Electronically delivered
November 2, 2023

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: September 13, 2023

Dear Administrator:

On September 25, 2023, we informed you of imposed enforcement remedies.

On November 1, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found 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 electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

K0211 -- S/S: E -- NFPA 101 -- Means Of Egress - General Bld: 01
K0225 -- S/S: E -- NFPA 101 -- Stairways And Smokeproof Enclosures Bld: 01
K0321 -- S/S: E -- NFPA 101 -- Hazardous Areas - Enclosure Bld: 01
K0353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance And Testing Bld: 01
K0372 -- S/S: E -- NFPA 101 -- Subdivision Of Building Spaces - Smoke Barrie Bld: 01
K0901 -- S/S: F -- NFPA 101 -- Fundamentals - Building System Categories Bld: 01
K0914 -- S/S: F -- NFPA 101 -- Electrical Systems - Maintenance And Testing Bld: 01
K0353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance And Testing Bld: 04
K0901 -- S/S: F -- NFPA 101 -- Fundamentals - Building System Categories Bld: 04
K0914 -- S/S: F -- NFPA 101 -- Electrical Systems - Maintenance And Testing Bld: 04

As a result of the revisit findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(b), effective December 13, 2023, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective December 13, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 13, 2023.

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

As we notified you in our letter of September 25, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 13, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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).

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 13, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 13, 2023

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: September 13, 2023

Dear Administrator:

On September 25, 2023, we informed you that we may impose enforcement remedies.

On September 27, 2023, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility 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), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 13, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 13, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 13, 2023.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 13, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, North Ridge Health And Rehab will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 13, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

Nikki Sassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 13, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 09/27/2023

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
E 000	Initial Comments On 9/25/23-9/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
F 000	INITIAL COMMENTS On 9/25/23-9/27/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H51835805C (MN96974) H51835696C (MN96371) H51835697C (MN87824) H51835698C (MN87769) H51835699C (MN87732) H51835700C (MN87491) The facility's plan of correction (POC) will serve	F 000		

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

Electronically Signed | 10/23/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 09/27/2023

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	Continued From page 1 as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		10/27/23

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 _____	C 09/27/2023

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 578	Continued From page 2 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure resident advanced directives were readily retrievable by any facility staff in the resident's medical record for 1 of 3 residents (R227) reviewed for closed record review. Findings include: R227's admission Minimum Data Set (MDS) dated 7/26/23, identified severe cognitive impairment with a diagnosis of fractures and other multiple trauma, hypertension (HTN), coronary artery disease (CAD), end stage renal disease (ESRD), pneumonia, diabetes mellitus (DM) type II, hyperlipidemia, and hemiplegia. R227 required extensive assistance for all activities of daily living (ADL's) and R227 is rarely/never understood. R27 is identified as life expectancy of greater than six months. R227's Discharge Instructions from Mercy Hospital dated 7/2/23, indicated resident as Do	F 578	F 578 R227 has DC from the facility. All current resident advanced directives are readily retrievable by any facility staff in the resident's medical record. Nursing staff have been educated how to access advanced directives in the resident's medical record. A designated spot has been established for each unit to put signed POLST's. The Friday PM Supervisor will check the folder in each unit for any signed POLST. If a signed POLST is in the folder, the House Supervisor will upload it to PCC and then put the signed original in the resident's hard chart (and remove any old POLST, if applicable). A new check sheet has been put with each POLST folder location to be signed with the date, time and initials of the person who checked the POLST	

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 _____	C 09/27/2023

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 578	Continued From page 3 Not Resusciatat (DNR)/Do Not Intubate (DNI). R227's code status in the electronic health record (EHR) listed resident as DNR. R227's Admission note dated 7/20/23, indicated R227 as DNR/DNI status. Provider Visit note dated 7/25/23, "Code Status Reviewed/Physician Order for Life Sustaining Treatment (POLST) Completed DNR/DNI, ok select treatment, ask if considering tube feeding, ok for by mouth (PO)/ intravenous (IV)/ intramuscular (IM) antibiotics. POLST completed with family on 7/21/23 and uploaded to misc[ellaneous] tab in MAM (Media Asset Management) and hard copy to facility". Progress Note dated 8/4/23 at 3:38p.m., "POLST completed". Nursing Progress Note dated 8/5/23 at 3:01a.m., "Writer was called in to attend to unresponsive client at 11pm. Found patient unresponsive, and mobilized staff team including the supervisors, and commenced CPR as per POLST record, while awaiting the arrival of paramedics. Paramedics continued with CPR until 12.14 AM, when they declared client had expired. Called TCP to inform of the passing and to obtain an order to release the body. Body was released to Cremation Society of America as per family request at 2.40am. Certificate of removal is filed". On 9/27/23 at 8:39 a.m., nursing assistant (NA)-A stated if a resident is found unresponsive, she would get the nurse and go back into the room to evaluate the resident further. If they do not know the status, they would call out to have one of the	F 578	folder. DON/Designee will check the POLST check sheet 3x weekly x4 weeks to ensure it is being utilized and POLST's are getting uploaded and placed in resident's charts and then monthly x2 months. HIM/Designee will audit 3 charts per unit weekly x4 weeks to ensure a signed POLST has been completed and then monthly x2 months The results of the audit will be reviewed in the facility QAPI committee for continued quality improvement and compliance.	

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 _____	C 09/27/2023

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 578	Continued From page 4	F 578		

staff that is available check the chart. The resident code status is also in the care plan, so they usually know off hand.

On 9/27/23 8:42 a.m., licensed practical nurse (LPN)-A stated if a resident is found unresponsive, she would make sure they are not sleeping, check vitals, alert nursing manager, have the other nurse check status in the medical record before initiating cardiopulmonary resuscitation (CPR).

On 9/27/23 at 8:52 a.m., registered nurse (RN)-A stated if a resident is found unresponsive, she would check airway, breathing, circulation (ABC)'s and pulse. If there is no pulse, she would start CPR if appropriate. Most current POLST is in resident's chart. Run and grab chart to check status on most current POLST before starting CPR.

On 9/27/23 at 9:06 a.m., director of nursing (DON) stated it is her expectation that if a resident is found unresponsive the staff would check the POLST in the hard chart prior to initiating CPR. When this occurs an overhead page for a code blue announces the room number where assistance is needed. Someone is checking the POLST and then initiate CPR is appropriate. DON stated if "she remembers correctly", he had a POLST that was a full code, and new POLST with DNR status had not been signed off by the physician yet, so they would follow the Full Code POLST until this had been completed. She stated she will review this incident and previous POLST's and discuss again later.

On 9/27/23 at 10:50 a.m., DON stated she was

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 _____	C 09/27/2023

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 578	Continued From page 5 "afraid to say" that after reviewing the closed record, the POLST in the chart was dated 5/11/22 and indicated Full Code, this was what the nurse verified at the time of the incident. Therefore, the nurse did as they were trained to do and initiated CPR. DON unable to comment on the POLST dated 7/21/23 without further investigation. On 9/27/23 at 12:03 p.m., DON stated she does not think the POLST dated 7/21/23 was received by the facility. DON was not sure who would be responsible to verify the POLST matches the current order in the electronic health record (EHR). In this instance it was signed on a Friday, late afternoon and would not be processed by the Health Unit Coordinator (HUC) until Monday morning. It would be scanned into the EHR and the hard copy placed in the resident's chart. The staff are trained to look in the chart and follow the POLST that is in the resident's chart. If the code status has changed since last admission, the expectation would be that it is verified that there is a current POLST matching the orders in the EHR. Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) policy provided and reviewed with no concerns. This should go at the end of the citation Advanced Directives policy provided and reviewed with no concerns. This should go at the end of the citation	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		10/27/23

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 _____	C 09/27/2023

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 677	Continued From page 6 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nail care was provided for 1 of 2 residents (R105) reviewed who were dependent on staff for personal cares. Findings include: R105's Quarterly Minimum Data Set (MDS) dated 6/30/23 identified R105 required extensive assistance with bathing and personal hygiene. R105's cognition was intact. R105's care plan dated 10/13/21 indicated assistance of one person for personal hygiene. R105's admission record printed 9/27/23 included diagnoses of diabetes mellitus and need for assistance with personal care. R105's Task on treatment administration record (TAR) dated September 2023 read to ensure weekly bath and skin assessment were completed every Thursday. Task was marked as complete 9/7/23, 9/14/23 and 9/21/23. On 9/25/23 at 1:38 p.m., R105 stated she wanted her toenails trimmed. Toenails on right foot were approximately 1/8 inch past end of toes, clean and not thick. On 9/27/23 at 11:32 a.m., NA-C stated the licensed nurse would complete nail care on diabetic residents. On 9/27/23 at 8:07 a.m., RN-C stated a nurse would trim toenails for diabetic residents. A nurse	F 677	F677 R105 nail care was provided. R105 had a nursing order added that reads nail care: fingernails and toenails to be trimmed, filed, and cleaned by a licensed nurse. A nursing order was put in for current diabetic residents that reads 'Nail Care: Fingernails and toenails to be trimmed, filed, and cleaned by a licensed nurse. Licensed nurses have been educated about the importance of trimming/filing nails of diabetic residents to prevent injury. A new nursing order has been added to PCC for any diabetic resident to coincide with their bath day to have their fingernails and toenails trimmed/filed. DON or designee will audit 3 different diabetic residents nails each week x4 weeks and then monthly x 2 months. The results of the audit will be reviewed in the facility QAPI committee for continued quality improvement and compliance.	

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 _____	C 09/27/2023

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 677	Continued From page 7 would typically trim toenails during skin check assessment preformed on bath days. On 9/27/23 on 12:35 p.m., director of nursing (DON) stated it is the expectation nurses would cut toenails on diabetic patients. DON stated this would be important to diabetic residents to prevent injury from overgrown toenails on diabetic residents. Facility policy dated 4/2023, Nursing Care of the Resident with Diabetes Mellitus, instructed toenails should only be trimmed by personnel qualified to do so. This can be regular staff, and does not have to be a podiatrist.	F 677		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		10/27/23

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 _____	C 09/27/2023

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 700	Continued From page 8 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure grab bars were assessed to determine appropriate and safety use for 1 of 1 resident (R181) who was observed to have a grab bar affixed to their bed. Findings include: R181's five-day Minimum Data Set (MDS) dated 8/18/23, identified R181 was cognitively intact and required extensive assistance with bed mobility and transfers. R181's diagnoses included orthopedic aftercare following surgical amputation (removal of a limb) and difficulty in walking. R181's care plan dated 9/6/23, included that R181 utilized grab bars on bed for resident safety. Additionally, the care plan included that the use of the grab bar would promote independence in mobility while in the bed and with getting in and out of the bed and also included that the resident had limited physical mobility r/t disease process and needed an extensive assist of one with slide board for transfers and a limited assist of one with bed mobility. On 9/26/23 at 2:33 p.m., Observed R181's bed had 1/4 bilateral grab bars affixed to the head of bed on both sides. Progress note dated 8/13/23, indicated spouse brought grab bars from home and installed on R181's bed. Progress note dated 8/28/23, indicated maintenance made aware of need to install facility grab bars on R181's bed and were	F 700	F700 R181 has side rail assessment completed by nurse, has a physicians order for grab bars and Grab bars added to the care plan and grab bars installed. Audit completed of current residents with side rails for current assessment, doctor order, and added on their care plan. Nurses have been educated to complete a side rail assessment, have a physicians order for grab bars prior to requesting installation and adding Grab bars to the care plan. Housekeeping and Maintenance teams have been educated about removing grab bars when a resident discharges. DON or designee will audit 3 new admissions weekly x4 weeks for side rail assessment completion then monthly x2 months. The Housekeeping Director/Facilities Director will audit 3 discharges weekly x4 weeks to ensure side rails are removed when a resident discharges then monthly x2 months. The results of the audit will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The results of the audit will be reviewed in the facility QAPI committee for continued quality improvement and compliance.	

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 _____	C 09/27/2023

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 700	Continued From page 9 installed on 8/28/23. R181's doctor's order dated 8/14/23, included that it was okay for unilateral grab bar to assist with bed mobility. R181's medical record lacked evidence an assessment had been completed to determine necessity and whether R181 could safely use grab bars. Additionally, R181's medical record lacked evidence alternatives were tried prior to installing the grab bars, the resident or representative were educated on the risk of having a grab bar on her bed, or if a consent form was completed. On 9/27/23 at 12:46 p.m., registered nurse (RN)-A stated R181 uses the grab bars for repositioning and sitting up. On 9/27/23 at 1:16 p.m., registered nurse (RN)-B manager stated prior to grab bar being installed on a bed, physical therapy would need to assess to ensure that grab bars are appropriate and there should be a device assessment completed and a doctor's order obtained prior to a grab bar being added to a resident's bed. The bar needs to be assessed to ensure that resident is able to use grab bar appropriately and that it is safe for the resident to use. RN-B confirmed that facility received an order from the provider on 8/14/23 and that an assessment should have been completed around 8/15/23 when the order was received and that no assessment had been completed. RN- B stated there should have been a device assessment completed prior to the grab bar being added to R181's bed. On 9/27/23 at 2:51 p.m., the director of nursing	F 700		

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 _____	C 09/27/2023

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 700	Continued From page 10 (DON) stated a device assessment should be completed before grab bars are added to a resident's bed to ensure the grab bars are safe and necessary. The DON stated a device assessment should have been completed before the grab bar was affixed to R181's bed, however the DON was unable to find a device assessment in R181's medical record. A Bed rail/grab bar policy was requested but was not provided.	F 700		

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** B. WING _____	**09/27/2023**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/27/2023. At the time of this survey, North Ridge Health and Rehab Bldg 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/27/2023**

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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. North Ridge Health & Rehab-Bldg 01 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	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** B. WING _____	**09/27/2023**

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
K 000	Continued From page 2 1(332) construction. The facility is fully protected throughout by an automatic fire sprinkler system. It has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 320 beds and had a census of 240 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1,7.2.1.4.5.1, and 7.2.1.5.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by observation that the keypads that unlock the egress doors at the end of the egress corridors in the east building are	K 211	K211 Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available to move the keypads that unlock the egress doors at the end of the egress corridors in the east building are mounted lower than the 48 maximum. The exit door at the end of the 600 wing has been repaired and opens with less than 30 lbf.	10/27/23

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** B. WING _____	**09/27/2023**

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
K 211	Continued From page 3 mounted higher than the maximum 48". 2. On 09/27/2023 at 02:16 PM, it was revealed by observation that the exit door at the end of the 600 wing was difficult to open exceeding 30 lbf (133 N). An interview with the Facilities Director verified these deficient findings at the time of discovery.	K 211	The Facilities Director will create a task in TELS for checking egress exit doors. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell access per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 19.2.2.2.5.2, 7.2.2.5.1.1, 7.1.3.2.1, and 7.2.1.5.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by observation that the keypads that unlock the egress doors leading into stairwells are mounted higher than the maximum 48".	K 225	K225 Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available to move the keypads that unlock the egress doors leading into stairwells are mounted lower than the 48 maximum. The exit door at the end of the southwest stairwell has been repaired and opens with less than 30 lbf. The Facilities Director will create a task in TELS for checking egress exit doors.	10/27/23

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** B. WING _____	**09/27/2023**

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
K 225	Continued From page 4 2. On 09/27/2023 at 10:01 AM, it was revealed by observation that the exit door leading out of the southwest stairwell out to staff parking was extremely difficult to open exceeding 30 lbf (133 N). 3. On 09/27/2023 at 02:32 PM, it was revealed by observation that the stairwell door near the paint shop had tape over the latch, and part of the latching mechanism would get stuck causing the door to not latch. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 225	Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5 and 7.2.4.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 226	K226 The penetrations caused by electrical wires in the firewall that is in between the care center and the assisted living have been filled to complete the smoke barrier. Completion will be audited monthly x3	10/27/23

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** B. WING _____	**09/27/2023**

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
K 226	Continued From page 5 On 09/27/2023 at 10:10 AM, it was revealed by observation that there is a penetration caused by wires in the firewall that is in between the care center and the assisted living. An interview with the Facilities Director verified this deficient finding at the time of discovery.	K 226	months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 at 11:11 AM, it was revealed by a review of available documentation that the documentation that was provided for the emergency lighting testing did not include the locations of the emergency lighting, so surveyor was unable to determine if all emergency lighting had been tested. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 291	K291 A complete list of all emergency lights in the building has been revised to include their location. A schedule for monthly and annual testing has been created. The Facilities Director will create a task in TELS for emergency lights and monitor for compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	10/27/23
K 293	Exit Signage	K 293		10/27/23

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** B. WING _____	**09/27/2023**

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
K 293 SS=E	Continued From page 6 CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, 7.10.1.2.1, and 7.10.5.2.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 at 12:54 PM, it was revealed by observation that the exit sign near the double glass exit doors in the lower level of the east building was removed. 2. On 09/27/2023 at 01:21 PM, it was revealed by observation that the exit sign in the kitchen near the freezer was not lit up. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 293	K293 The Exit sign near the double glass exit doors in the lower level of the east building have been installed. The Exit sign in the kitchen near the freezer is now lit up and working properly. Exit signs will be audited monthly to ensure operability. A task has been created in TELS to ensure compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		10/27/23

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** B. WING _____	**09/27/2023**

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
K 321	Continued From page 7 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, 19.3.2.1.5, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 321	K321 Facility secured vendor and the vendor has committed to completing the work listed in this K321 tag as soon as they can schedule labor and materials are available. The sitting/dining area in the lower level of the East building no longer is being used as a storage room. Rooms	

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** B. WING _____	**09/27/2023**

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
K 321	Continued From page 8 1. On 09/27/2023 at 12:55 PM, it was revealed by observation that the sitting/ dining area in the lower level of the east building was repurposed as a storage room and there is no fire separation from the rest of the building. 2. On 09/27/2023 at 01:09 PM, it was revealed by observation that the rooms in the 900 wing on the lower level of the east building were being used as storage rooms and there were missing doors, doors with no self-closing devices, and some of the rooms were missing sections of the walls. 3. On 09/27/2023 at 02:15 PM, it was revealed by observation that the soiled utility room in the 600 wing of the TCU would not latch when testing the self-closing device. 4. On 09/27/2023 at 12:55 PM, it was revealed by observation that rooms 118, 120 through 125, 127, and 129 located in the southwest wing of the west building were repurposed as storage rooms and the doors did not have self-closing devices. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 321	in the 900 wing on the lower level of the east building that are being used as storage have doors with self-closing devices and all sections of the walls that were missing have been repaired. The soiled utility room in the 600 wing of the TCU latches when testing the self closing device. Rooms 118, 120, 121, 122 have self-closing devices installed on doors. Rooms 123, 124, 125, 127, and 129 no longer have storage. Doors in the facility will be routinely monitored to ensure they meet compliance. Doors in the facility will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		10/27/23

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** B. WING _____	**09/27/2023**

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
K 324	Continued From page 9 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1, 19.3.2.5.3 (9), 19.3.2.5.4, and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that the facility provided a kitchen hood suppression system inspection report dated 01/12/2023, but could not provide documentation	K 324	K324 Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available to install. The kitchen hood suppression system inspection has been completed by a vendor. The residential stoves located in the physical therapy room in the east building and in the west building activities room has a lockout device installed by that incorporates a 120 minute timer. The kitchen hood suppression system inspection will be scheduled for future completion. A task has been created in TELS to ensure compliance.	

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** B. WING _____	**09/27/2023**

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
K 324	Continued From page 10 for an inspection being completed within six (6) months after that date. 2. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by observation that the residential stoves were located in the physical therapy room in the east building and in the west building activities room did not have a lockout device that incorporated a 120 minute timer. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 324	Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and 9.6.1.5, NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2, 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3, and NFPA 70, (2011 edition), National Electrical Code, sections 760.24 and 760.53 (A) (1). These deficient findings could have a widespread impact on the residents within	K 345	K345 The battery operated Smoke Detector that is not hooked up to the fire alarm system has been removed. The fire alarm junction box near the smoke barrier doors going in to the 200 wing of the RCU has been checked by a vendor for proper operations and seals properly. The fire alarm junction box in the storage room that is in the locker room in the lower level	10/27/23

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** B. WING _____	**09/27/2023**

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
K 345	Continued From page 11 the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of smoke detector sensitivity testing. 2. On 09/27/2023 at 10:42 AM, it was revealed by observation that above the smoke barrier doors going into the 200 wing of the RCU there is a fire alarm junction box that was open with the wires pulled out. 3. On 09/27/2023 at 12:49 PM, it was revealed by observation that in the storage room that is located in the locker room in the lower level of the east building there was a fire alarm junction box that was open with wires pulled out of it. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 345	of the east building has been checked by a vendor for proper operations and seals properly. If future smoke detectors are install, the Smoke Detector sensitivity testing will be scheduled for future completion. A task has been created in TELS to ensure compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install smoke detection per NFPA 101 (2012 edition), Life Safety Code, section	K 347	K347 Facility secured vendor and the vendor	10/27/23

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** B. WING _____	**09/27/2023**

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
K 347	Continued From page 12 19.3.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/27/2023 at 01:05 PM, it was revealed by observation that the house keeping wheelchair maintenance room next to room 906 was open to the corridor and there was no smoke detection in the room. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 347	has committed to completing the work as soon as they can schedule labor and materials are available for the room next to room 906 door installation. Doors will be routinely monitored to ensure compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		10/27/23

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** B. WING _____	**09/27/2023**

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
K 353	Continued From page 13 by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.4.1, 4.3.1, 5.1.1.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.4, and 5.4.1.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of a sprinkler inspection being completed during the third quarter of 2022. 2. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that there were four deficiencies listed on the annual fire sprinkler inspection report dated 04/07/2023, and at the time of the survey, the facility did not have documentation showing that corrections had been made. 3. On 09/27/2023 at 12:38 PM, it was revealed by observation that the spare sprinkler heads for the kitchen were in a plastic bag attached to the wall near the sprinkler riser and were not in a sprinkler box. 4. On 09/27/2023 at 01:24 PM, it was revealed by observation that the sprinklers located in the kitchen near the dishwashing area were showing	K 353	K353 Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available. Annual and quarterly sprinkler tests will be scheduled out for future completion. The facility has documentation of completion in regards to the four deficiencies listed on the annual fire sprinkler inspection report dated 04/07/2023. The spare sprinkler heads for the kitchen near the sprinkler riser are now in a sprinkler box. The sprinklers located in the kitchen near the dishwashing area that were showing signs of oxidation have been replaced. Annual and quarterly sprinkler tests will be scheduled for future completion. A task has been created in TELS to ensure compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	

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** B. WING _____	**09/27/2023**

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
K 353	Continued From page 14 signs of oxidation. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.4 and 6.1.3.8.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/27/2023 between 9:15 AM and 3:30 PM, it was revealed by observation that the fire extinguisher in the Business office was not mounted and was sitting on the floor. An interview with the Interim Administrator verified this deficient finding at the time of discovery.	K 355	K355 The fire extinguisher in the Business office is mounted on the wall. Fire extinguishers will be routinely monitored to ensure compliance and proper installation. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	10/27/23
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		10/27/23

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** B. WING _____	**09/27/2023**

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
K 363	Continued From page 15 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		

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** B. WING _____	**09/27/2023**

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
K 363	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 at 12:58 PM, it was revealed by observation that the door to office 900 was being held open with a rubber wedge. 2. On 09/27/2023 at 12:59 PM, it was revealed by observation that the door to office 902 was being held open with a rubber wedge. 3. On 09/27/2023 at 12:58 PM, it was revealed by observation that there was paper wedged in the strike plate for the door to the RT office in the 400 wing of the RTU causing the door to not latch. An interview with the Facilities Director verified these deficient findings at the time of discovery.	K 363	K363 The door to office 900 and 902 are no longer held open with a rubber wedge, both doors latch properly. The door to the RT office the 400 wing of the RCU latches properly. Doors will be routinely monitored to ensure compliance and positive latching. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 372		10/27/23

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** B. WING _____	**09/27/2023**

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
K 372	Continued From page 17 smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 at 09:54 AM, it was revealed by observation that there was a large section of drywall missing in the smoke barrier above the doors going into 2 northwest. 2. On 09/27/2023 at 09:55 AM, it was revealed by observation that there was a large piece of electrical conduit that was not fire-stopped around it in the smoke barrier above the smoke barrier doors going into 2 southwest. 3. On 09/27/2023 at 10:23 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors going into the 600 wing in the TCU caused by orange PVC. 4. On 09/27/2023 at 10:23 AM, it was revealed by observation that there were penetrations in the smoke barrier above the smoke barrier doors going into the 400 wing of the RCU caused by pipes and wires.	K 372	K372 The section of drywall in the smoke barrier above the doors going into 2 northwest has been installed and the large piece of electrical conduit has been fire stopped to complete the smoke barrier. The large piece of electrical conduit in the smoke barrier above the doors going into 2 southwest has been fire stopped to complete the smoke barrier. The penetration in the smoke barrier doors going into the 600 wing in the TCU caused by orange PVC has been fire stopped to complete the smoke barrier. The penetrations caused by pipes and wires in the smoke barrier above the smoke barrier doors going into the 400 wing of the RCU have been filled to complete the smoke barrier. The penetrations caused by electrical flex conduit in the smoke barrier above the smoke barrier doors going into the 300 wing of the RCU have been filled to complete the smoke barrier. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be	

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** B. WING _____	**09/27/2023**

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
K 372	Continued From page 18 5. On 09/27/2023 at 10:23 AM, it was revealed by observation that there was a penetrations in the smoke barrier above the smoke barrier doors going into the 300 wing of the RCU caused by an electrical flex conduit. An interview with the Facilities Director verified these deficient findings at the time of discovery.	K 372	responsible for compliance.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 09/27/2023 at 01:27 PM, it was revealed by	K 374	K374 The smoke barrier doors going into the 200 wing of the RCU fully close when tested. The smoke barrier doors going into the 400 wing of the RCU fully close when tested. The smoke barrier doors going into the 300 wing of the RCU fully close when tested. A schedule was created to routinely	10/27/23

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** B. WING _____	**09/27/2023**

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
K 374	Continued From page 19 observation that the smoke barrier doors going into the 200 wing of the RCU would not fully close when tested. 2. On 09/27/2023 at 01:43 PM, it was revealed by observation that the smoke barrier doors going into the 400 wing of the RCU would get stuck on each other causing the door to not fully close when tested. 3. On 09/27/2023 at 01:57 PM, it was revealed by observation that the smoke barrier doors going into the 300 wing of the RCU would not fully close when tested. An interview with the Facilities Director verified these deficient findings at the time of discovery.	K 374	monitor fire doors. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6. This deficient findings	K 712	K712 A calendar was created to outline all dates and times that fire drills will occur in 2023	10/27/23

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** B. WING _____	**09/27/2023**

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
K 712	Continued From page 20 could have a widespread impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 1st shift in the 4th quarter of 2022. 2. On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 2nd shift in the 2nd and 3rd quarter of 2023 and the 2nd shift and 4th quarter of 2022. 3. On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 3rd shift of the 1st quarter of 2023. An interview with the Interim Administrator verified this deficient findings at the time of discovery.	K 712	and 2024. The Fire Drill Calendar will be monitored for compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience	K 761		10/27/23

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** B. WING _____	**09/27/2023**

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
K 761	Continued From page 21 that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for annual fire door inspections. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 761	K761 The annual inspection of fire rated doors was completed. A schedule was created to routinely monitor fire doors, including the annual fire door inspection. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		10/27/23

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** B. WING _____	**09/27/2023**

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
K 901	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 3:15 PM, it was revealed by a review of available documentation that the facility could not provide an NFPA 99 Risk Assessment. An interview with the Interim Administrator verified this deficient findings at the time of discovery.	K 901	K901 The NFPA 99 Risk Assessment has been completed. The QAPI Committee will review the Risk Assessment annually and as needed. QAPI Committee Minutes will be reviewed to ensure compliance The Administrator or designee will be responsible for compliance.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For	K 914		10/27/23

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** B. WING _____	**09/27/2023**

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
K 914	Continued From page 23 LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for patient care receptacle testing and it was noticed during the walk-through that some of the receptacles in the patient rooms were hospital grade, but not all of them were. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 914	K914 The NFPA 99 documentation for patient care receptacle testing was completed. A schedule was created to routinely monitor fire doors, including the annual fire door inspection. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		10/27/23

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** B. WING _____	**09/27/2023**

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
K 918	Continued From page 24 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and	K 918	K918 Facility secured vendor and the vendor has committed to completing the work as	

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** B. WING _____	**09/27/2023**

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
K 918	Continued From page 25 NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.1, 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.2.4, 8.4.9, 8.4.9.1, .8.4.9.2, 8.4.9.5.3, and 8.4.9.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency generator had been tested for four hours within the last 36 months. 2. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a letter of reliability from their natural gas company for the natural gas that powers one of their emergency generators. 3. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that the facility provided for weekly and monthly inspections and testing of the emergency generator was not organized in a manner that the surveyor could verify that all of the required inspections were completed. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 918	soon as they can schedule labor. A vendor has completed the four-hour emergency generator test. A letter of reliability from the natural gas company for the natural gas that powers the emergency generator. The weekly and monthly inspections and testing of the emergency generator is organized in a manner that can be verified that all of the required inspections were completed. The Facilities Director will create a task in TELS for emergency generators and monitor for compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and	K 920		10/27/23

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** B. WING _____	**09/27/2023**

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
K 920	Continued From page 26 Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by observation in room 241 an air	K 920	K920 The extension cord was immediately removed from room 241. The air conditioner in room 241 will be upgraded to a PTAC unit. During this upgrade a new outlet added near the PTAC. Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available. Air conditioners in the facility will be routinely monitored to ensure they meet	

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** B. WING _____	**09/27/2023**

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
K 920	Continued From page 27 conditioner plugged into an extension cord. An interview with the Interim Administrator verified this deficient finding at the time of discovery.	K 920	compliance. Air conditioners in the facility will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted on 09/27/2023 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, North Ridge Health and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. In 2018 a remodel was conducted on the 800 Wing. Because the original building and the 4 additions are of existing construction, the new remodel will be surveyed as a separate building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 320 beds and had a	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 **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 000	Continued From page 2 census of 240 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 321	Continued From page 3 Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.1, 18.3.6.3.11, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/27/2023 at 02:08 PM, it was revealed by observation that the soiled utility room in the 800 wing of the TCU had paper wedged in the strike plate causing the door to not latch. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 321	K321 The soiled utility room in the 800 wing of the TCU properly latches. Doors in the facility will be routinely monitored to ensure they meet compliance. Doors in the facility will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.4.1, 9.6.1.3, and 9.6.1.5, NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2, 14.4.5.3.1, 14.4.5.3.2, and	K 345	K345 The battery operated Smoke Detector that is not hooked up to the fire alarm system has been removed. If future smoke detectors are installed, the	10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 345	Continued From page 4 14.4.5.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of smoke detector sensitivity testing. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 345	Smoke Detector sensitivity testing will be scheduled for future completion. A task has been created in TELS to ensure compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 353	Continued From page 5 by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.4.1, 4.3.1, and 5.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of a sprinkler inspection being completed during the third quarter of 2022. 2. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that there were four deficiencies listed on the annual fire sprinkler inspection report dated 04/07/2023, and at the time of the survey the facility did not have documentation showing that corrections had been made. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 353	K353 Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available. Annual and quarterly sprinkler tests will be scheduled out for future completion. The facility has documentation of completion in regards to the four deficiencies listed on the annual fire sprinkler inspection report dated 04/07/2023. Annual and quarterly sprinkler tests will be scheduled for future completion. A task has been created in TELS to ensure compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW	K 372		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 372	Continued From page 6 Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.1, 18.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/27/2023 at 10:35 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors leading into the 800 wing in the TCU caused by two pieces of electrical conduit. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 372	K372 The penetrations caused by two pieces of electrical conduit in the smoke barrier above the doors leading into the 800 wing in the TCU has been fire stopped to complete the smoke barrier. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 712	Continued From page 7 with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 18.7.1.6. This deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 1st shift in the 4th quarter of 2022. 2. On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 2nd shift in the 2nd and 3rd quarter of 2023 and the 2nd shift and 4th quarter of 2022. 3. On 09/27/2023 between 09:15 AM and 3:30 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 3rd shift of the 1st quarter of 2023. An interview with the Interim Administrator verified this deficient findings at the time of discovery.	K 712	K712 A calendar was created to outline all dates and times that fire drills will occur in 2023 and 2024. The Fire Drill Calendar will be monitored for compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors	K 761		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 761	Continued From page 8 CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for annual fire door inspections. An interview with the Interim Administrator and the Facilities Director verified these deficient findings at the time of discovery.	K 761	K761 The annual inspection of fire rated doors was completed. A schedule was created to routinely monitor fire doors, including the annual fire door inspection. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 3:15 PM, it was revealed by a review of available documentation that the facility could not provide an NFPA 99 Risk Assessment. An interview with the Interim Administrator verified this deficient findings at the time of discovery.	K 901	K901 The NFPA 99 Risk Assessment has been completed. The QAPI Committee will review the Risk Assessment annually and as needed. QAPI Committee Minutes will be reviewed to ensure compliance. The Administrator or designee will be responsible for compliance.	10/27/23
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 914	Continued From page 10 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for patient care receptacle testing and it was noticed during the walk-through that some of the receptacles in the patient rooms were hospital grade, but not all of them were. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 914	K914 The NFPA 99 documentation for patient care receptacle testing was completed. A schedule was created to routinely monitor fire doors, including the annual fire door inspection. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 918	K918	10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**09/27/2023**

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
K 918	Continued From page 12 and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.1, 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.2.4, 8.4.9, 8.4.9.1, .8.4.9.2, 8.4.9.5.3, and 8.4.9.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency generator had been tested for four hours within the last 36 months. 2. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a letter of reliability from their natural gas company for the natural gas that powers one of their emergency generators. 3. On 09/27/2023 between 09:15 AM and 03:30 PM, it was revealed by a review of available documentation that the facility provided for weekly and monthly inspections and testing of the emergency generator was not organized in a manner that the surveyor could verify that all of the required inspections were completed. An interview with the Interim Administrator and the Facilities Director verified this deficient finding at the time of discovery.	K 918	Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor. A vendor has completed the four-hour emergency generator test. A letter of reliability from the natural gas company for the natural gas that powers the emergency generator. The weekly and monthly inspections and testing of the emergency generator is organized in a manner that can be verified that all of the required inspections were completed. The Facilities Director will create a task in TELS for emergency generators and monitor for compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 4, 2024

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: September 13, 2023

Dear Administrator:

On October 13, 2023, we notified you a remedy was imposed. On December 15, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 11, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 13, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 13, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 13, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 11, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
November 2, 2023

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: September 13, 2023

Dear Administrator:

On September 25, 2023, we informed you of imposed enforcement remedies.

On November 1, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found 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 electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

K0211 -- S/S: E -- NFPA 101 -- Means Of Egress - General Bld: 01
K0225 -- S/S: E -- NFPA 101 -- Stairways And Smokeproof Enclosures Bld: 01
K0321 -- S/S: E -- NFPA 101 -- Hazardous Areas - Enclosure Bld: 01
K0353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance And Testing Bld: 01
K0372 -- S/S: E -- NFPA 101 -- Subdivision Of Building Spaces - Smoke Barrie Bld: 01
K0901 -- S/S: F -- NFPA 101 -- Fundamentals - Building System Categories Bld: 01
K0914 -- S/S: F -- NFPA 101 -- Electrical Systems - Maintenance And Testing Bld: 01
K0353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance And Testing Bld: 04
K0901 -- S/S: F -- NFPA 101 -- Fundamentals - Building System Categories Bld: 04
K0914 -- S/S: F -- NFPA 101 -- Electrical Systems - Maintenance And Testing Bld: 04

As a result of the revisit findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(b), effective December 13, 2023, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective December 13, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 13, 2023.

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

As we notified you in our letter of September 25, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 13, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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).

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 13, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us