supposed to check the dates but was busy, did not look, and stated the reason was "The usual. "<br><br>800 Wing Cart:<br>On 4/14/14, at 2:30 p.m. a tour of the medication storage room was completed with licensed practical nurse (LPN)-A. During the tour a vial of TST solution with Lot # 699227 was observed stored in a clear tote with expiration dated 10/15, and was undated. Upon finding LPN-A commented, "The nurse that opened it should have dated it."<br><br>On 4/14/14, at 2:42 p.m. RN-B stated "We usually like to have TST vial solutions dated when opened." Regarding the expired Aspirin she stated the nurses are supposed to check to make sure expired medications are removed from the carts. | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 431 | Continued From page 54<br><br>3SW medication cart:<br>On 4/18/14, at 9:30 a.m. the med cart on 3SW was reviewed with LPN-E. There were eye drops in the medication cart for R309; Latanoprost 0.005% (first line treatment for increased intraocular pressure) drops. The directions read instill one drop into both eyes every evening. The label on the medication box directed staff to discard 42 days after opened. The date the medication was opened was 1/22/14. LPN-E confirmed the mediation was expired and should have been discarded.<br><br>3SW medication room:<br>There was an observed insulin pen for R85 that had been opened but there was no date when the insulin pen had been opened. R85 was on Lantus Solostar 100 units/ml (decrease hyperglycemia) the instructions were for 22 units subcutaneously at bedtime. LPN-E confirmed the insulin pen should have been dated when opened.<br><br>3NW medication room:<br>The room was reviewed on 4/18/14, on 9:50 a.m. with LPN-G. The refrigerator had two plastic medication bottles for R8. The first bottle had Amoxicillin 250 mg/5 milliliters (ml) (antibiotic) give 10 ml (500 mg) orally three times a day (TID) daily for seven days. The medication expired on 2/26/14. The second bottle of Amoxicillin 250mg/5ml give 10 ml (500mg) orally TID a day times seven days. The label had a date when opened of 3/12/14, and a note which read discard after 14 days. The medication also had expired and LPN-G said she would get rid of both the medication bottles since they both had expired.<br><br>2W North medication cart: | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 431 | Continued From page 55<br>During an observation on 4/18/14, at 8:54 a.m. the 2W north medication cart was observed in the hallway. The cart was noted to be unlocked and there were no staff members who could see the cart.<br><br>Multiple medications were noted in the medication cart and on top of the medication cart multiple medications were noted in a med cup. Also there was a bottle of eye drops labeled, Azopt (an eye drop to lower intraocular pressure), an inhaler, and a Nitro-Patch (transdermal for angina) was left unattended. No staff members were in sight.<br><br>On 4/18/14, at 8:58 a.m. LPN-D verified to writer that yes the cart was unlocked and that there were medications, an inhaler, drops, and a patch on top of cart. LPN-D also verified that there is a fair number of cognitively impaired residents in this hall. LPN-D stated she had been in the near resident ' s room and had been racing.<br><br>While interviewing RN-J she stated yes med carts should be locked all the time when not attended and medications should not be left on top of cart unattended. She stated it was not their policy and that sometimes it " gets crazy but still was not okay. "<br><br>When interviewed on 4/18/14, at 3:34 a.m. the director of nursing (DON) stated her expectation was the nurses were supposed to date the Tuberculin solution when opened and for the expiration medications " My expectation is the medication was supposed to be pulled from the cart." DON further stated the nurses and nurse managers are responsible to make sure expired medications are removed from the carts. | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 431 | Continued From page 56<br><br>The facility Storage Of Medications policy dated 6/6/12, directed "Medications are not to be kept after the expiration date. Contaminated or deteriorated medications are destroyed..." and the policy indicated medications will be stored safely in the medication rooms or the medication carts. | F 431 | | |
| F 465 SS=E | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the floor in 1 of 6 kitchenette areas were kept clean and had a cleanable surface respectively. This had the potential to affect 41 residents who resided on the unit, family, and visitors.<br><br>Findings include:<br>On 4/18/14, at 10:37 a.m. an environmental tour was completed with the regional vice president (VP)/acting administrator, account manager,direct manager and maintenance staff. During the tour the concerns were identified:<br>Bridge Way South<br>On 4/14/14, at 12:00 p.m. a rectangular piece of cardboard was observed with duct tape used to secure the edges around the entire perimeter on the laminated floor in the kitchenette area creating un-cleanable surface as the cardboard | F 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING _____ B. WING _____ | 04/18/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTH RIDGE HEALTH AND REHAB | 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 |

| (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 465 | Continued From page 57<br>was porous.<br><br>During the tour on 4/18/14, at 11:03 p.m. the regional vice president and maintenance staff verified the area was not a cleanable surface. Maintenance staff indicated the facility was aware of the area and had a work order to replace the floor, was waiting for someone to fix it and indicated would provide documentation for the work order.<br><br>On 4/18/14, at 11:05 a.m. the work order for replacing the floor was requested but was never provided to surveyor. | F 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/18/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH**<br>**NEW HOPE, MN 55428** |

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, North Ridge Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 19 Existing Health Care..<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to: | K 000 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/18/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH**<br>**NEW HOPE, MN 55428** |

| (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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>North Ridge Care Center is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. Because the original building and the 4 additions are of the same complying construction type, the facility was surveyed as 1 building.<br><br>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for fire department notification. The facility has a full fire sprinkler system. The facility has a capacity of 351 beds. At the time of the survey the census was 319. | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/18/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH**<br>**NEW HOPE, MN 55428** |

| (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 |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 018<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents.<br><br>Findings include:<br><br>During facility tour between 9:30 AM and 1:30 PM on 04/18/2014, observation revealed that there | K 018 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/18/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH**<br>**NEW HOPE, MN 55428** |

| (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 |
|---|---|---|---|---|
| K 018 | Continued From page 3<br>are several dutch doors in the memory care unit with manual latching hardware on the door leaves. These doors lead from various offices into the corridor.<br><br>These deficient practices were verified by the Maintenance Director at the time of the inspection. | K 018 | | |
| K 020<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 1:30 PM on 04/18/2014, observation revealed the the second floor east center stair door latches via electronic strike only. There is no positive latching hardware on the corridor side of the door.<br><br>This deficient practice was verified by the Maintenance Director at the time of the inspection. | K 020 | | |
| K 029<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD | K 029 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/18/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH**<br>**NEW HOPE, MN 55428** |

| (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 |
|---|---|---|---|---|
| K 029 | Continued From page 4<br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all patients.<br><br>Findings include:<br><br>During facility tour between 9:30 AM and 1:30 PM on 04/18/2014, observation revealed that:<br>1. In the 900 Wing, the unused resident rooms are now being utilized at combustible storage rooms. These rooms do not have door closers installed,<br>2. The gift shop opens to the corridor via a set of double doors. The inactive leaf automatic flush bolt is not functional.<br><br>These deficient practices were verified by the Maintenance Director at the time of the inspection. | K 029 | | |
| K 144 | NFPA 101 LIFE SAFETY CODE STANDARD | K 144 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245183 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/18/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH RIDGE HEALTH AND REHAB** | **5430 BOONE AVENUE NORTH**<br>**NEW HOPE, MN 55428** |

| (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 |
|---|---|---|---|---|
| K 144 SS=F | Continued From page 5<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all patients.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 1:30 PM on 04/18/2014, record review revealed that the west building generator amp meter has not functioned for over a year. The semi-annual contractor inspection dated 04/11/2014 did not reference this deficiency.<br><br>This deficient practice was verified by the Maintenance Director at the time of the inspection. | K 144 | | |