#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OHM9 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00238 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) NORTH RIDGE HEALTH AND REHAB (L1) 245183 1. Initial 2. Recertification (L4) 5430 BOONE AVENUE NORTH 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55428 531716900 (L2)(L5) NEW HOPE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 02 7. PROVIDER/SUPPLIER CATEGORY (L7)8. Full Survey After Complaint (L9) 01/01/2014 13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 06/05/2015 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 6 DATE OF SURVEY 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): 2. Technical Personnel Program Requirements 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 351 (L18) \_1. Acceptable POC 8. Patient Room Size \_\_\_ 9. Beds/Room 5. Life Safety Code Not in Compliance with Program 351 (L17) 13. Total Certified Beds (L12) Requirements and/or Applied Waivers: \* Code: Α 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)351 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Date: Kamala Fiske-Downing, Enforcement Specialist 09/03/2015 09/02/2015 Christine Bodick-Nord, HFE NE II (L19)(L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 05/01/1972 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (1.41)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00270 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

**DETERMINATION APPROVAL** 

08/06/2015

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245183

September 3, 2015

Mr. Ryan Chies, Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, Minnesota 55428

Dear Mr. Chies:

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

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

Effective July 12, 2015 the above facility is certified for:

351 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 10, 2015

Mr Ryan Chies, Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, Minnesota 55428

RE: Project Number S5183024 and Complaint Numbers H5183106, H5183107

Dear Mr. Chies:

On June 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on June 5, 2015 that included an investigation of complaint numbers H5183106 and H5183107. This surveys found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 4, 2015, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs and to investigation complaint H5183108. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

On July 20, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard surveys, completed on June 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 12, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to an abbreviated standard survey, completed on June 3, 2015.

However, compliance with the health deficiencies issued pursuant to the June 4 & 5, 2015 abbreviated standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the abbreviated standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 4, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 4, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 4, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, North Ridge Health And Rehab is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 4, 2015. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

### **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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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:

### Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245183	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/13/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
NO	ORTH RIDGE HEALTH AND REHAB		5430 BOONE AVENUE NORTH	
			NEW HOPE MN 55428	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(	(Y5)	Date
	F0176 483.10(n)		Correction Completed 07/12/2015	Reg. #	F0221 483.13(a)		Correction Completed 07/12/2015			F0225 483.13(c)(1)(ii		
	F0226 483.13(c)		Correction Completed 07/12/2015		483.15(e)(	1)	Correction Completed 07/12/2015		Reg. #	F0278 483.20(q) - (j)		Correction Completed 07/12/2015
ID Prefix Reg. # LSC	483.20(d)(3).		Correction Completed 07/12/2015	ID Prefix Reg. # LSC	-		Correction Completed 07/12/2015		Reg. #	F0311 483.25(a)(2)		Correction Completed 07/12/2015
Reg. #	F0312 483.25(a)(3)		Correction Completed 07/12/2015	Reg. #	F0314 483.25(c)		Correction Completed 07/12/2015		Reg. #	F0315 483.25(d)		Correction Completed 07/12/2015
ID Prefix Reg. #	F0323 483.25(h)		Correction Completed 07/12/2015	ID Prefix Reg. #	F0353		Correction Completed 07/12/2015		ID Prefix Reg. #	F0364 483.35(d)(1)-(	2)	Correction Completed 07/12/2015
		Reviewed GD/kfd Reviewed		Date: 09/02/20 Date:	15	nature of Sur 2' nature of Sur	7955				Date:	3/13/2015
CMS RO												

Form Approved OMB NO. 0938-0390

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(Y1)	Provider / Supplier / CLIA / Identification Number 245183	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/13/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
NORTH RIDGE HEALTH AND REHAB			5430 BOONE AVENUE NORTH NEW HOPE. MN 55428	

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(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		C	Correction				Correction					Correction
15 5 °		(	Completed	15.5 "			Completed			=		Completed
ID Prefix	·		7/12/2015	ID Prefix			07/12/2015		ID Prefix			07/12/2015
	483.60(b), (d), (e	)			483.70(h)					483.70(h)(2)		
LSC				LSC					LSC			
-											_	
Reviewed	ByRe	viewed I	Зу	Date:	Signature	of Sur	veyor:				Date:	
State Agen	су											
Reviewed	By Re	viewed I	Зу	Date:	Signature	of Sur	veyor:				Date:	
CMS RO												
Followup	to Survey Comple	eted on:			Check for any	/ Unco	rrected Defic	cienc	ies. Was a	Summary of	1	
	6/5/201	5			Uncorrecte	d Defic	ciencies (CN	IS-25	67) Sent to	the Facility?	YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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(Y1) Provider / Supplier / CLIA / Identification Number 245183	( <b>Y2) Multiple Con</b> A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 7/20/2015
Name of Facility		Street Address, City, State, Zip Code	
NORTH RIDGE HEALTH AND REHAB		5430 BOONE AVENUE NORTH	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5	) Date	(Y4)	Item		(Y5)	Date
			Correction				Correction					Correction
ID Prefix			Completed <b>07/12/2015</b>	ID Prefix			Completed <b>07/12/2015</b>		ID Prefix			Completed <b>07/12/2015</b>
	NFPA 101		01/12/2013		NFPA 101		_01712/2013			NFPA 101		07/12/2013
-	K0018				K0038		_		-	K0043		
			Correction				Correction					Correction
ID Prefix			Completed <b>07/12/2015</b>	ID Prefix			Completed <b>07/12/2015</b>		ID Prefix			Completed
	NFPA 101		0171272010		NFPA 101				Reg. #			<del></del> ;
•	K0072				K0076		<del>-</del>			-		<del>-</del> -
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix			-		ID Prefix			_
Reg. #				Reg. #			=		Reg. #			_
LSC				LSC			_		LSC			_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix			_		ID Prefix			_
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				130			_					<u> </u>
			Correction				Correction					Correction
ID Duefis			Completed	ID Duefic			Completed		ID Dueffy			Completed
Reg. # LSC				Reg. # LSC	-		_		Reg. # LSC			
							-					
Reviewed I	Bv	Reviewed	Bv	Date:	Sic	nature of Su	rvevor:				Date:	
State Agen		GS/kfd	-	09/02/20	_	mature or Su		8120	)		Date.	07/20/2015
	-	Reviewed		Date:		nature of Su	rveyor:				Date:	
CMS RO												
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?				- <del> </del>					
	6/3/2015				Unc	orrected Defi	ciencies (CI	/IS-25	67) Sent to	the Facility?	YES	NO

	State Form: Revisit Report								
(Y1)	Provider / Supplier / CLIA / Identification Number 00238	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/13/2015					
Name of Facility			Street Address, City, State, Zip Code						
NORTH RIDGE HEALTH AND REHAB			5430 BOONE AVENUE NORTH NEW HOPE, MN 55428						

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item			(Y5)	Date	(Y4)	Item		(Y5)	Date
			orrection Completed					Correction Completed					Correction Completed
ID Prefix	20530		7/12/2015	ID Prefix	205	540		7/12/2015		ID Prefix	20570		07/12/2015
Reg. # LSC	MN Rule 46	58.0300 Subp	<b>).</b> (	Reg. # LSC		Rule 4658.0		p. '		Reg. # LSC	MN Rule 465		<del>_</del>
U	MN Rule 46	0 0 58.0510 Subp	correction completed 7/12/2015	ID Prefix Reg. # LSC	MN	Rule 4658.0	520 Sub	Correction Completed 07/12/2015			MN Rule 465		
LSC				LSC						LSC			
ID Prefix	-	O	correction completed 7/12/2015	ID Prefix			(	Correction Completed 17/12/2015		ID Prefix			Correction Completed 07/12/2015
Reg. # MN Rule 4658.0525 Subp.			Heg. # LSC	MN	Rule 4658.0	615			Reg. # LSC	MN St. Statu	te 144A.C	14 Su 	
ID Prefix	21565	C	correction completed 7/12/2015	ID Prefix	216	510	(	Correction Completed 17/12/2015		ID Prefix	21685		Correction Completed 07/12/2015
Reg. # LSC	MN Rule 46	58.1325 Subp	).	Reg. # LSC	MNI	Rule 4658.1	340 Sub	<b>D.</b> '		Reg. # LSC	MN Rule 465		
_	-	C	correction completed 7/12/2015 ul	_		000 St. Statute	(	Correction Completed 17/12/2015 Su		-	23240 MN Rule 465	8.5405	Correction Completed 07/12/2015
LSC				LSC						LSC			
Reviewed E	Зу	Reviewed E	Ву	Date:		Signature	of Surv	eyor:	I			Date:	
State Agen	су	GD/kfd		09/02/201	15			2	7955			(	08/13/2015
Reviewed E	Зу	Reviewed E	Ву	Date:		Signature	e of Surv	eyor:				Date:	
Followup t	Followup to Survey Completed on: 6/5/2015			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO				NO					
STATE FORM: REVISIT REPORT (5/99)						Page 1 of	1				Event ID:	OHM912	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

		AKE/MEDICALI TO BE COMPI							ID: OHM9 Facility ID: 00	0238
1. MEDICARE/MEDICAID PROV (L1) 245183 2.STATE VENDOR OR MEDICAI (L2) 531716900		3. NAME AND AE (L3) NORTH RII (L4) 5430 BOON (L5) NEW HOPE	OGE HEALTI E AVENUE N	H AND RE	CHAB (L6) 5	55428	1. Initia 3. Tern 5. Valid	ination lation	2. Recerti 4. CHOW 6. Compla	,
5. EFFECTIVE DATE CHANGE (L9) <b>01/01/2014</b> 6. DATE OF SURVEY <b>00</b>	OF OWNERSHIP (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	IPPLIER CATEO  05 HHA  06 PRTF	GORY 09 ESRD 10 NF	02 (L7) 13 PTIP 14 CORF	22 CLIA		Survey After	9. Other	
8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/II 12 RHC		FISCAL YEAR ENDING DATE: (L35)  12/31			(L35)	
11LTC PERIOD OF CERTIFICAT From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	351 (L18) 351 (L17)	Compliance1. Accept Acce	nce With equirements e Based On: cceptable POC	gram	2. Techi 3. 24 He 4. 7-Dai 5. Life 9	y RN (Rural SN	6. \$ 7. I F) 8. I		rvices Limit rector m Size	
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY M	EETS				
18 SNF 18/19 SN 351	NF 19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):		(L15)		
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY RI	EMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL		Date:	
Theresa Gullingsrud,	HFE NE II		07/01/2015	(L19)	Kamala Fiske-	Downing, B	Enforceme	nt Speci	<u>alist</u> 07/2	29/2015 (L20)
I	PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR	SINGLE S	TATE AGI	ENCY		
DETERMINATION OF ELIGI     1. Facility is Eligible     2. Facility is not Eligible	to Participate		IPLIANCE WIT HTS ACT:	H CIVIL	2. O	atement of Finar wnership/Contro oth of the Above	l Interest Disc			
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREE	MENT	26. TERMINAT	ΓΙΟΝ ACTION:			(L30)	
OF PARTICIPATION <b>05/01/1972</b>	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closu		_	INVOLUN 05-Fail to	NTARY Meet Health/Sa	afety
(L24)	(L41)		(L25)		02-Dissatisfactio			06-Fail to	Meet Agreeme	nt
25. LTC EXTENSION DATE: 27. ALTERNATT A. Suspension		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	•	n	OTHER 07-Provide 00-Active	er Status Chan	ge
	(L45)									
28. TERMINATION DATE:	8. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.									
	(L28)	<b>00270</b> (L31)								
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE										

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

### Revised Letter 7/2/2015

Electronically delivered July 2, 2015

Mr. Ryan Chies, Administrator North Ridge Health and Rehab 5430 Boone Avenue North New Hope, Minnesota 55428

RE: Complaint Number H5183108. Project Number S5183024 and Complaint Numbers H5183106, H5183107

Dear Mr. Chies:

On June 4, 2015, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

In addition, on June 5, 2015 a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs and to complete an investigation of complaint numbers H5183106 and H5183107 which were found to be substantiated at F323. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACTS

Questions regarding this letter and all documents submitted as a response to the abbreviated survey, i.e., the plan of correction should be directed to:

Michelle Ness, Investigation Unit Supervisor
Office of Health Facility Complaints, Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4217 Fax: (651) 281-9796

General Information: (651) 201-4217 Fax. (651) 281-9790

Questions regarding this letter and all documents submitted as a response to the standard survey, i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, Minnesota 56601 Telephone: (218) 308-2104

Fax: (218) 308-2122

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey

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and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 14, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 14, 2015 the following remedy will be imposed:

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

### Original deficiencies not corrected

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

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

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

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

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will

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recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

Please note that the failure to complete the informal dispute resolution process will not delay the dates

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specified for compliance or the imposition of remedies.

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

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Kumalu Fiske Downing

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 07/13/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  \$308 BOONE WENUE NORTH NEW HOPE, MN 55428  SUMMARY STATEMENT OF DEFICIENCIES FROM DEPICIENCY MUST BE PRECEDED BY FIAL REGULATORY OR LOS DESTIFYING INFORMATION)  F 000  INITIAL COMMENTS  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance with the regulations has been attained in accordance with your verification.  Investigation of complaints H5183106 and H5183107 were also completed. The complaints were substantiated at F933.  483.10(n) RESIDENT SELF-ADMINISTER SS=D  An individual resident may self-administer drugs if the interdisciplinary team, as defined by \$483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for the safe practice of self administration of nebulizer medication (a inhaltion treatment of respiratory medication) for 1 of 1 resident (R270) observed self-administering a nebulizer treatment / medication (SAM).		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (	(X3) DATE COMPI	SURVEY LETED
NORTH RIDGE HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES THEET ADDRESS, CITY, STATE, ZIP CODE  \$430 BOONE AVENUE NORTH NEW HOPE, MN 55428  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR USO IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.  Investigation of completed. The complaints were substantiated at F353.  F176 483.20(d) (2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for the safe practice of self administration of nebulizer medication (a inhalation treatment of respiratory medication) for 1 of 1 resident (R270) observed self-administering a nebulizer treatment / medication (SAM).  STREET ADDRESS, CITY, STREET, PROMORY  PREFIX TAG  PREFIX TAG PROVIDER PLAN OF CORRECTION CECATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  CECATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEPARTMENT OF THE APPROPRIATE  CECATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEPARTMENT OF THE APPROPRIATE  PREFIX TAG  TAG  TAG  TAG  TAG  TAG  THOR HOPE PREFIX TAG  F 000  INTEL PREFIX TAG  F 000  INTEL PREFIX TAG  F 000  INTEL PREFIX TAG  TAG  THE TAG PROPRIATE TOON CECATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  TAG  TAG  THE TAG TAG  THE			245183	B. WING	<del></del>	06/0	5/2015
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/01/2015

**Electronically Signed** 

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  IG		E SURVEY IPLETED
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F 176	Findings include:  R270's Discharge (and electronically sidirected albuterol-1/3 milliliters (ml) so inhale orally via net COPD. The Order of self-administer this  R270's significant Mated 5/15/15, indicincluded chronic ob (COPD) and demer R270's care plan dishad behavior problem of the personality disorder to administer R270 however did not adadministration of monomorphic of the company of th	Orders and Information dated igned by physician 5/4/15, pratropium 2.5-0.5 milligrams olution vial (Duoneb) 3 ml oulizer every four hours for did not indicate R270 could medication nor any others.  Minimum Data Set (MDS) cated R270's diagnoses estructive pulmonary disease natia.  Acted 5/22/15, indicated R270 cms related to yelling out, as/oxygen secondary to sions and narcissistic r. The care plan directed staff of semedications as ordered, dress R270's self edication ability.  A.m. R270 was observed in his back on the edge of the bed ned out to the floor, sleeping, mask was resting loosely on bulizer machine was turned	F 17	,	ve been ed, and ate for self er nurse  ucated ng ation of neb audit 2 ninistration	
	R270's a nebulizer mask was resting loosely on his forward. The nebulizer machine was turned on and running with liquid medication noted in the nebulizer chamber. R270 was did not easily arouse to voice or noise.  -At 6:13 a.m. licensed practical nurse (LPN)-E was observed to wheel a medication cart past R270's room and came to the nursing station.  -At 6:20 a.m. LPN-E remained at the desk administering pain medication to R508.  -At 6:23 a.m. when asked if R270 had a					

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F 176	medication, LPN-E After LPN-E review orders, she verified self-administer med R270 required a SA completed to deterr practice self admini-At 6:27 a.m. both ti walked into R270's still running. LPN-E rest of the treatment On 6/4/15, at 2:13 pt (DON) stated this with R270 required a self and physician order medications.  Administering Medication and Physician Interdisciplinary Callinary Callinar	order for the nebulizer indicated she would check. ed R270's electronic physician R270 did not have an order to dications. LPN-E confirmed and order and an assessment mine R270's ability to safely stration of medication. The surveyor and LPN-E room and found the nebulizer remained in the room for the strate of nursing was poor practice and verified of administration assessment as prior to self administering cation policy revised rected "Residents may own medications only if the strate planning Team, has	F 17	,		
F 221 SS=E	capacity to do so sa 483.13(a) RIGHT T PHYSICAL RESTR The resident has th physical restraints in	O BE FREE FROM AINTS  e right to be free from any mposed for purposes of lience, and not required to	F 22	:1		7/12/15
	by:	NT is not met as evidenced ion, interview and document		F221- Residents #74 & 566 have h	nad	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06/	05/2015
	PROVIDER OR SUPPLIER  RIDGE HEALTH AND	REHAB	;	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	
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F 221	zipped backed, full failed to follow the failed to follow thich prevented from the facility also fail wheelchairs (w/c) I which prevented from the failed to fail wheelchairs (R327, Rw/c brakes which provement.  Findings include:  R566's Diagnosis FR566's diagnoses and depression, cerebrokemiplegia (weaking coordination and good R566's quarterly May 17/15, indicated From the failed the fa	ailed to identify the use of body suits as a restraint and facility's restraint policy for 2 of R74) observed wearing full nited access to one's body. ed to recognize the use of prakes as restraint devices edom of movement for 2 of 2 138) observed with engaged revented freedom of  Report dated 1/22/15, identified as Alzheimer's disease, ovascular disease (stroke) with ess on one side), lack of eneralized muscle weakness. In immum Data Set (MDS) dated R566 had severe cognitive ed extensive assist with nal hygiene and had upper or impairment on one side. In DS assessment for restraint e used" for bed rail, trunk, for bed rail, trunk, as p.m. registered nurse (RN)-E, mursing assistant (NA)-E m and using a mechanical lift in his wheelchair to his bed. In this wheelchai	F 221	restraints reviewed and are approorders, assessments, consents, plans have been obtained. Resid 327 & R138 are not having their wheelchair brakes applied at the table.  Current residents have been revipotential restraints with no other identified.  New residents will be review for ruse in M-F stand up meeting. An equipment put in place will be as determine if it is a restraint.  1. Nursing staff will be re-educate definition of a restraint and types devices which may become restremant to the use of restraints, cassessment and documentation.  3. Nursing Assistant staff will be re-educated on the appropriate pregards to the use of restraints, cassessment and documentation.  3. Nursing Assistant staff will be re-educated on the process's sur the use of restraints.  DON/Designee will audit and rev resident with a restraint weekly x weekly x 4, monthly x 3 for approdocumentation, consent and follows.	and care ents # dining ewed for residents restraint y new sessed to ed on the of aints.  brocess in consent, rounding iew each 4, bi opriate	

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F 221	zipped up the back On 6/4/15, at 9:45 a seated in his wheel a cobalt blue, one pack.  R566's Order Summerevealed it was oka one piece outfit at a R566's care plan deplace R566 in a one as available, due to feces.  R566's treatment a 4/1/15, thru 6/3/15, placed in a one piece outfit at a resident's at 10:44 wore a full body suiton 6/4/15, at 10:44 wore a one piece b back. RN-E stated zip up the back in a cacessing part of the phad not identified with the backed zip restraint; however in physical restraint as the resident's body.  On 6/4/15, at 11:53 understood the one	ody suit which remained a.m. R566 was observed chair by the aviary dressed in piece body suit zipped up the mary Report dated 2/10/15, by for R566 to be placed in a all times to prevent disrobing.  ated 2/17/15, directed staff to be piece garment at all times, or disrobing and smearing of disrobing and smearing of disrobing and smearing of complete garment at all times.  b.m. NA-G confirmed R566 to which zipped up the back.  a.m. RN-E verified R566 ody suit which zipped up the the body suits were made to order to keep the resident from their body. RN-E confirmed ied the one piece body suits ped enclosure as a physical ne understood they were a se they had limited access to	F 2	221		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		0	6/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 221	assessment complete the physical restraint knowledgeable of the restraint policy.  R74 utilized a full be back and prevented facility failed to recomplete facility failed to restrain to the use.  R74's Diagnosis Reference failed faile	d not had a pre-restraint eted prior to implementation of ht. RN-F stated she was not he content of the facility's ody suit which zipped up the d R74 access to body and the ognize this as a restraint and a policy and procedures related and 3/16/15, directed staff to ece outfit at night and during eport dated 3/19/14, identified a cerebrovascular disease (difficulty in swallowing), blood pressure), muscle	F 2	21		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245183	B. WING _	····	06	/05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 221	enter R74's room. If one piece, dark blu which was zipped usercess to her body remove R74's body brief, provide perine brief while following While reapplying R noticed the one pie NA-E attempted to R74's closet and st suit must be in the dress R74 in sweat stated he would pur R74 later once it was considered by the continent brien NA-E also verified I suit because he durent to R566 was currently which was zipped userced by suit with a back SW-A both confirmed SW-A both agreed be viewed as a residence body suits with were absolutely conconfirmed R74's calone piece body suit had a pre-restraint	p.m. NA-E was observed to R74 was observed wearing a e, neck to ankle body suit up the back and prevented R74. NA-E was observed to visuit, change her incontinent eal-care and apply a clean grinfection control practices. 74's one piece suit, NA-E ce suit's legs were soiled. If find another one piece suit in ated R74's other one piece laundry. NA-E proceeded to pants and sweatshirt and that another one piece suit on as washed.  In p.m. NA-E verified R74 piece body suit with a backed of day because she picked at find would tear it apart. R566 wore a one piece body grin his brief. NA-E verified of wearing a one piece body suit up the back.  In a.m. RN-E and social worker med R74 wore a one piece, cked zip enclosure. RN-E and they could see how this could	F 25	21			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245183	B. WING _	·····	06.	/05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 221	restraint usage.  On 6/4/15, at 2:03 pronfirmed it was the the facility's restraint and R566's medical documentation of ir a physical restraint monitoring of these R327 was observed which limited move recognize the use a implement their rese R327's quarterly MI R327's diagnoses in difficulty walking, responding to the protocol and had mone R327's Fall Care At 3/5/15, indicated R3 falls related to attenstaff were directed protocol. R327's C3/5/15, indicated R3 able to communicate talker and was able could not hear then R327's care plan daws at risk for falls, and R327 utilized at On 6/3/14, at 8:24 addining room seated table. R327 was obpull self forward by	contative with regards to communication CAA dated approximate and self-existed monitoring self-existed self-existed monitoring	F 22				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	backwards, the w/o back device was er w/c. R327 was obs step over the foot pocket talker in her ambulated, with a sfeet when the dieta asked another staff-At 8:32 a.m. R327 down the unit hallw NA-C intervened ar to use the walker or R327 responded shall NA-C proceeded to her room at which pasked another staff R327's w/c was whomedication cart nestated R327 neede was a fall risk. RN-did not respond. Upw/c an anti-roll brakinstalled. At 8:45 a.m. R327 at the dining room observed engaged. At 9:02 a.m. NA-B R327's brakes, clear R327 out of the din-At 9:11 a.m. NA-B were engaged and use the w/c to when and would also use R327 was able to in brakes, NA-B state to do so and added would be considered.	R27 attempted to wheel self would not move as an anti-roll agged on the back of R327's erved to independently stand, and as she held the hand, she independently steady gait, approximately 30 ary manager intervened and member to get her w/c. was observed to ambulate ay to the nursing station where and asked R327 if she wanted asked R327 if she wanted asked R327 if she wanted ar w/c for mobility in which he wanted to use her w/c. ambulate with R327 back to boint NA-C turned around and member if they knew where ich was found near the ar the nursing station. NA-C d to use the w/c because she B who heard this conversation, bon looking at the back of the see black bar was noted to be was observed seated in a w/c table. The w/c brakes were	F 23	21		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06	6/05/2015
-	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 221	encouraged the rewhen self transferrexpect the staff to the dining room. Retimes the residents while eating, howe responsible to enswhen the resident' unable to answer took the residents then release the brook the residents then release the brook had a restraint.  On 6/4/15, at 2:20 (DON) stated she and indicated if R3 independently she not have the brake R327 could release.  R138 was observed which limited move recognize the use implement their residents was independently on the assist upon request R138's annual MD R138 had moderate physical behaviors of one staff for local staff fo	3 a.m. RN-D stated staff sidents to lock their w/c brakes ring or standing and would not lock the w/c brakes while in N-D further stated during meals w/c brakes would be locked ver when asked who was ure the brakes were released were done eating, RN-D was but indicated when the staff back to their room they would rakes. RN-D verified R327 had assessment completed.  p.m. the director of nursing was not so familiar with R327 was able to wheel herself would have expected staff to be engaged and was not sure if the brakes herself.  In with engaged w/c brakes ement and the facility failed to as a restraint device and straint policy and procedures.  Our mobility initiated 3/7/15, is able to propel his wheelchair the unit and directed staff to	F 2	21		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, Z 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 221	diagnoses that inclu (stroke) with hemip on one side of the but muscle weakness, anxiety.  R138's Activity of D 5/15/15, indicated For transportation was able to independent staff assistance.  R138's medical rechistory of falls with occurred during stamedical record lack restraint use.  On 6/3/15, at 5:42 presented in a w/c at the independently eating -At 5:48 p.m. upon was observed atternaway from the table R138' w/c tipped slimove. R138 was observed atternaway from the table R138' w/c seat w/c back. The left wengaged therefore -At 5:53 p.m. R138 members in the dimmove. RN-H was considered.	ce Sheet indicated R138 had uded cerebrovascular disease legia (weakness or paralysis body), difficulty walking, convulsions, dementia and aily Living (ADL) CAA dated R138's primary mode of the wheelchair and R138 was tly propel himself and also with ord indicated R138 had a majority of falls having ff assisted transfers. The ted documentation of physical of the dining room table	F 2	221			
		o.m. RN-H confirmed if a evented movement it would be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	R138's w/c brake w of any type of restra assessment for the was to be complete.  On 6/5/15, at 11:20 locking w/c brakes prevented freedom resident was unable would be considere.  The Use of Restrain 9/2012, indicated:  Defined a phys method, or physica material or equipmeresident's body whice one's body  Directed staff to assessment prior to restraints  Directed staff to the use of restraints benefits of all option including the use of reflect interventions immediate medical underlying problem symptom(s)  A resident restraints document these ob 483.13(c)(1)(ii)-(iii), (iii), (iiii), (iiiii), (iiiii), (iiiii), (iiiii), (iiiii), (iiiii), (iiiii), (iiiii), (iiiii), (iiiiii), (iiiiiii), (iiiiiiiii), (iiiiiiiiii	rated she did not know why was engaged and was unaware aint assessment or w/c brakes to be locked that ed.  a.m. RN-H verified that at the dining table which of movement when the eto independently release, ed a restraint.  Ints policy, revision date ical restraint as any manual or mechanical device, ent attached or adjacent to the ch restricted normal access to compete a pre-restraint or placing a resident in cobtain informed consent for swhich included the risks and ensunder consideration, for restraints and alternatives residents in restraints would as that addressed not only the symptom(s), but the symptom(s), but the sthat may be causing the rained would be monitored at anutes and the staff would servations (c)(2) - (4)	F 2				7/12/15
SS=D	INVESTIGATE/REF ALLEGATIONS/IND	PORT					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245183	B. WING	<del> </del>	06	/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE	OULD BE	(X5) COMPLETION DATE
F 225	The facility must no been found guilty o mistreating residen had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness foother facility staff to or licensing authori.  The facility must entire involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and control of the facility must have a survey and c	of employ individuals who have if abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a it an employee, which would or service as a nurse aide or of the State nurse aide registry ties.  Insure that all alleged violations area, neglect, or abuse, if unknown source and if resident property are reported administrator of the facility and accordance with State law disprocedures (including to the pertification agency).  Insure evidence that all alleged ughly investigated, and must cential abuse while the rogress.  Investigations must be reported	F 2	25		
	by:	NT is not met as evidenced tion, interview and document		Residents 138,228 and 152 in	cidents	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE 5430 BOONE AVENUE NORTI NEW HOPE, MN 55428	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 225	State agency and /a abuse, neglect, inju accidents with seric involving 3 of 3 res reviewed for abuse.  Findings include:  An incident report of indicated R138 fell transfer from the w R138 lost his balant. The report indicate and the left side of indicated the direct nursing supervisor note on the inciden R138's care plan w staff assist was near ambulation. The preport also indicate was notified on 5/7 physician was notified on 5/7 physician was notified on 5/7 physician was notification.  R138's undated Faprinted 6/4/15, indicincluded hemiplegic body) due to cereb convulsions (seizur muscle weakness, disturbance, depresent A Fall Risk Evaluat R138 was at high r	ailed to report timely to the or investigate allegations of tires of unknown origin and ous injury for 3 of 5 incidents (R138, R228, R152).  dated 5/7/15, at 7:40 p.m. during a one staff assisted heelchair to the toilet when ce and fell against the wall. d R138 bumped his left arm his head. The report also or of nursing (DON) and the were notified. The nursing t report dated 5/8/15, indicated as updated to indicated two eded for transfers and edisposing physiological ied as weakness/fainted. The d R138's responsible party (15, at 7:50 p.m., and the ied on 5/8/15, at 2:04 p.m. lacked indication of State	F 2	have been reported ar P&P and regulations.  Prior to MDH survey - RN who failed to follow procedure in regards to a investigated and reported and investigated and investigated and investigated and investigated and investigated and investigation and investigation requirements at QA&A.	facility re-educated v proper reporting to resident 152.  are being ted per regulation.  educated regarding ating requirements.  dit 2 reporting and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 225	indicated R138 had ambulated with pro was unsteady and assistance to stabil R138's Progress no indicated R138 comboth sides. R138's Progress no indicated R138 comboth sides. R138's Progress no p.m. indicated R138 pointing to the rib a was noted.  An order by the nur 5/11/15, directed ar and chest x-ray for A radiology report of had acute rib fracture fifth ribs. R138's Progress no indicated a chest x-fractures of 3 ribs. placed to the assist (ADON) to report the report was reviewed R138 was spoken to fractures occurred to previous week and on a scale of 1-10, unbearable pain. R138's NP progress.	I no cognitive changes, blems and a device, his gait he required physical ize.  ote dated 5/8/15, indicated of pain in ribs from the fall.  ote dated 5/10/15 at 2:41 p.m., applained of pain in his chest on the dated 5/10/15, at 10:30 8 complained of left side pain, rea. No bruising or swelling as exercitioner (NP) dated a x-ray of the right and left ribs	F 2	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _	<del></del>	06	/05/2015	
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  5430 BOONE AVENUE NORTH  NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)				(X5) COMPLETION DATE		
F 225	Continued From page 15 rib fractures. In addition, the NP noted R138 had a 10 pound weight loss and his blood pressures were too low and the blood pressure medication had just been decreased and labs had been ordered. The note also indicated the NP had ordered R138's blood pressures and heart rate checks twice daily for one week.  R138's annual Minimum Data Set (MDS) assessment dated 5/15/15, indicated R138 had moderate cognitive deficit, displayed no rejection of care and required extensive assistance of two staff for transfers and ambulation. The MDS also indicated R138 had balance problems and was unsteady with position changes. In addition, the MDS indicated R138 had almost constant pain rated at 10 out of 10, which indicated almost unbearable pain.  R138's Fall Care Area Assessment (CAA) dated 5/15/15, indicated R138 was potentially at risk for falls due to balance problems during position changes and receiving an antidepressant medication. The CAA indicated R138 required assistance with transfers and would ambulate short distances in his room with staff assist and the use of a walker, but the wheelchair was his primary mode of transportation.  R138's Progress note dated 5/29/15, at 7:45 a.m. indicated R138 reported, "someone busted up my neck." The note indicated when R138 was asked what was going on, he talked about how no one helped him the previous night, something was wrong with his neck and he wanted an x-ray. The progress note indicated R138 was told the charge nurse would be notified to schedule an x-ray and the doctor would be informed.		F 22	5			

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NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CO 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	( (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 225	R138's Progress no indicated R138 commeck, running along R138 stated he felt morning and said the way as to cause paindicated the nurse R138's pain.  R138's medical record the State agency with resultant rib framedical record lack to R138's report of movement.  R138's falls care planed and directed staff to protocol, review the attempt to determine possible root cause or remove any pote care plan further directed resident, family and R138's care plan for (ADLs), initiated 3/7 indicated R138 required and the potential for was able to call for able to reposition secommunicate how in the said of the potential for was able to call for able to reposition secommunicate how in the said of the potential for was able to call for able to reposition secommunicate how in the said of the potential for able to reposition secommunicate how in the said of the potential for able to reposition secommunicate how in the said of the potential for able to reposition secommunicate how in the said of the potential for able to reposition secommunicate how in the said of the potential for able to reposition secommunicate how in the potential for able to reposition secommunicate how in the potential for able to reposition secommunicate how in the potential for able to reposition secommunicate how in the potential for able to reposition secommunicate how in the potential for able to reposition secommunicate how in the potential for able to reposition secommunicate how in the potential for the potential for able to reposition secommunicate how in the potential for the potential fo	be dated 5/29/15, at 8:54 a.m. applained of pain in the lower gupper shoulder blade region. pain when moved by NA that nat he was moved in such a in in his neck. The progress assessed the location of ord lacked any documentation on notification related to the fall actures. In addition, R138's and any documentation related and rough an initiated 6/12/14, and cated R138 was at risk for falls of follow the facility's fall information on past falls and are cause of falls, record as of the fall, and then to alternatial causes, if possible. The rected staff to educate the lataff regarding the causes.  In activities of daily living 8/15, and revised 5/8/15, uired the assistance of two need mobility and toilet use.  Sated 4/24/15, indicated R138 of pain related to arthritis and assistance when in pain, was self, ask for medication,	F 2	25			

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NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB				54	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW 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	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	indicated R138 requistaff for ambulation 4 ends, hemi cane) ambulate daily with one staff.  R138's previous call updated as recently was to ambulate will 300 feet with the asquad cane on the rilindicated R138 was extensive assistant transfers with the queeded varied daily confusion.  R138's care plan up R138 had a fall and R138's Resident Caby nursing assistant use of two staff for the quad cane for a for toilet use. The R3/9/15, indicated R138/9/15, indicated R138/9/15, indicated R138/9/15, indicated R138/9/15, indicated R13/9/15, indicate	ge 17  In mobility initiated 3/7/15, uired the assistance of two with a quad cane (a cane with with a goal for R138 to the quad cane and assist of the quad cane and assist quality of the ght side. The care plan at risk for falls, required the of 1 to 2 staff for pivot the quad cane and assistance and assistance of the care card was updated.  The care card was updated.  The care plan used the care card was updated.  The	F 2	25			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 225	provided by RN-H to the Care Card for guidance. The grow R138 was to ambute Tracking Form for made by the facility indicated R138's in and the report of n by treatment by state of the staff purposeful and its stated he was not the staff purposeful confirmed he had be from falls.  On 6/4/15, at 2:09 to 12/5/14, R138 h staff. RN-H stated major injuries, brui in odd spots and a allegations of abusthe State agency. Fractures were proloccurred that week was unaware if the State agency. RN-related to the neck	indicated the NAs were to refer or transfers and toilet use oup sheet did not indicate how late or if he could ambulate.  ota Department of Health vulnerable adult (VA) reports y lacked documentation which incident of 5/7/15, rib fractures eck pain alleged to be caused	F 22	25			
	(DON) stated she	p.m. the director of nursing would expect staff to follow the s when providing cares as the					

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F 225	NA's to use. The D DON with all falls a were related to his verified R138's care the incident and the have been reported required. In additionallegation of neck pwas not reported the pain had diminished was to protect their staff member from allegation to the Staff member from the facility faile incident as required R228's diagnoses in decision making sk walking and transfer wheelchair for mobile R228's significant of indicated R228's diagnorable for mobile fracture. The MDS indicated impaired decision rependent on two sonon-ambulatory. Trimpairment in ranger fractions and the facility of the fa	Individual resident care plan for ON stated staff called the nd stated R138's fractured ribs fall on 5/7/15. The DON explan was not followed during the fall with a fracture should that the State agency, as now, the DON verified R138's the next day because R138's the floor and report the alleged the floor and report the attendance or right away.  So dated 2/6/15, indicated included, non-Alzheimer's and osteoporosis. The MDS Indicated ills, required limited assist with the pring and used a walker and illity.	F 22	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			06/	05/2015
	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE VENUE NORTH MN 55428	, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTI I CORRECTIVE ACTION SHOUI REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 225	R228's Nurse Progrides are lying on right side. The note indicated screamed when right further revealed R rotated therefore a physician and sup. The 9:29 a.m. nurs x-ray showed hip for the 2/14/15, Fall rin her room, was of imbalance, impaire had weakness/fair R228's predisposit ambulating withou The report indicate unattended, and confall.  Review of the facil indicated R228's fareport.  On 6/4/15, at 12:3 would not be on the report was not confollowing R228's c. RN-D added, it was an incident such a staff were following RN-D also verified investigation related because staff were on 6/5/15, at 3:00 were interviewed.	gress note dated 2/14/15, at d R228 was found on the floor, between the bathroom door. I R228 was yelling out and ght leg was touched. The note 228's right leg was shorter and a telephone call placed to ervisor. See progress note indicated racture.  eport indicated R228 had a fall confused, incontinent, had gait ed memory, was non-compliant, ated. The report indicated ng situation factors were	F 2	25			

AND DIAN OF CODDECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		<del></del>	06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		5430	EET ADDRESS, CITY, STATE, ZIP CODE BOONE AVENUE NORTH V HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	following R228's can R152 sustained a frand the facility failed to the State agency R152's undated Traindicated R152 had Dementia, generalizarteriosclerosis and A facility Investigation indicated on 5/3/15 sided pain, R152 doordered and revealer ib. The section of tadministrator and mas blank. The Surwas also blank.  The Investigation RR152's incident occand location of incident of the VA report filed dated 5/5/15, therefore immediately, as recommediately, as recommediately, as required. The administrator involved and education was The facility policy at the supervisor involved and education was The facility policy at the supervisor and the supervisor and the facility policy at the supervisor and the supervisor and the facility policy at the supervisor and t	fracture because staff were re plan at the time of the fall.  ractured rib of unknown origin d to timely report the incident as required.  Insfer/Discharge report diagnoses of Alzheimer's zed pain, coronary depression.  On Report dated 5/4/15, R152 had complained of right enied falling, an X-Ray was ed an acute right 7th fractured he report form titled, date nedical director notification mmary of Investigation section deport-undated indicated curred/or was noted on 5/4/15, dent was "unknown."  with the State agency was fore was not reported juired.  O.m. the administer and DON the administrator verified the eported timely and stated the alld reported the incident as nistrator stated the RN was given disciplinary action	F 2	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 225	Entities/Individuals suspected violation mistreatment, negle source, or abuse (ir abuse) be reported the State agency.  The facility policy at Signs and Sympton 2006, indicated negprovide goods and avoid physical harm illness". The policy abuse or neglect in of care and caregiv personal care and results.	revised 2006, directed if a or substantiated incident of ect, injuries of an unknown including resident to resident, the facility will promptly notify and procedure for Recognizing ins of Abuse/Neglect revised elect was defined as "failure to services as necessary to in, mental anguish, or mental identified some signs of cluding inadequate provision er indifference to resident's	F 2	25		
F 226 SS=D	Abuse to Facility Maindicated it was the employees to prom suspected incident including injuries of misappropriation of management. The employees must im suspected abuse of direct supervisor, a administrator. In act DON must be immediabuse or incidents of time lapse since the 483.13(c) DEVELO ABUSE/NEGLECT.	anagement revised 9/12, responsibility of the ptly report any incident or of neglect or resident abuse, unknown source, and theft or resident property to facility policy and procedure directed mediately report any rincidents of abuse to their buse coordinator and/or addition the administrator or ediately notified of suspected of abuse regardless of the eincident occurred.  P/IMPLMENT ETC POLICIES	F 2	26		7/12/15

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06/05/2015	
_	PROVIDER OR SUPPLIER	REHAB	5	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428	50.00.2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
F 226	o o management per	nge 23 on of resident property.	F 226			
	by: Based on observareview, the facility fabuse prohibition properties to investigate allegation of unknown origin a injury for 3 of 5 incits of 3 residents (Resident familiary for 3 of 5 incits of 3 residents (Resident familiary for 3 of 5 incits of 3 residents (Resident familiary for 3 of 5 incits of 3 residents (Resident familiary	dated 5/7/15, at 7:40 p.m. during a one staff assisted heelchair to the toilet when ce and fell against the wall. d R138 bumped his left arm his head. The report also or of nursing (DON) and the were notified. The nursing t report dated 5/8/15, indicated as updated to indicated two edde for transfers and edisposing physiological ied as weakness/fainted. The d R138's responsible party /15, at 7:50 p.m., and the ied on 5/8/15, at 2:04 p.m. lacked indication of State		The community has operationalize P&P for reporting and investigating incidents and potential abuse.  All incidents are being investigated reported.  All staff have been re-educated reg reporting and investigating requirent DON/Designee will audit 2 incidents/unit/week to ensure that shave operationalized the policies are procedures for reporting and invest Audit results will be reviewed at QA	and arding nents.  taff nd igating.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _	·····	06/	05/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 226	body) due to cerebe convulsions (seizu muscle weakness, disturbance, depression of the 90 days prior. Indicated R138 was at high in the 90 days prior. Indicated R138 has ambulated with prowas unsteady and assistance to stability. R138's Progress in R138's Progress in R138's Progress in Indicated R138 comboth sides.  R138's Progress in p.m. Indicated R138 was noted.  An order by the nut 5/11/15, directed a and chest x-ray for A radiology report had acute rib fractifith ribs.  R138's Progress in indicated a chest x fractures of 3 ribs. placed to the assist placed to the assist placed to the sides.	provascular disease (stroke), res), difficulty in walking, dementia without behavioral essive disorder and anxiety.  Ition dated 5/6/15, indicated risk for falls and had 1-2 falls in The fall risk evaluation do no cognitive changes, oblems and a device, his gait he required physical lize.  Ition dated 5/8/15, indicated of pain in ribs from the fall.  Ote dated 5/8/15, indicated of pain in his chest on the dated 5/10/15 at 2:41 p.m., mplained of pain in his chest on the dated 5/10/15, at 10:30 at a complained of left side pain, area. No bruising or swelling the right and left ribs	F 22	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06	/05/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	R138 was spoken the fractures occurred previous week and on a scale of 1-10, unbearable pain.  R138's NP progres R138 had falls with rib fractures. In add a 10 pound weight were too low and the had just been decreordered. The note ordered R138's blochecks twice daily for the care and require staff for transfers a indicated R138 had unsteady with posit MDS indicated R138 rated at 10 out of 1 unbearable pain.  R138's Fall Care Alfolia falls due to balance changes and receive medication. The Cassistance with transhort distances in hithe use of a walker primary mode of transfers of the control of the care of the cassistance of the cassistance with transhort distances in hithe use of a walker primary mode of transfers.	o and he reported the when he had fallen the reported his pain level as 10 which indicated almost  s note dated 5/12/15, indicated injury and noted R138 had left lition, the NP noted R138 had loss and his blood pressures be blood pressure medication eased and labs had been also indicated the NP had od pressures and heart rate for one week.  mum Data Set (MDS) 5/15/15, indicated R138 had deficit, displayed no rejection dextensive assistance of two ambulation. The MDS also balance problems and was ion changes. In addition, the shad almost constant pain 0, which indicated almost rea Assessment (CAA) dated R138 was potentially at risk for a problems during position and indicated R138 required asfers and would ambulate his room with staff assist and but the wheelchair was his	F 2	226		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD E HE APPROPRI	3E	(X5) COMPLETION DATE
F 226	what was going on, helped him the prey wrong with his neck The progress note is charge nurse would x-ray and the docto. R138's Progress not indicated R138 comneck, running along R138 stated he felt morning and said the way as to cause paindicated the nurse R138's medical recoft the State agency with resultant rib framedical record lack to R138's report of movement.  R138's falls care planed and directed staff to protocol, review the attempt to determine possible root cause or remove any pote care plan further directed to R138's care plan for (ADLs), initiated 3/7 indicated R138 required.	ge 26 dicated when R138 was asked he talked about how no one vious night, something was and he wanted an x-ray. Indicated R138 was told the least be notified to schedule an rewould be informed.  The dated 5/29/15, at 8:54 a.m. Inplained of pain in the lower gupper shoulder blade region. Pain when moved by NA this nat he was moved in such a in in his neck. The progress assessed the location of the ord lacked any documentation of notification related to the fall actures. In addition, R138's ared any documentation related neck pain and rough  The progress assessed the location of the fall actures are notification of located R138 was at risk for falls of follow the facility's fall are information on past falls and the cause of falls, record sof the fall, and then to alter notial causes, if possible. The rected staff to educate the lataff regarding the causes.  The activities of daily living 7/15, and revised 5/8/15, uired the assistance of two need mobility and toilet use.	F 2	26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _	<del> </del>	06/	05/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 226	R138's care plan of had the potential for was able to call for able to reposition scommunicate how experiencing and very pain.	lated 4/24/15, indicated R138 or pain related to arthritis and rassistance when in pain, was self, ask for medication, much pain he was what increased or alleviated the or mobility initiated 3/7/15,	F 22	6				
	staff for ambulation 4 ends, hemi cane ambulate daily with one staff.	quired the assistance of two n with a quad cane (a cane with ) with a goal for R138 to n the quad cane and assist of						
	updated as recently was to ambulate which and some on the sindicated R138 was extensive assistant ransfers with the control of the sindicated R138 was extensive assistant ransfers with the control of the sindicated R138 was extensive assistant ransfers with the control of the sindicated R138 was extensive assistant ransfers with the control of the sindicated R138 was extensive as a sindicated R138	are plan printed 12/20/13, and y as 1/15/15, indicated R138 with restorative nursing up to ssistance of one staff using the right side. The care plan s at risk for falls, required ce of 1 to 2 staff for pivot quad cane and assistance y due to weakness, pain and						
	R138 had a fall an R138's Resident C by nursing assistatuse of two staff for the quad cane for for toilet use. The 3/9/15, indicated F transferring. A note (RN)-H dated 12/1 care card dated 12	apdated on 12/5/14, indicated d the care card was updated.  Care Card (the care plan used ints) printed 6/4/15, directed the transfers, two staff assist with ambulation and two staff assist Resident Care Card printed 138 required two staff for the by the registered nurse 6/14, indicated R138's resident 2/5/14, directed staff to transfer f assist and also indicated the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING _	· · · · · · · · · · · · · · · · · · ·	06	/05/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 226	care plan was not of 12/5/14, when Fonly one staff assis R138's care card h12/5/14, directing the transfer.  The undated nursing provided by RN-H to the Care Card for guidance. The growing R138 was to ambute the facility Minnes Tracking Form for made by the facility indicated R138's in and the report of n by treatment by staff on 6/3/15, at 2:17 were rough in the rale a hurry. R138 also the morning and addisrespectful and it stated he was not the staff purposeful confirmed he had be from falls.  On 6/4/15, at 2:09 stated since prior to the assist of two streported falls with unknown cause, but altercations as well neglect and mistre RN-H stated R138	followed during R138's incident ta 138 fell during a transfer with st. RN-H stated this indicated and been changed prior to the use of two staff assist for assistant (NA) group sheet indicated the NAs were to refer or transfers and toilet use to sup sheet did not indicate how alate or if he could ambulate.  Ota Department of Health vulnerable adult (VA) reports y lacked documentation which acident of 5/7/15, rib fractures eck pain alleged to be caused	F 22	26				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245183	B. WING			06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPR	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 29	F 2	26			
	during a transfer, he incident was reported the allegation	owever was unaware if the ed to the State agency. RN-H ons related to the neck pain eported to the State agency,					
	(DON) stated she was resident care cards care card was the in NA's to use. The DON with all falls a were related to his verified R138's care the incident and the have been reported required. In additional legation of neck powas not reported the pain had diminished was to protect the restaff member from	o.m. the director of nursing would expect staff to follow the when providing cares as the individual resident care plan for ON stated staff called the individual stated R138's fractured ribs fall on 5/7/15. The DON is plan was not followed during in fall with a fracture should if to the State agency, as in, the DON verified R138's seain and mistreatment by staff is enext day because R138's id. The DON stated the nurse resident first, pull the alleged the floor and report the late agency right away.					
	and the facility faile agency and investig R228's annual MDS R228's diagnoses i dementia, arthritis a indicated R228 had decision making sk	unwitnessed right hip fracture d to report timely to the State gate the incident as required.  S dated 2/6/15, indicated ncluded, non-Alzheimer's and osteoporosis. The MDS I memory loss, impaired ills, required limited assist with erring and used a walker and ility.					
	R228's significant of indicated R228's diameter	change MDS dated 5/22/15, agnoses included					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06	/05/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 226	non-Alzheimer's de and hip fracture. The MDS indicated impaired decision dependent on two non-ambulatory. Timpairment in ranglower extremity an R228's Nurse Prog 7:39 a.m. indicated lying on right side of the note indicated screamed when we note further reveal and rotated therefor physician and support of the 9:29 a.m. nurs x-ray showed hip for the 2/14/15, Fall rin her room, was of imbalance, impaired had weakness/fair R228's predisposit ambulating without The report indicated unattended, and confident for the facility indicated R228's fair report.  On 6/4/15, at 12:36 would not be on the facility of the facility	ementia, arthritis, osteoporosis di R228 had memory loss, making skills, was totally staff for transfers and was he MDS indicated R228 had ge of motion on one side in di used a wheelchair.  Gress note dated 2/14/15, at di R228 was found on the floor, between the bathroom door.  I R228 was yelling out and hen right leg was touched. The ed R228's right leg was shorter ore a telephone call placed to ervisor.  Greport indicated R228 had a fall onfused, incontinent, had gait and memory, was non-compliant, ated. The report indicated ng situation factors were	F 22	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06.	/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	staff were following RN-D also verified and investigation refracture because st plan.  On 6/5/15, at 3:00 pwere interviewed. The sustained a frank the facility faile agency, as required R152's undated Traindicated R152 had Dementia, generalial arteriosclerosis and A facility Investigation indicated on 5/3/15 sided pain, R152 doordered and reveal rib. The section of the administrator and mass blank. The Surwas also blank.  The Investigation FR152's incident occ 5/4/15, and location.	R228's hip fracture because the resident's care plan. the facility did not complete elated to R228's fall and aff were following the care  o.m. the administer and DON he administrator stated it was eport an incident such as fracture because staff were re plan at the time of the fall.  ractured rib of unknown origin d to report timely to the State d.  ansfer / Discharge report diagnoses of Alzheimer's zed pain, coronary depression.  on Report dated 5/4/15, R152 had complained of right enied falling, an X-Ray was ed an acute right 7th fractured he report form titled, date nedical director notification mmary of Investigation section deport-undated indicated eurred / or was noted on of incident was "unknown."	F 22	6		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION			E SURVEY IPLETED
		245183	B. WING			06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS 5430 BOONE AVE NEW HOPE, MM		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL EFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	were interviewed. To VA report was not reactive to the supervisor involved and education was. The facility policy at Abuse to the State Entities/Individuals suspected violation mistreatment, negles source, or abuse (if abuse) be reported the State agency.  The facility policy at Signs and Symptom 2006, indicated negprovide goods and avoid physical harm illness. The policy or neglect including and caregiver indifficate and needs.  The facility policy at Abuse to Facility Mindicated it was the employees to prom suspected incident including injuries of misappropriation of management. The employees must im suspected abuse of direct supervisor, at a supervisor, at a supervisor, at a supervisor, at a supervisor involved and the supervisor, at a supervisor, at a supervisor, at a supervisor involved and a supervisor invol	o.m. the administer and DON The administrator verified the eported timely and stated the full reported the incident as inistrator stated the RN was given disciplinary action	F 2	26			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245183	B. WING		06/05/2015
	PROVIDER OR SUPPLIER	REHAB	5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 246 SS=D	DON must be imme abuse or incidents of time lapse since the 483.15(e)(1) REAS OF NEEDS/PREFE  A resident has the reservices in the facility accommodations of preferences, exceptions.	ediately notified of suspected of abuse regardless of the encident occurred. ONABLE ACCOMMODATION RENCES	F 226		7/12/15
	by: Based on observat review, the facility fa accessible for 1 of 3 needing staff assist call light, however ti reach during 2 of 2  Findings include: R298 was able to u staff assistance, ho place the call light v R298's Fall Care Ar 12/15/14, indicated to difficulty maintair impairment and imp transitions. R298's quarterly Mi	se her call light to summon wever the facility failed to vithin R298's reach.  The a Assessment (CAA) dated R298 was at risk for falls due hing sitting balance, cognitive paired balance during  The summary of the summon of the summary of the summ		Resident #298 has her call light within reach.  All resident have their call lights within reach. All call light cords have been checked to ensure a clip is available the cord for secure placement.  All staff have been re-educated regard having call lights within reach.  DON/Designee will audit 2 residents/unit/week to ensure appropicall light placement. Results of audits be reviewed at QA&A.	n on rding riate
		nimum Data Set (MDS) dated 298's diagnoses included			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06	/05/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 246	muscle weakness, dementia. The MD extensive physical activities of daily livimpaired cognition mobility.  R298's care plan in lacked indication of the mobility.  R298's care plan in lacked indication of the mobility.  R298's care plan in lacked indication of the mobility.  On 6/1/15, from 6: was heard yelling. Upon entering R29 lying on her back in elevated at approximate asked the surveyor when R298 was a use the call light, Find know where it is." I lying on floor with the grab bar facing R298. The surveyor licensed practical in nurses station. LPI repositioned her careat 6:18 p.m. where using the call light LPN-D stated "yes supposed to be with the model of the R298's roof in her wheelchair with the model of the R298 stated the careat and asked the reach and asked the reach and asked the model of the R298 stated the careat and asked t	fatigue and malaise and S also indicated R298 required assist of one to two staff for all ving (ADLs), had moderately and used a wheelchair for most recently revised 6/15, f R298's call light use.  10 p.m. until 6:17 p.m. R298 help help" from her room. 18's room, R298 was observed in bed with the head of the bed imately 45 degrees. R298 in to lower the head of bed. sked asked if she was able to 8298 stated "yes but I don't The call light was observed he call light cord hanging on a downward not accessible to be requested assistance from hurse (LPN)-D who was at the N-D assisted R298 and all light within R298's reach. In asked if R298 was capable of to summon staff assistance, "and acknowledged it was	F 24	6			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245183	B. WING		06/	/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPF  DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 246	and asked R298 where the call light and right wheelchair arms he was going to fin acknowledged R29 light and stated it should be considered to within the resident those able to use the Con 6/2/15, at 4:03 per did not have a policilight use.	RN)-C who came to the room hat she needed, reached out divrapped it around R298's mrest, activated it and stated had help for R298. RN-C 8 was unable to reach the call hould have been within R298's a.m. the director of nursing ent call lights were supposed has reach at all times, for hem.	F 2			7/12/15
SS=E	The assessment m resident's status.  A registered nurse each assessment v participation of heat.  A registered nurse assessment is come.  Each individual who assessment must state portion of the attention of th	RDINATION/CERTIFIED  Tust accurately reflect the  must conduct or coordinate with the appropriate lth professionals.  must sign and certify that the appleted.  Do completes a portion of the sign and certify the accuracy of	1 2			7712/13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245183	B. WING		06/05/2	2015
	PROVIDER OR SUPPLIER	REHAB	5	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) DMPLETION DATE
F 278	\$1,000 for each ass willfully and knowin to certify a material resident assessme penalty of not more assessment.  Clinical disagreeme material and false so the control of	sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each ent does not constitute a statement.  NT is not met as evidenced tion, interview and document ailed to ensure Minimum Data nents accurately reflected the atus for 2 of 3 residents (R228, teeth/dental and accurately estraint status for 2 of 2 66) reviewed for restraints.  Change Minimum Data Set 15, inaccurately indicated R228 es.  Change MDS dated 5/22/15, ad "no" broken or loosely fit full and "no natural teeth or tooth  Screening dated 4/21/15, I an exam which noted multiple al recommendations for leave as is, take x-rays and 1 tooth and make new upper	F 278	Residents 228, 163, 74, 566 have modifications completed for an acc MDS assessment.  All residents' assessments are revifor accuracy prior to submission.  MDS staff have been re-educated regarding accuracy of MDS data.  Director of Reimbursement/Design audit 2 residents/unit/week MDS to ensure accurate coding. Results o will be reviewed at QA&A.	ewed ee will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		TE SURVEY MPLETED
		245183	B. WING		06	6/05/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	R228's care plan daher own teeth. On 6/2/15, at 11:54 her front teeth miss. On 6/3/15, at 5:30 pteeth fell out and he about it. She stated going to get new te. On 6/4/15, at 7:00 at (LPN)-F verified stateeth and stated R22/15. On 6/4/15, at 10:10 MDS's were review coordinator. RN-E vand stated they bot have broken, missin R163's MDS dated reflect R163's dentareflect R163's dentareflect R163's dentareflect R163's care plan da "has her own teeth. On 6/2/15, at 8:23 awithout the lower defended on 6/2/15, at 10:22 (FM)-A, stated R16 properly and had no	a.m. R228 was observed with sing.  o.m. R228 stated her front er power of attorney knew I she did not know if she was eth or not.  a.m. licensed practical nurse aff knew R228 had missing 228 had lost three teeth around  a.m. the above identified ed with RN-E, the MDS verified the MDS information h were incorrect as R228 did not teeth.  5/22/15, failed to accurately al status.  DS dated 5/22/15, and MDS dated 10/6/14, indicated en or loosely fitting partial or  ated 5/28/15, indicated R163  a.m. R163 was observed	F 2	78		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING	·····	06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	wear her bottom de her mouth and did r On 6/5/15, at 1:53 p stated R163 did not On 6/5/15, at 2:06 p verified the care plateeth.  06/05/2015, at 3:19 identified MDS dock MDS assessments  According to the Lo Resident Assessments  According t	ntures as they "wobbled" in not fit her.  2.m. nursing assistant (NA)-U have bottom dentures.  2.m. registered nurse (RN)-D in indicated R163 had her own p.m. RN-E verified the above umentation and confirmed the were inaccurately coded.  Ing Term Care Facility ent Instrument User's Manual ast revised on October 2014, ent" directed staff to: amily, or significant other at had or recently had dentures into or family/significant other sident recently had dentures did not have them at the ason).  Identures or partials, examine ions directed a denture was a resident complained that it ure visibly moved when the sor her mouth, or the denture sident tried to talk. The further directed to check "no the fragment(s) (edentulous)" if lentulous or lacked all natural h.	F 2	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		TE SURVEY MPLETED
		245183	B. WING _		06	/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 278	R74's significant chindicated R74's assindicated "none us other.  On 6/3/15, at 12:30 dressed in a one pi body suit which was prevent R74 access.  R74's Order Summ revealed a physicia be worn at night anday.  R74's care plan dat put R74 in a one pit the day as needed.  R74's treatment ad 4/1/15, thru 6/3/15, placed in a one pie for 4/24/15.  On 6/3/15, at 12:30 usually wore a one zip enclosure every her brief and would On 6/4/15, at 10:50 (SW)-A confirmed I suit with a backed 2 SW-A agreed they as a restraint.	p.m. R74 was observed ece, dark blue neck to ankle is zipped up the back and is to own body.  ary Report dated 8/6/14, in order for a one piece suit to das needed throughout the red 3/16/15, directed staff to ece outfit at night and during ministration records from indicated R74 had been be suit every evening except p.m. NA-E verified R74 piece body suit with a backed of day because she picked at tear it apart.  a.m. RN-E and social worker R74 wore a one piece body sip enclosure. RN-E and saw how this could be viewed p.m. RN-F confirmed the one	F 2	78		
		the backed zip enclosures				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG			E SURVEY PLETED
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD I	BE	(X5) COMPLETION DATE
F 278	On 6/4/15, at 12:25 R74's MDS was ina R74 utilized a physisuit) and this had no restraint section of R566's MDS dated reflect the use of a R566's quarterly MI R566's assessment "none used" for be On 6/3/15, at 12:18 observed to enter F from his wheelchair lift. R566 was obset topped one piece bothe back and preve On 6/3/15, at 7:06 pseated in his wheelchair lift. R566 was obset topped one piece bothe back and preve On 6/3/15, at 7:06 pseated in his wheelchair lift. R566's care planda one piece body si R566's Order Summerevealed it was okat one piece outfit at a R566's care planda place R566 in a one available due to dis movement.	p.m. RN-E and RN-F verified accurate for restraint use as cal restraint (one piece body of been reflected on the the MDS.  4/17/15, failed to accurately physical restraint.  DS dated 4/17/15, indicated the for restraint use indicated drail, trunk, limb or other.  p.m. RN-E, NA-E were as 66's room and transfer R566's room and transfer R566's rinto bed using a mechanical rived dressed in a light blue ody suit which was zipped up inted R566 access to his body.  D.m. R566 was observed chair wearing the light blue ody suit which remained	F 2	78			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER			54	TREET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	4/1/15, thru 6/3/15, placed in a one piece on 6/3/15, at 7:40 wore a full body sure on 6/4/15, at 10:44 wore a one piece of back. RN-E confir one piece body sure enclosure as a phy understood they willimited R566 access on 6/4/15, at 11:53 understood the one backed zipped encrestricted access to On 6/4/15, at 12:12 MDS was inaccurated utilize a physical reand this had not be section of the MDS According to the La Resident Assessmit version 3.0 dated lathe "DEFINITIONS any manual methodevice, material or adjacent to the rescannot remove easing movement or normal addition, the manual Assessment" and control of the methodevice of the m	indicated R566 had been bee garment at all times.  p.m. NA-G confirmed R566 it which zipped up the back.  A a.m. RN-E verified R566 body suit which zipped up the med they had not identified the ts with the backed zipped vsical restraint; however he ere a physical restraint as they as to his body.  B a.m. RN-F stated she is piece body suits with the closure were restraints as they to the residents' body.  P. p.m. RN-E verified R566's the for restraints as R566 did estraint (one piece body suit) the reflected on the restraint one piece body suit) the reflected on Cotober 2014, as PHYSICAL RESTRAINT" was done or physical or mechanical equipment attached or ident's body. In all provided "Steps for"	F 2	278			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		E SURVEY IPLETED
		245183	B. WING _		06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280 SS=D	observe the resider restraint has on the Evaluate if the Voluntarily remove the equipment. If the Evaluate if the Evaluation of th	e physical restraint definition, at to determine the effect the resident's normal function. The resident can easily and the device, material, or resident cannot easily and the restraint, continue with the ermine whether the device foody.  O(k)(2) RIGHT TO NNING CARE-REVISE CP  The right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 28			7/12/15
	by:	NT is not met as evidenced ion, interview and document		Resident 63 has had her care pla	n	

AND BLAN OF CORRECTION INDESTRUCTION NUMBER:		` '	X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	review, the facility finclude intervention and incontinence caidentified with a prefor 1 of 2 residents  Findings include:  R63's undated Diaghad diagnoses that partial paralysis of cerebrovascular disof language, affecti comprehension of sor write), generalize osteoarthrosis, dendisease.  R63's quarterly Min 4/1/15, indicated R6 understood and has skills for daily decisindicated R63 requit two staff for bed month and functional of the upper and low impairment on one identified R63 as all bladder and was at pressure ulcers.  R63's Care Plan dainterventions regard incontinence care fincontinence as we	ailed to revise the care plan to s regarding pressure ulcer are for 1 of 3 residents (R63) ssure ulcer and incontinence (R63) reviewed.  gnosis Report indicated R63 included hemiplegia (total or one side of the body) due to sease, aphasia (an impairment and the production or speech and the ability to read and muscle weakness, nentia and peripheral vascular imum Data Set (MDS) dated	F 28	80	reviewed and revised to reflect her B&B and skin status.  All residents with skin impairment of incontinence have been reviewed a updated to reflect their current status.  Licensed staff have been re-educal regarding revision of care plans.  DON/Designee will audit 2 residents/unit/week to ensure care accurately reflect B&B and skin status Audits will be reviewed at QA&A.	or B&B and us. ted plans	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 280	identified R63 had a shallow crater in tright buttock measured. On 6/3/15, R63 was offered or assisted a.m. until 10:05 a.m. assisted with incontuntil 10:24 a.m.  On 6/4/15, at 10:21 verified the care plaregarding the prevention of the fresidents as well as incontinence every.	Report dated 6/1/15, a stage II (abrasion, blister or the skin) pressure ulcer to her uring 0.6 cm x 0.4 cm x 0 cm.  sobserved to not have been with positioning from 7:05 a. and was not offered or tinence care from 7:05 a.m.  a.m. registered nurse (RN)-G an lacked specific interventions ention of pressure ulcers or and stated it was the minimum acility to turn and reposition is check and change for 2 hours.	F 2	80		
F 309 SS=D	comprehensive car assessment of the indicated care plans about the resident a changed. The policipurposes of the car goals, timetables, a outcomes.  483.25 PROVIDE OHIGHEST WELL BE Each resident must provide the necessior maintain the highmental, and psychologicals.	entified the basis of the e plan was a thorough resident that was ongoing and s were revised as information and the resident's condition by indicated one of the e plan was to reflect treatment and objectives in measurable CARE/SERVICES FOR EING  Treceive and the facility must ary care and services to attain nest practicable physical, associal well-being, in ecomprehensive assessment	F 3	09		7/12/15

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		245183	B. WING		06/0	5/2015	
	245183  E OF PROVIDER OR SUPPLIER  RTH RIDGE HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 45  This REQUIREMENT is not met as evidence by: Based on observation, document review and interview, the facility failed to ensure appropris positioning was provided during meal time for 3 (R152, R19, R287) residents reviewed for positioning.  Findings include:  R152 was observed seated parallel to her evening meal during the evening meal observation on 6/3/15.  R152's Diagnosis Report dated 7/25/14, ident R152's diagnoses as esophageal reflux, Alzheimer's disease and dementia.  R152's quarterly Minimum Data Set (MDS) da 3/6/15, indicated R152 had severe cognitive impairment, required extensive assist with transfers and required staff to assist with setti up her meal tray. The Activities of Daily Living Care Area Assessment (CAA) identified R152 having difficulty maintaining a sitting balance impaired balance during transitions.  On 6/3/15, at 6:06 p.m. R152 was observed	REHAB	ţ	STREET ADDRESS, CITY, STATE, ZIP CODE  5430 BOONE AVENUE NORTH  NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 45	F 309				
	by: Based on observarinterview, the facility positioning was produced as (R152, R19, R28) positioning.  Findings include: R152 was observed evening meal during observation on 6/3/R152's Diagnosis FR152's diagnoses and Alzheimer's diseased Alzheimer's diseased R152's quarterly M3/6/15, indicated R impairment, require transfers and required belance do no 6/3/15, at 6:06 peated off to the righigh wing backed of desk. R152's mean placed on the desk repeatedly twisting her food on the tray-At 6:08 p.m. R152	tion, document review and y failed to ensure appropriate vided during meal time for 3 of 7) residents reviewed for  d seated parallel to her g the evening meal 15.  Report dated 7/25/14, identified as esophageal reflux, e and dementia.  Inimum Data Set (MDS) dated 152 had severe cognitive ed extensive assist with red staff to assist with setting The Activities of Daily Living nent (CAA) identified R152 as intaining a sitting balance and uring transitions.  D.m. R152 was observed the open dining area in a hair parallel to a large wooden tray was observed at her waist in order to reach		Resident #152, table has been low Table was adjusted to decrease the overall height that would be appropriate seating areas for mealtime. The demoved to adjacent area and will not be used for meal times.  Current residents have the potential affected by this alleged deficiency. Residents are being provided appropriate and positioning staff have been re-educated regarding appropriate and positioning at mealtime.  Current nursing staff have been re-educated regarding appropriate and positioning at mealtime.  DON/Designee will audit each dining at lunch daily x 5, weekly x 4, monto validate that each resident requial additional seating needs will be accommodated.	e priate de and e e esk was o longer al to be copriate seating ling ang room thly x 3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	waist in order to plady tray. R152 took a and while holding a it to her mouth. Ear food off of her tray waist and brought to food across her borought to her borought to food across her borought to her borought to food across her borought to her b	R152 again had to twist at the ace the bowl back on the table forkful of mashed potatoes anapkin under the fork brought on time R152 took items of she needed to twist at the he eating utensil and morsel of dy and up to her mouth. Was observed to have turned the corner of the tray was hung was observed holding her ice or lap with a napkin placed arected staff to assist R152 in tray.  Seessment dated 5/20/15, uired assistance with setting an addition, R152 had showed a cant weight loss at 30, 90, 180 for weight loss was not desired.  Form indicated she consumed hing meal on 6/3/15.  Seated at a table which was evening meal on 6/3/15, identified a dementia, muscle weakness, iculty walking.  DS dated 5/15/15, indicated gnitive impairment, required the transfers and required staff.	F3	809			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION  NG	` '	TE SURVEY MPLETED
		245183	B. WING _		06	/05/2015
	NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 309 Continued From page 47 On 6/3/15, at 6:11 p.m. R19 was observed sea in the dining area at a high table. Her meal tray was positioned directly in front of her. The heig of the table was approximately two inches awa from R19's chin. When asked, R19 stated it w difficult for her to eat at this table as she thoug her chair was "really low." From 6:11 p.m. until 6:45 p.m. R19 was observed to have to raise he right arm (the arm/hand she used to feed herse up even with her shoulder in order to reach the food on her tray.  R19's care plan directed staff to assist R19 in setting up her meal tray.  R19's nutritional assessment dated 5/20/15, indicated R19 was 63 inches in height, and she			STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	On 6/3/15, at 6:11 pin the dining area a was positioned dire of the table was approm R19's chin. Was difficult for her to eather chair was "reall 6:45 p.m. R19 was right arm (the arm/hup even with her shood on her tray.  R19's care plan diresetting up her meal R19's nutritional as indicated R19 was required assistance R19's meal intake for 0-25% of her evening R287 was observed during the evening R287's Diagnosis Fidentified R287's diagnosis Fiden	c.m. R19 was observed seated t a high table. Her meal tray ctly in front of her. The height proximately two inches away then asked, R19 stated it was at at this table as she thought y low." From 6:11 p.m. until observed to have to raise her hand she used to feed herself) noulder in order to reach the extend staff to assist R19 in tray.  sessment dated 5/20/15, 63 inches in height, and she with setting up her tray.  orm indicated she consumed and meal on 6/3/15.  d seated parallel to her meal meal on 6/3/15.  Report dated 10/26/11, agnoses as dementia, in swallowing), esophageal veakness.  DS dated 5/15/15, indicated ognitive impairment, d vision, was on a d die, and required staff to up her meal tray. The Activities identified R287 as having g a sitting balance and	F 30	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245183	B. WING _		06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	the right of the ope back chair parallel was seated across was placed on the (TA)-L. R287 contitowards the open of meal tray. R287 writine 6:26 p.m. until her waist, bring the towards her mouth. (RN)-E, R287 and stowards the desk, it parallel to her meal spilling Jello on her tried to bring the Jemouth.  R287's care plan disetting up her meal ray.  R287's nutritional a indicated R287 requip her meal tray.  R287's meal intake 51-75% of her ever On 6/3/15, at 6:43 processed at addition, the two reseated at the wood parallel and facing	p.m. R287 was seated off to in dining area in a high winged to a large wooden desk. R287 from R152. R287's meal tray desk by therapeutic aide nued to be positioned facing lining area and parallel to her as observed during the meal 6:45 p.m. as having to twist at food across her body and up. At 6:31 p.m. registered nurse slightly repositioned her chair nowever, R287 remained tray. R287 was observed clothing protector as she was ello across her body and to her irrected staff to assist R287 in tray.  It is sessment dated 5/15/15, uired assistance with setting efform indicated she consumed hing meal on 6/3/15.  p.m. RN-E confirmed the table was too high for her. In sidents (R152 and R287) en desk were positioned away from their meal trays.	F 30	09		
F 311 SS=D		nce were not provided. TMENT/SERVICES TO NN ADLS	F 3	11		7/12/15

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 311	services to maintain specified in paragra.  This REQUIREMENT by: Based on observation review, the facility forder for a physical evaluation and treat (R228) reviewed for Findings include: R228's annual Minit 2/6/15, indicated R2001 non-Alzheimer's death osteoporosis. The finding memory loss, impaired limited asstransferring used a mobility.  R228's significant of indicated R228's diamon-Alzheimer's deand hip fracture. The MDS indicated impaired decision in dependent on two sonon-ambulatory. The impairment in ranger in the maintain ranger in ranger in the maintain ranger in the maintain ranger in ranger in the maintain ranger in ranger in the maintain ranger	the appropriate treatment and nor improve his or her abilities aph (a)(1) of this section.  NT is not met as evidenced tion, interview and document ailed to act upon a physician's and occupational therapy treatment for 1 of 3 residents ambulation.  mum Data Set (MDS) dated 228's diagnoses included, mentia, arthritis and MDS indicated R228 had irred decision making skills, sist with walking and walker and wheelchair for thange MDS dated 5/22/15,	F3	Resident #228 orders for current and is receiving th per order.  Current residents with the were reviewed to validate provided per order.  Licensed Nursing staff we on the process of therapy therapy staff will review cuagainst notification, daily meeting.  DON/Designee will review caseload with the Therapy M-F, x 4 weeks, bi weekly and as a standing item on clinical stand up meeting.  Phone orders and electror reviewed daily M-F between therapy in clinical standup	rapy orders therapy is being re re-educated notification and irrent case load M-F in standup current therapy Staff, weekly, M-F x 4 weeks going in daily nic orders will be en nursing and	
	Assessment (CAA)	Daily Living (ADL) Care Area dated 5/29/2015, indicated functional decline due to				

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 311	incontinence and d R228's physical lim weakness, limited in coordination, poor lipain.  The 2/14/15, Fall R imbalance, impaire weakness/fainted a assistance.  The medical record right hip fracture or right hip fracture or R228's physician's order in physical therapy (P services. On 5/19/1 x-ray the hip for he order was clarified bearing. However, in the PT/OT depair R228's care plan re was weak and had fracture requiring a and was non-ambulon 6/3/15, at 8:10 was observed to will NA-T and another IR228 onto the toilet the toilet, both NA's	imobility such as contractures, epression. The CAA indicated ditations consisted of range of motion, poor balance, visual impairment and deport indicated R228 had gait d memory, non-compliant, and had ambulated without did indicated R228 sustained a n 2/14/15.  Order dated 5/18/15, indicated R228 was to receive to receive to receive dilated R228 was to receive to receive dilated R228 was received to realing. On 5/20/15, the PT/OT with an "Ok" for full weight the order was never received to receive dilated R228 a recent history of right hip sists of two staff for transfers a received to the bathroom.  NA were observed to transfer to the R228 was done using the was received to transfer to the pathroom.  NA were observed to transfer wheelchair and wheeled her	F 31			

				(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		06/	05/2015
AND PLAN OF CORRECTION    DENTIFICATION NUMBER:   A. BUILDING						30,23.0
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 311	On 6/4/15, at 11:10 verified R228 had a evaluate and treat find any additional record as to whether or not.  On 6/4/15, at 11:30 stated there was so PT had not evaluatit.  On 6/5/15, at 8:45 physician order to have been completed next day.  On 6/5/15, at 9:25 recall writing down physician regarding for the physician (a had not heard anyt (6/4/15-during surve the order was lost in not received the or PT-N stated when therapy evaluation considered complete their schedule which Assistant Rehabilities stated R228 was of evaluation today (6) On 6/5/15, at 9:33 Rehabilitation Direct got the 5/18/15, PT R228. She stated rorder to the therapy order to the therapy or the same transfer or the therapy order to the therapy or	a.m. registered nurse (RN)-D a physician's order for PT to R228, however, was unable to information in R228's medical er the order was fully process a.m. physical therapist (PT)-O ome miscommunication and ed R228 but would get right on a.m. PT-L, stated the 5/18/15, evaluate and treat R228 should ted the day it was written or the g R228's weight bearing status around 5/18/15) to answer and hing further until yesterday ey). PT-N stated he thought n communication as they had der in the therapy department. There was an order written for and treatment the orders were sted when it would show up on the was made out by the ation Director/COTA. PT-N in the schedule for an (/5/15).	F 3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06/	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311 F 312 SS=D	answer during roun in the computer system for a physician response week she stated she case.  On 6/5/15, at 3:50 ppon were interview DON stated they we treat to be acted on administrator stated had occurred.  483.25(a)(3) ADL CODEPENDENT RESPONSE A resident who is undaily living receives	tions for R228's physician to ds and she had been looking stem for the next couple days conse, however by the next e had forgotten about R228's c.m. the administrator and ved. The could expect a PT evaluate and a that day or the next. The dit sounded like a "mix-up"	F 31			7/12/15
	by: Based on observative review the facility fatassistance for 1 of who was not provided directed or approprienhance independent observations.  Findings include:  R247's annual Minit 5/15/15, indicated F	NT is not met as evidenced tion, interview and document ailed to provide eating 1 resident (R247) observed ed adequate assistance as iate positioning in order to ent eating during 1 of 2 dining mum Data Set (MDS) dated R247 was rarely/never d diagnoses that included		Resident # 247 is receiving timely assistance with eating.  Current residents with assistance region meals are potentially affected by the alleged deficiency. Residents ident through MDS as needing assistance eating were reviewed.  Current nursing staff (licensed and nursing assistants) have been re-educated regarding provision of appropriate assistance with dining assistance.	e ified e with	

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F 312	aphasia (an impair production or compability to read or wrhemiplegia (total or the body), abnorma and oropharyngeal problem involving the MDS also indicated assistance of one productional limitation upper and lower exerceived a mechanical mec	ment of language, affecting the prehension of speech and the lite), stroke, dementia, repartial paralysis of one side of all posture, muscle weakness dysphagia (a swallowing he mouth and throat). The difference required extensive person for eating, had a min range of motion to the stremity on one side and hically altered diet.  a.m. R247 was observed dining room in a tilt in space is wheelchair was positioned at the strematically altered diet.  The shade of the strematical strength is shaded in the strematical strength is shaded in the strength is shaded in the shaded of the strength is shaded in the shaded in	F 312	meals.  Point of Care System and resider care cards have been updated to specific task to identify those who additional assistance.  Care plans reviewed and updated those requiring additional assistance bon/Designee will audit each direct breakfast, lunch, and dinner More weeks, bi weekly x 4 weeks, wee weeks, monthly x 3 to validate the appropriate feeding assistance is given at the times of meals.	add a om need d for nce.  hing room -F x4 kly x4 e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		06/	/05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 312	R247. Staff did no move his food with -At 8:27 a.m. NA-h to R247 and assist R247 looked their v foodAt 8:34 a.m. NA-L R247's table, stable, stable, hand it to hin continue distributin slice of toast indep -At 8:37 a.m. NA-L attempted to assist refused assistance had finished eating however NA-I did nany additional item -At 8:38 a.m. NA-I straw and stood ne to assist him to drir	but the dining room, passing by toffer assistance to R247 or in his reach.  (i) joined NA-J at the table next ed another resident to eat.  (ii) way, still unable to reach his was observed to walk up to a half piece of toast on R247's in and left R247's table to g meals. R247 ate the half endently.  (ii) sat at R247's table and it his tablemate to eat who so NA-I left the table. R247 the half slice of toast, not offer R247 assistance to eat is on his tray.  Teturned to the table, brought a lext to R247 and held his glass in the fluids. R247 turned his	F 31	2			
	closer to the table, began to assist R2 breakfast.  On 06/03/2015, at could feed himself NA-I stated he cou other finger foods to food items and hole NA-I confirmed R2 tray and required a On 06/04/2015, at (RN)-G confirmed eat. She stated sh	moved R247's wheelchair sat in a chair next to him and 47 to eat the remainder of his 10:46 a.m. NA-I stated R247 once the food was in his hand. Id feed himself his toast and but had difficulty with other ding onto cups or glasses. 47 could not reach all of his					

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-	
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F 312 F 314 SS=D	Policies regarding of requested but none 483.25(c) TREATM PREVENT/HEAL P	titit.  dining or dignified care were were provided.  ENT/SVCS TO	F 31			7/12/15
	resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores	must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and e healing, prevent infection and				
	by: Based on observat review, the facility for repositioning assist	ion, interview and document ailed to provide timely ance in order to enhance of 3 residents (R63) reviewed		Resident 63 is being repositioned plan of care.  All residents requiring assistance repositioning to prevent pressure are being provided with assistance reposition per plan of care.	vith Ilcers	
	diagnoses that inclupartial paralysis of cerebrovascular disof language, affecticomprehension of sor write), generalize	eport indicated R63 had uded hemiplegia (total or one side of the body) due to sease, aphasia (an impairmenting the production or speech and the ability to readed muscle weakness, nentia and peripheral vascular		All nursing staff have been re-educe regarding providing assistance wit repositioning.  DON/Designee will audit 2 residents/unit/week to ensure apprepositioning is occurring. Audit rewill be reviewed at QA&A.	ropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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F 314	4/1/15, indicated R understood and ha skills for daily decis indicated R63 requition two staff for bed mand had functional of the upper and lo impairment on one identified R63 as a bladder and was at pressure ulcers.  R63's Pressure Ulc (CAA) dated 10/10 for pressure ulcers incontinence, assis living (ADLs) and condicated R63 was off-load and had a mattress and cushing R63's Care Plan defence and an encourage R63 to the encou	nimum Data Set (MDS) dated 63 was rarely/never d severely impaired cognitive sion making. The MDS also ired extensive assistance of obility, transfer and toilet use. Cated R63 was non-ambulatory limitations in range of motion wer extremities with side. The MDS further lways incontinent of bowel and crisk for the development of the care Area Assessment of the care Area Assessment of the care with activities of daily ognitive losses. The CAA assisted to turn, reposition and pressure redistribution in place.  The dated 4/10/15, directed staff to change position frequently and itting in one position for long to a diagnosis of peripheral The Care Plan also identified asive assist of two staff or use, EZ stand, as needed for the Plan further identified R63	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			06/0	05/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIF 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	ODE CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 314	or both. The ulcer is clinically as an abra to her right buttock (cm) x 0.4 cm x 0 cm x 0 cm x 0.4 cm x 0 cm x 0.5 cm. At 7:05 a.m. until 10:2 observed:  At 7:05 a.m. R63 wher wheelchair at a -At 7:56 a.m. break for R63.  -At 8:32 a.m. volunt and asked if she wow v-A then transporter room to the 2nd florent at 8:54 a.m. R63 wheelchair, in the brack 10:04 a.m. R63 room and was obseindependently in her at 10:05 a.m. nursentered R63's room R63 was observed -At 10:06 a.m. NA-1 adjusted R63 so sheat 10:11 a.m. R63 room for a musical -At 10:27 a.m. NA-2 during the day and repositioning. NA-R63 every 2 hours. staff assistance for observation R63 was repositioning or off	involving epidermis, dermis, is superficial and presents asion, blister, or shallow crater) measuring 0.6 centimeters in.  ontinuous observation from 4 a.m. the following was  vas observed seated erect in table in the 1SW dining room. If ast was delivered and set up  seer (V)-A approached R63 and like to have her hair done. If a directly from the dining or beauty shop.  vas seated in her wheelchair in the beauty shop.  was assisted back to her erved wheeling her wheelchair in room.  ing assistant (NA)-I and NA-Jan and adjusted her posture as leaning in her wheelchair.  confirmed they had just in the ewasn't leaning in her chair.  was assisted to the dining activity.  J stated R63 preferred to sit up	F3	:14			

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F 314		ge 58 Prevention of Pressure Ulcers May 2013, recommended	F3	14		
	general intervention a person in a chair least every hour. T recommended inter measures for reside chair-fast to include every 2 hours. A ris incontinence recom preventive measure	ns and preventive measure for to include change position at				
F 315 SS=D	confirmed R63 had pressure ulcers. RI go." RN-G confirmed II pressure ulcer to stated R63 would a refused most of the confirmed R63 staff attempted to reposi 2 hours or more fre	HETER, PREVENT UTI,	F 3	15		7/12/15
	assessment, the factoresident who enters indwelling catheter resident's clinical contraction was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a sthe facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder e.				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		5430	EET ADDRESS, CITY, STATE, ZIP CODE  D BOONE AVENUE NORTH  W HOPE, MN 55428	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 59 NT is not met as evidenced	F 3	15			
	by: Based on observat review, the facility fa assistance for 1 of a incontinence.  Findings include:  R63's Diagnosis Red diagnoses that inclupartial paralysis of a cerebrovascular dis of language, affecti comprehension of a or write), generalize osteoarthrosis, dem disease.  R63's quarterly Min 4/1/15, indicated R6 understood and had skills for daily decis indicated R63 requi staff for transfer and indicated R63 was functional limitation upper and lower ex one side. The MDS always incontinent	ion, interview and document ailed to provide timely toileting 2 residents (R63) reviewed for eport indicated R63 had uded hemiplegia (total or one side of the body) due to sease, aphasia (an impairment ng the production or speech and the ability to read and muscle weakness, nentia and peripheral vascular imum Data Set (MDS) dated		t c c c c c c c c c c c c c c c c c c c	Resident 63 is being provided toile assistance per plan of care.  All residents requiring assistance violeting are receiving assistance pof care.  Nursing staff have been re-educate regarding provision of toileting assister plan of care.  DON/Designee will audit 2 residents/unit/week to ensure toile assistance. Audit results will be revat QA&A.	vith er plan ed sistance	
	Catheter Care Area 10/15/14, indicated bowel and bladder,	Assessment (CAA) dated R63 remained incontinent of did not verbalize the need to aphasic and had some					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		06/05/2	015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) IPLETION DATE	
F 315	to use the toilet and incontinence pad p R63's Bladder Inco 12/31/14, identified ADLs and wore add	A indicated staff assisted R63 managed/changed	F 31	5			
	was at risk for skin incontinence, weak hemiplegia and dire treatments as orde and symptoms of u The Care Plan also extensive assist of care plan lacked in	tted 4/10/15, identified R63 breakdown related to ness, immobility, aphasia, and ected staff to complete skin red and to monitor for signs rinary tract infection. identified R63 required two staff for toilet use. The terventions regarding or bladder incontinence.					
	R63 had a stage II thickness skin loss or both. The ulcer is clinically as an abra	Report dated 6/1/15 identified pressure ulcer (partial involving epidermis, dermis, s superficial and presents asion, blister, or shallow crater) measuring 0.6 centimeters m.					
	continuous observa -At 7:05 a.m. R63 v at a table in the 1S' -At 7:56 a.m. break for R63. -At 8:32 a.m. R63 h her meal. Volunteel asked if she would	25 a.m. until 10:24 a.m. ation revealed the following: was seated in her wheelchair W dining room. fast was delivered and set up and independently completed or (V)-A approached R63 and like to have her hair done.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		245183	B. WING _		06	/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	room to the 2nd flo -At 8:54 a.m. R63 or done in the beauty -At 8:56 a.m. R63 or -At 10:04 a.m. R63 or -At 10:05 a.m. nurs entered R63's room R63 was leaning in -At 10:06 a.m. NA- adjusted R63 so sh NA-J confirmed the incontinence since but would be doing -At 10:11 a.m. R63 room for a musical -At 10:24 a.m. NA- activity and reques incontinence which -At 10:27 a.m. NA- during the day and incontinence cares check on R63 ever required two staff at On 6/3/15 at 2:38 at confirmed R63 curr ulcer to her right gl should have been of incontinence at lea frequently and inco least been offered/ On 6/4/15, at 10:21 plan lacked specific incontinence care at expectation of the fire	or beauty shop. was observed having her hair shop. remained in the beauty shop. was assisted back to her erved wheeling her wheelchair er room. sing assistant (NA)-I and NA-J and adjusted her posture as the wheelchair. I confirmed they had just he wasn't leaning in her chair. by had not checked R63 for they got her up that morning, so later. I was assisted to the dining activity. I approached R63 during the ted to check her for R63 refused. J stated R63 preferred to sit up	F 31	5		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06/0	05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315 F 323 SS=G	dated May 2013, in and bladder incontiinterventions and princluded check resievery 2 hours and casta 25(h) FREE OF HAZARDS/SUPER  The facility must enenvironment remains is possible; and	Pressure Ulcers Guidelines dicated a risk factor of bowel nence recommended reventive measures that dent for incontinence at least elean skin when soiled.	F 31			7/12/15
	by: Based on observat review the facility fa root cause for falls, interventions and fo which resulted in ac (R138) reviewed for sustained fractures Findings include: R138's incident rep R138 fell while bein with the assistance A Fall Risk Evaluati	ion, interview and document iled to thoroughly evaluate the implement appropriate illow the individual care plan etual harm for 1 of 3 residents accidents and who had from falls.  Ort dated 11/16/14, indicated g transferred from the toilet of one staff member.  on dated 11/17/14, indicated in the 90 days prior and had		Resident 138 has had root cause analysis regarding his falls comple post falls QAPI has been complete resident #138.  Current residents whom are at risk falls have the potential to be affect the alleged deficiency. Residents ware having falls investigated and rocause analysis completed in our daincident meetings.  Nursing Assistants have been re-educated on the process of licer nursing notification in the event of	for for ed by vith falls oot aily	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	no cognitive change indicated R138 aml device for ambulati was unable to stable assistance of staff. indicating he was a An incident report of fell while being transistance of one shis balance when the him from the left sic indicated R138 had left hemiplegia (par The subsequent nuindicated R138 req staff for transfers a R138's Care Card (which resulted in the indicated R138's diagraphow to approach him A nurse practitioner 12/18/14, indicated There were no character with the note indicated R138 down quickly in the wheelchair to tip bathead on the floor. Incident report date required the assistations as sistant and the state of the sindicated R138 down quickly in the wheelchair to tip bathead on the floor. Incident report date required the assistations as sistant and the sindicated R138 down quickly in the wheelchair to tip bathead on the floor. Incident report date required the assistant as sistant and the sindicated R138 down quickly in the wheelchair to tip bathead on the floor. Incident report date required the assistant as sistant and the sindicated R138 down quickly in the wheelchair to tip bathead on the floor. Incident report date required the assistant and the sindicated R138 down quickly in the wheelchair to tip bathead on the floor.	es. The Fall Risk Evaluation bulated with problems, used a on, his gait was unsteady and dize without physical R138's fall risk score was 18, thigh risk for falls.  Idated 12/5/14, indicated R138 sferred in the bathroom with staff. R138 indicated he lost the nursing assistant (NA) held de. The incident report I a diagnosis of a stroke with ralysis of one side of the body). It is in the NA did not follow (the care plan used by NAs) the fall. The note further are Card was updated to nosis of left hemiplegia and m during transfers.  If (NP) progress note dated R138 had a fall on 12/5/14. Inges in orders.  Idated 1/15/15, indicated R138 sferred from the toilet to the assistance of one staff. The B's legs gave out and he sat wheelchair causing the ackwards and R138 hit his The nursing note on the id 1/15/15, indicated R138 ance of two staff for transfers an was not followed by the NA	F 323	Licensed nurses have been re-ed to complete the process post fall, including the post fall QAPI, incidereport, care plan update, and notion DON/Designee will review each favalidate required post fall metrix at followed. Incident reports will be completed per community procedd DON/Designee will review each refalls weekly in Patient Risk meeting validate the post fall process has followed, including Post Fall QAP (identification of cause). Administ review incident reports and post fareview ongoing.	ent fications.  all to ure ure. esidents ng to been I rator will	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	P CODE		
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F 323	A Fall Risk Evalua R138 was at high the previous 90 daindicated R138 habut was confined twas not able to atthelp.  A nursing progress R138 fell during a The note also indicon his left arm. Arindicated R138 relanded on his arm -A progress note of had gone to an unand was sent to the his left arm due to of breaking his arm -A progress note of facility was informed humerus (upper alfurther information A physician's consindicated R138 had office for a follow the fall on 4/8/15. previous day and on his left upper exemergency room from the humerus related to indicated R138 was a fractured from the humerus related fractured from the humerus related from the humerus related fractured fractured from the humerus related fractured fractured fractured fractured fractured fractured fractured fractured fractur	tion dated 2/6/15 indicated risk for falls and had 1-2 falls in tys. The fall risk assessment d no cognitive status changes o a chair, did not ambulate and empt standing without physical s note dated 4/8/15, indicated transfer to the shower chair. Cated R138 fell back on the bed incident report dated 4/8/15, ported arm pain and stated he lated 4/9/15, indicated R138 related physician appointment e emergency room for x-rays of complaints of pain and report	F3	323			

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		245183	B. WING			06/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, S 5430 BOONE AVENUE N NEW HOPE, MN 5542	ORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)	
F 323	R138 was at high rithe 90 days prior. indicated R138 had ambulated with prowas unsteady and assistance to stabil.  An incident report of fell during a transfe wheelchair to the tobalance and fell aghis left arm and the director of nursing (supervisor were no incident report date care plan was updated for transfers and arphysiological factor identified as weakn -A progress note dated andicated R138 comboth sides.  -A progress note dated indicated R138 compointing to the rib at was noted.  -A progress note dated are plan was noted.  -A progress note dated indicated R138 compointing to the rib at was noted.  -A progress note dated indicated R138 reported the fill the previous week in his pain level as 10.  A radiology report of the results of the re	on dated 5/6/15, indicated sk for falls and had 1-2 falls in The Fall Risk Evaluation Ino cognitive changes, blems and a device, his gait he required staff physical ize.  Idated 5/7/15, indicated R138 r with one assist from the billet when R138 lost his ainst the wall. R138 bumped left side of his head. The (DON) and the nursing tified. The nursing note on the d 5/8/15, indicated R138's ated to direct two staff assist inbulation. The predisposing indicated on the report were ess/fainted.  In the bathroom in his chest on the d 5/10/15, at 10:30 p.m. inplained of left side pain, rea. No bruising or swelling ated 5/11/15, indicated a chest is had three rib fractures. In the bathroom. He reported	F3	23		

-	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		. 06/	/05/2015	
	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE  5430 BOONE AVENUE NORTH  NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From pa	ge 66	F 3	23			
		e dated 5/12/15, indicated injury and noted R138 had left					
	thorough post fall a analysis to determinor was a trend in f	s and documentation lacked a ssessment and root cause ne causal factors of each fall talls identified, interventions nented in order to minimize / and injury.					
	printed 6/4/15, indic included hemiplegia body) due to cereb convulsions (seizur	ce Sheet and Diagnosis list cated R138's diagnoses a (paralysis on one side of the rovascular disease (stroke), es), difficulty in walking, dementia, depressive disorder					
	assessment dated moderate cognitive of care and require staff for transfers a	mum Data Set (MDS) 5/15/15, indicated R138 had a deficit, displayed no rejection d extensive assistance of two nd ambulation. The MDS also I balance problems and was ion changes.					
	5/15/15, indicated If falls due to balance changes and receive medication. The Cassistance with transhort distance in his	Area Assessment (CAA) dated R138 was potentially at risk for a problems during position ving an antidepressant AA indicated R138 required asfers and would ambulate is room with staff assist and but the wheelchair was his ansportation.					
	R138's care plan fo	or falls initiated 6/12/14, and					

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F 323	falls. The care plar facility fall protocol, falls and attempt to record possible root to alter or remove a possible. Staff wer family and staff reg R138's care plan for (ADLs) initiated 3/7 indicated R138 req staff for transfers, but R138's care plan for indicated R138 req staff for ambulation with 4 ends, hemically for a mountain the previous Resident Care for ambulation The previous Resident R138 req transferring. A note (RN)-H dated 12/16 Care Card for the Care Card for	indicated R138 was at risk for a directed staff to follow the review the information on past determine cause of falls, it causes of the falls and then any potential causes if e to educate the resident, arding the causes.  or activities of daily living /15, and revised 5/8/15, uired the assistance of two bed mobility and toilet use.  or mobility initiated 3/7/15, uired the assistance of two with the quad cane (a cane	F 32	23		

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION  LDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/0	05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CIT 5430 BOONE AVENUE NEW HOPE, MN 55	E NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTIOI ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	bed and had put on assistance to get up assistant (TMA)-C at then stand R138 up unsteady and requistaff, a gait belt and walked a few steps wheelchair.  During an interview stated he did not try stated he had a fall and has had broker had not always use the bathroom. R138 on his arms and on were from his falls a balance and also la he had pain from hi had not helped muc Card with a print da posted in his closet be transferred with  During an observat NA-Q and NA-R we	o.m. R138 was observed lying his call light to request of trained medication and RN-I were observed to sit of R138 was observed to be the extensive assist of two of the hemi walker while he and turned to sit in the safe of two staff to transfer him into 8 was noted to have bruising his back. R138 stated they and from trying to get his sying on it. R138 further stated as falls and that the pain pills och. At this time, R138's Care the of 5/27/15, was observed which indicated R138 was to two staff assistance.	F3	23	DEFICIENCY)			
	bathroom. NA-Q to walk, "Remember, informed him they wheelchair. The NA R138 to stand, walk the wheelchair. R13 his feet and require two staff as R138 wonce in the bathroom require two staff as	d asked to walk to the old R138 that he could not you can't walk." NA-Q were going to use the as were observed to assist a few steps, turn and sit in 38 was observed unsteady on d the balancing support of the vas unable to steady himself. om, R138 was observed to sistance to transfer onto the sometimes they used two staff						

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		245183	B. WING		06.	/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	to transfer him and were observed to sonto the grab bar a transferred R138 bar and holding on to the R138 could not usually buring an interview RN-H verified R138 assistance of two spreviously transferr staff but had an incenting the assist of two states as the staff had interdimeetings to discuss determine the root has had different care documented pertine that had been ruled root cause for the inhis wheelchair in the foot under the chair R138 fell on 4/8/15, incident report with fall. RN-H stated the from the incident the while being transferone. RN-H stated the two staff becompleting R138 was assist of two staff becompleting R138's gotten the care plan RN-H stated she chair and the completing R138's gotten the care plan RN-H stated she chair and the completing R138's gotten the care plan RN-H stated she chair and the ch	sometimes not. Both NA's tand R138 up, cue him to hold is they dressed him then ack into the wheelchair. Both has doing good while standing the handrail. Both NAs said hally stand that long.  I on 6/04/15, at 2:09 p.m. accurrently transferred with the staff. RN-H verified R138 had the ded with the assistance of 1-2 ident/fall and was changed to faff. In addition, RN-H stated sciplinary team (IDT) is resident falls, injuries and to causes. RN-H stated R138		23		

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	245183	B. WING		06/	05/2015	
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	1 33	30/2313	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
reflected that. RN should have indicated with the assist of the provided education on 12/16/14, regard because R138's Contransfers on 12/5/15 RN-H further stated care it was to be we communication because and read that there residents' care new expectation R138's staff. RN-H against Cards were the care directives.  During an interview stated R138 require transfers.  During an interview stated R138 require ambulation and trawas sometimes were well when he was the left side and stated R138 transitions before he broke his staff assist. NA-X the left side and stated stated stated stated stated stated stated stated and s	Is 100% sure the group sheets I-H verified R138's care plan ated R138 was required transfer wo staff and that she had In and communication to staff rding R138's fall on 12/5/14, Itare Card was not followed for I4, which resulted in the fall. It when there was a change in written in the staff look so that the NAs could see Ite was a change/ update in a Itered RN-H verified it was her Itered Card was followed by verified the residents' Care Itered	F 323				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	NAs and stated it is followed the Care stated staff could a assistance they provide the amount of assisted the amount of assisted the nurse who associated the DO The DON stated is determine the root request a therapy DON stated R138' related to a fall on the During an observation of the DON stated it was the finand stated it was grame to assist R13 lunch. NA-R put the R138's left leg and regular tennis shown needed his black as at up in bed with staff. A gait belt was given to him, the extensive assis allowed R138 times slowly and deliberation and down the hall the gait belt on each During an interview certified occupation stated therapy recand would screen	was her expectation the staff Cards as written. The DON always increase the amount of ovided but could not decrease stance provided to the ed on the Care Cards. The distance December 2014, isted a resident up after a fall N, and that was with every fall. aff had an IDT meeting to cause of falls and to also screen following the fall. The srib fractures on 5/11/15, were 5/7/15.  Ition and interview on 6/5/15, at stated R138 had walked to the is bed that morning. R138 and the state of the county walked good to walk. NA-R and NA-Q and the county walked to the interview on the ankle/foot orthotic brace on was going to put on his es. R138 reminded him that he choes on with the brace. R138 the extensive assistance of two as put on and his hemi-walker. He stood up from his bed with stance of two staff, staff to get steadied and R138 ately walked out of his room with NA-R and NA-Q holding	F 32	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	following a fall and status to 1-2 staff d had slipped during the had previously be assist. When COTA Card had indicated transfers since the "Oh, Ok."  During an interview DON stated she was Card had been chas assist with transfers plan had been follow floor interdisciplinary held to also review the daily clinical full reviewed the facility included facility falls. The facility policy as Guidelines revised Evaluation would be and quarterly and the attempt to identify in and risk factors for and procedure furth occur, the staff would investigative Works Report. The care putime with a review of the staff with	ened R138 on 5/8/15, had changed R138's transfer uring toileting because R138 toilet transfers with an NA and een transferred with one A-I was informed R138's Care two staff to assist with end of November, she said,  on 6/05/15, at 2:55 p.m. the as not aware R138's Care nged to indicate two staff and thought R138's care wed. The DON verified the y team meetings were to be falls and root causes and then team met daily and also yes 24 hour report board which are interdisciplinary team would not indicated a Fall Risk of completed upon admission ne interdisciplinary team would not indicated if a fall should ald complete the Falls sheet as well as an Incident alan was to be updated at that of current interventions and taff. A request for therapy	F 3.	23		
F 353 SS=F	483.30(a) SUFFICI PER CARE PLANS	ENT 24-HR NURSING STAFF	F 3	53		7/12/15
	.,	- 3 <b>10</b>				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 353	maintain the highe and psychosocial was determined by resi individual plans of  The facility must proper numbers of each opersonnel on a 24-care to all resident care plans:  Except when waive section, licensed in personnel.  Except when waive section, the facility nurse to serve as a duty.	d related services to attain or st practicable physical, mental, well-being of each resident, as dent assessments and care.  rovide services by sufficient f the following types of hour basis to provide nursing in accordance with resident ed under paragraph (c) of this urses and other nursing ed under paragraph (c) of this must designate a licensed a charge nurse on each tour of	F3	53			
	by: Based on observareview, the facility qualified nursing sineeds of residents R285, R290, R627 as family members concerns regarding resident needs we potential to affect a 5 of 5 units at the findings include:  Complaints of inad	NT is not met as evidenced tion, interview and document failed to ensure sufficient aff was available to meet the observed / interviewed (R71, R365, R376, R177) as well and staff who voiced glack of staff to assure re met timely. This had the all 351 residents that resided in acility.		Resident 71, 285, 290, 6 177 needs are being met staff.  Prior to MDH survey facil addressed in QA&A industrial industria	ity had stry wide nursing leveloped an y address staff i. ne potential to be eficiency. Staff wed for the ents made where		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	Residents voiced canswer the call ligh do not meet or responsive to the call ligh do not meet or responsive to the call ligh do not meet or responsive to the call light observed on.  At 5:53 p.m. regist overheard after beinursing assistant (Noneeded help.  At 5:54 p.m. again Observed a staff where the room, turnimmediately came and the call light call light and another start of the call light and another stated she was goin available to help heart 6:05 p.m. anoth R71's room shut the again, then came on the call light room call light room call light room. At 6:05 p.m. R71's LPN-F was observed medications as sheart 6:06 p.m. LPN-I observed to walk profered to assist heart 6:07 p.m. anoth stated somebody we call light and another stated somebody we call light another stated somebody we call light and another stated somebody we call light another stated somebody we call lig	oncerns that staff either do not the call lights and cond to their needs.  o.m. R71's call light was ered nurse (RN)-D was ng in R71's room tell an NA) in the hallway that R71  R71 put her call light on. Howas passing the room trays in the call light off and cout.  Out her call light on again. Practical nurse (LPN)-F go eling another resident.  Walked pasted the room. At A was observed passing room the hallway and walked past the aff again went past the light.  F and NA-A both walked past the arever went to room to answer er staff again approached R71 ng to see if someone was er.  er staff was observed go to be door then call light was off ut.  call light was on again and end in the hallway setting up a stood by the medication cart.  and NA-A both were ast R71's call light and never	F 350	met by sufficient staff.  Staffing personnel and nursing supervisors have been re-educate regarding planning and assignin sufficient staffing. Nursing staff been educated regarding chang staffing patterns.  Daily monitoring of staffing ratios performed by staffing. Any staffing will be filled as appropriate.	g for have es in s will be	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245183	B. WING _		06	/05/2015	
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 353	angry and yelled "I bed."  -At 6:09 p.m. NA-L end of the hallway! same NA-P again was hallway.  -At 6:10 NA-L was shallway.  -At 6:10 NA-L was shut the call light of and went and stood was observed carry went into R71's root-At 6:45 p.m. when was even better an begging at staff to unknown that the stimes did things that residents. When as assistance to come light on, R71 stated and this had gotten	want somebody to put me to was observed standing at the by the nursing station. At the went past R71's room and lp. R71's call light was still on audible when standing in the observed go to R71's room, if then came out of the room dat the nursing station. NA-L ying a towel and gown and om and shut the door. approached R71 stated this d sometimes she would be use the toilet or be put to bed. staff were slow, rude and at at would benefit them not the sked how long it would take for when she had put her call if 45 minutes to over an hour worse since the new and thought the staff were	F 35	53			
	the nursing floors w usually was not end with resident cares	o.m. activity aide (AA)-A stated were always busy as there bugh staff members to assist. She stated the facility ave enough staff members.					
	Bridgewater memo in the evening. She frequently displayed they were busy. Sh	o.m. LPN-B stated the ry care area was always busy stated the residents d behaviors in the evening and ne stated the facility did not members to assist the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5430 BOONE AVENUE NORTH  NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	Continued From paresidents.	age 76	F 350	3		
	been at the facility admissions. R285 to answer call light and a half hours the wrapped. R285 answer call lights it assigned to work. The worse for answer the worse for answer that the worse for answe	a.m. family member (FM)-A				
	staff members do requests timely. S family member, sh staff to assist her f but the staff were staking her family merself. She stated	atly visited the facility and the not always respond to resident he stated when she visited her e may put the light on for the amily member to the bathroom, slow and she usually ended up nember to the bathroom d the facility did not seem to to care for the residents.				
	on the second floo when she had arriv morning shift, she floor west building nurses instead of f second floor was s of the four medical during the day. RN	a.m. RN-A who was working r of the west building stated yed at the facility for the had been informed the second would be working with three ive. She stated normally the staffed with one nurse on each tion carts and a charge nurse I-A stated in order to cover all ned medication aide (TMA) had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		Of	6/05/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	been assigned to assigned wing. She would then be requested as injections for the wing. She was completing of duties were not cowished. She indic frequently and the their assignments for the day.  On 6/3/15, at 10:0 to do her work load company took ove and they were hirr don't stay. TMA-B times we work a localling you to work times they were floatso included the runit you are not fa was very hard to dand if someone was long time to do so have to be careful and have to keep tell you the truth at they will tell you the resident care is sa staff problem."  On 6/3/15, at 10:10 observed on. R290 across from the numerical single control of the problem."	chass medications on an the stated the charge nurse duired to complete the MA was unable to complete and complete any treatments stated when the charge nurse ther assignments, the charge impleted as effectively as she atted this problem occurred staff were not made aware of until they arrived at the facility.  O when asked if she was able of TMA-B stated since the new if a lot of the original people quiting, however the people just is stated they worked a lot and at it of doubles and they will be all the time. TMA-B stated at oated around the units which hourses and when you go to a miliar with the resident care of as you don't know the routine as passing medications it took a in a different unit because you to not get medication errors checking and checking. I will and if you asked the other staff the same. "I feel like sometimes crificed because of the short.  O a.m. R290's call light was observed the call light and even louder when	F3	53		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06	/05/2015
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	, 33	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	-At 10:14 a.m. RN nursing station as observed standing -At 10:16 a.m. NA with call light still g the nursing desk a observed and hea their hours of work-At 10:17 a.m. RN was observed go i exit the room and get out of bedAt 10:18 a.m. NA R290's room with On 6/3/15, at 11:3 could use more he that really bothere she felt the reside residents to have so is a nursing assight shift."  On 6/3/15, from 12 R627's call light w was observed to w towards the dining the room was obshallway then went -At 12:08 p.m. to 1 remained on. NA-lobserved to stand overheard talking were working and days offAt 12:09 p.m. NA family member rer	age 78  -J was observed seated at the NA-B and another NA were at the nursing station.  -B walked past R290's room going off. NA-B then returned to and all three staff were rd talking to each other about as the call light was still going.  -J stood up from the desk and into R290's room, immediacy stated to NA-B R290 wanted to a transfer lift to assist R290.  2 a.m. RN-B stated the facility elp and thought the only thing d her was the split groups as nts were neglected "I want a nurse assigned to them and sistant. It just bugs me with the valk past the call light and walk proom area. A family member in erved peeking outside the back in the room at 12:06 p.m. 12:09 p.m. the call light B and another NA-T were both outside of room 240 and about the double hours they what they had done on recent  -T went to R627's room, a mained in the room and was ang NA-T R627 needed to use	F 35	53		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	for you" then came room 240 and came then went to R627 toilet at 12:12 p.m.  R627's admission assessment dated memory impairmed assistance of two state wheelchair for  On 6/3/15, at 1:05 frequently did not he cover all of the are she was informed what area of the beand the facility was basis ("almost eve On 6/3/15, at 1:22 her father was not (cath) in a timely meaking and get so sore in the groin, in R120 had a neurog straight catheterizi now a physician or which clarified staff when R120 felt the stated, it took 45-5 to be straight cath him. If would put the call I come in, turn the come in the come in the come in turn turn turn turn the come in turn turn turn turn turn turn turn tur	e out of the room and straight to be out with another NA who is room to assist R627 to the Minimum Data Set (MDS) 4/30/15, indicated R627 had nt, required extensive physical staff with toilet use and used mobility.  p.m. RN-B stated the facility have enough licensed nurses to as of the building. She stated when she came to work as to uilding she would be working a short staffed on an regular	F3	53		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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F 353	verified R120's urin cathed.  R120's admission R130 had moderal required extensive transferring and recatheterization.  On 6/3/15, at 2:38 wished to remain a licensed nurses ar worked short staffe stated the nursing the unstaffed work stated this caused harder and they may completed timely.  On 6/4/15, at 6:05 very heavy and we sometimes we have even take our breastaffed. They fire pan't keep people good staff for very are not able to do at the residents on tirt they know it's bad.  On 6/4/15, at 7:38 call light was observed in the standing by the memodications.  -At 7:41 a.m. a NA R365's room.  -At 7:44 a.m. the Na R365's room.	MDS dated 4/25/15, indicated ely impaired cognition, assistance with toileting,	F 35	53		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	()	,	SURVEY PLETED
		245183	B. WING			06/0	05/2015
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F 353	"today is your show -At 7:47 a.m. R365 stated about 10-15 call light on and sor shut the call light of coming back to ass R365 stated he put of the staff who had even understand ar room without R365 went on to state "I hursing station and screwing up, this is waiting for a long tir or they would turn tome back again. It to be late for breakf upset and closed hit -At 7:58 a.m. NA waroom to assist whice since he had initially R365's quarterly MI resident had moder required extensive transferring, bed mit hygiene and used the common of the side of the room. At 8:08 a.m. a NA and informed R376 left the room. NA turned to assist R376.  On 6/4/15, at 10:21 requested the facilities.	er" then left the room. was observed lying in bed and minutes ago he had put his neone had been in his room, f and told him they were ist me to get up for breakfast. his call light back on and one been to his room he did not not that staff member left the receiving assistance. R365 hope this light is going to the the nurse sees someone is what they do, I am always me for help and nobody comes he light off, leave and not R365 stated he was now going fast. R365 appeared sad, is eyes. It is a seed to enter R365's he was more than 20 minutes and y asked for assistance.  OS dated 5/9/15, indicated ately impaired cognition and assistance with toileting, obility, dressing and personal ne wheelchair for mobility.  A.m. R376's call light was was observed enter the room she would find their NA and rned the call light off. obody came back to the room  a.m. when the surveyor	F3	53			

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F 353	indicated the facility logged call light us surveyor requested none were provided. On 6/4/15, at 12:00 staffing coordinator. The SC stated the determined by residuation the polystated the how the groups we at the groups individed are needs. The Dowith the nurse man to determine if this concerns. When S when she was not there were two others and shared the job left. When asked were stated the staff the department and manage the calls a when asked what was low and if the nodded and stated when the census were to another unit when polystated it was asked if the in the last 3 monthing going to find out an when asked what the polystated it wasked the number wasked it the number wasked in the polystated it wasked the number wasked the number wasked the number wasked the number wasked wasked wasked the number wasked w	y did not have a system that e and response times. The If the facility call light audits but	F3	353			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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F 353	quality assurance (DON confirmed state asked if staff had be concerns about the staff had not indicate work but had compulled them in to he further stated the famultiple call-in's poon facility core value had problems with been working at the non-profit and would levels which has chefor profit managem though the facility his staffing was being a continued to have of family members republic which included growing the standard of the staff would compute the staff would would be staff would would be staff would would be staff would	er rate had been reported to QA) at the last meeting, the affing was discussed. When rought to her attention workloads, the DON stated ted being able to finish their lained about the staffing so we selp problem solve. The DON acility was reinforcing their licy and were educating staff es and some of the staff who staffing were those that had a facility when the facility was a did reflect the previous staffing manged since Mission Health ent had taken over. Even and indicated the insufficient addressed, the facility complaints from residents and corting poor resident care oming, positioning and call swered timely among others exported to the surveyors as survey days.  a.m. R376 stated sometimes turn the call light off, leave ar later. R367 stated "I used to this as a nurse and I have them they do come eventually. I have them they do come eventually. I have an in bed I want to get up and the call of the complexity."  DS dated 4/10/15, indicated gnition, had no rejection of extensive assistance of one to	F 35	3		

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		245183	B. WING		06	/05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 2 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•		
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F 353	interview, R190's F came the facility the stated one of two swas last fall when 45 minutes to get a had arrived at the fp.m. and at that time had been on for all she waited until 6:2 to the nurses desk across a NA by the when she told the her call light to be a by saying "they know The NA further staresidents' during diffeeding people. FN the aids were sent other residents to be to help answer light stated she had distunit manager who been having proble explained the unit sher the facility was stated the second shift in April when second shift in April when second station she observe the desk with a mether resident's call I when she approach him if he was ok, the go to the bathroom report the resident.	age 84 5 a.m. via a telephone 6 m-D stated every time she ere were call lights on. FM-D specific incidents she recalled R190's call light had taken over answered. FM-D stated she facility at approximately 5:30 are R190 indicated her call light out 10 minutes. FM-D stated 20 p.m. at which time she went to look for help and had come a nurse's station. FM-D stated NA R190 had been waiting for answered, the NA responded ow we can't help during dinner." ted they could not assist inner as they were too busy M-D stated during meal time, to the dining room to help eat and then there was no one ts during that time. FM-D cussed this concern with the informed her the facility had ems with his, had also staffing pattern and assured looking into the matter. FM-D occurrence was on an evening she had arrived at the facility at noticed the resident in the all from R190 had their call light as she walked past the nurse's ed a staff member seated at the line front of her. At 5:07 p.m. tight was still on. FM-D stated the resident and asked the resident stated he needed to the FM-D stated she went to care need to the staff member and the staff member and the staff member stated	F3	353			

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F 353	had other things to member was obse room at 5:14 p.m., turn the call light of	age 85 ering the call light because she do. FM-D stated the staff rved to enter the residents ask the resident how he was, ff and left the room. The staff sisted the resident to the	F 350	3	
	observed onAt 10:38 a.m. NA- turn the call light of -At 10:41 a.m. R17 -At 10:43 a.m. NA- nursing station. NA down he hallway a walking talkie R17 continued to walk of observed walking to room, shut the light roomAt 10:45 a.m. whe wanted someone to if her need had been turned off two time told her they were her. R177 stated s -At 10:52 a.m. R17 wheelchair with he closedAt 10:56 a.m. R17 againAt 10:59 a.m. RN- and asked R177 w R177 stated again -At 11:00 a.m. RN-	O was observed going into the, ff and exited the room. To put the call light on again. O was observed seated at the A-O stood up, started walking and was heard stating on the T's call light was on. As NA-O down the hallway, NA-J was towards R177's room, enter the toff and immediately exit the en approached R177 stated she or put her to bed. When asked en met after her call light was s, R177 stated the staff had going to find her aide to assist he wanted to lay down. To remained seated in the remained over and eyes to was observed going to room that she needed help with. She wanted to lay down. Do and TMA-D were observed on, briefly shut the door then			

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F 353	seated in her wheel-At 11:03 a.m. TMA observed in room the At 11:06 a.m. where the staff had told has one she was going is would be laid down.  On 6/5/15, at 11:08 had requested wheeler room, TMA-D in the room prior with she wanted to lay down the room prior with she wanted to lay down the room prior with she wanted to lay down the room prior with she wanted to lay down the room prior with she wanted to lay down the room prior with she wanted to lay down the room prior with she wanted to lay down the room prior with she wanted to lay down the prior with she wanted to lay down the prior was the late of the late	chairD and two NA's were nen came out of room. n approached R177 indicated it was almost lunch time and tay up until after lunch and	F3	853		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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F 353	indicated the work time a group was s do their work timely the residents and that the facility and mas not doing anythot good for the resont met timely.  On 6/5/15, at 2:20   Layout for all the unade of the content o	is a.m. both NA-M and NA-N load was heavy and all the plit and they were not able to which included repositioning his was a continuous problems hanagement was aware and hing. Both indicated this was sidents when their needs were by the problems hanagement was aware and hing. Both indicated this was sidents when their needs were by the problems had been staffing Guide hits for randomly selected days 1/15, 3/15/15, 3/16/15, 4/12/15, 2/15, and 5/30/15, were had been staff who or had no call no show were do resident group assignments groups which was all indicated dition she verified on the shifts. When the cares/needs were supposed the supervisor determined the ne units. She verified on the staff had left early and had and the groups had been split. If its difference in late or left the supervisor had been split.	F 35	3		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 353	time it was hard at the replaced.  On 6/5/15, at 3:40 properties were on, the attempt to a sexpect her staff to a	ge 88 ort time frame to shift start times to replace and would not o.m. when asked what she ed her staff to do when call administrator stated she would answer call lights and not vs talking about their personal	F 35	53		
F 364 SS=E	Tracking logs dated it was revealed 44 convolved either poor response during the positioning concern members. Although had been reached to occur from different facility over time to by staff activity. In a facility annualized to 2014 rate was 44.6 (YTD) 2015 was 50 483.35(d)(1)-(2) NL PALATABLE/PREFIE Each resident receif food prepared by movalue, flavor, and appalatable, attractive temperature.	TRITIVE VALUE/APPEAR, ER TEMP  ves and the facility provides ethods that conserve nutritive opearance; and food that is	F 36	54		7/12/15
	by: Based on observat	ion, interview and document		F364- Food is being served within		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245183	B. WING			06/0	05/2015
_	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	review, the facility frensure food was set temperature for 5 or R257, R234, R515) regarding food qual (R457 R385) who version food.  Findings include:  R365's quarterly Mis5/9/15, identified R36/2/15, at 9:23 a.m. cold.  R117's quarterly MIR117 had intact cog a.m. R117 stated the explained the food between 45 minute stated her table was served and the food minute stated her table was served and the food a.m. R257's quarterly MIR257 had intact cog a.m. R257 stated the table was the lasecond seating in hidd not stay warm.  R234's quarterly MIR234 had intact cog a.m. R234 stated the R515's admission Minutes and intact cog a.m. R234 stated the R515's admission Minutes and intact cog a.m. R234 stated the R515's admission Minutes and intact cog a.m. R515's admission Minutes and int	ailed to develop a system to brived at the proper f 21 residents (R365, R117, who were interviewed ity and for 2 of 2 residents were observed to receive cold on the system of the syste	F3	64	temperature guidelines and within appropriate serving texture.  Current residents receiving oral nu have the potential to be affected by alleged deficiency.  Resident 365, 117, 257, 234, and 5 not voiced complaints or concerns regards to cold food.  Qualified staff that assist with feedibe re-educated by the DON/Design checking appropriate temperatures community procedure.  The Dietary Manager will re-educated dietary staff responsible for the sertables to maintain appropriate temperatures per community procedure.  Plate warmers have been added to with retaining food temperatures.  Hot top serving tables temperature been increased.  Food temperatures are taken as followes kitchen and when it arrives designated dining room.  Food temperatures will be taken as food leaves the kitchen, daily x 14, x 4, monthly x 3. Food temperatures designated dining room, daily x 14, x 4, monthly x 3.  A interdisciplinary food tasting community and the serving testing community in the serving testing community in the serving testing	or this of thi	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06	/05/2015	
	PROVIDER OR SUPPLIER	REHAB	;	STREET ADDRESS, CITY, STATE, ZIP CC 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 364	dietary service was dietician (RD).  -At 11:23 a.m. Cooremove the hot me check the temperar consisted of tuna number mashed potatoes. degrees Fahrenhei 160 degrees Fahrenhei 160 degrees F.  -At 11:33 a.m. C-A into an insulated carbier of the push the different floor dining roored to push the composition of the hot of the precision of the hot of the precision of the hot of the composition of the chick 150 degrees F, the degrees F and the composition of the chick 130 degrees F and 134 degrees. The last a serving of the chipotatoes. The RD of the potatoes. The RD of the process and had no process and had no composition of the chick 130 degrees for the potatoes. The RD of the potatoes of the chipotatoes and had no composition of the chipotatoes. The RD of the potatoes and had no composition of the chipotatoes and had no composition of the chipotatoes.	a.m. the main kitchen area cobserved with the registered k (C)-A was observed to al items from the oven and tures. The hot meal choices nelts, chicken patties and The tuna melts were 180 t (F), the chicken patties were the mashed potatoes were loaded the steam table pans art and dietary aide (DA)-A was he cart out of the main kitchen. he food to the west building,	F 364	has been formed to audit test ensure proper temperature a are maintained on a monthly first interdisciplinary food tast committee has tested breakf and dinner meals on July 1st Results of audits will be revie QA&A.	nd texture basis. The ting ast, lunch, , 2015.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	245183	B. WING		06	6/05/2015	
	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			1 00/00/20:0	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
Continued From pa	age 91	F 3	64			
food. She stated sh	ne would work on the concern.					
identified R457's di	agnoses as dementia and					
indicated R457 had was sometimes about and required extensional Care Are 3/10/15, identified Factivities of daily liv	d severe cognitive impairment, le to make herself understood sive assist with meals. R457's a Assessment (CAA) dated R457's inability to perform ring (ADL)s without significant					
seated in a tilt back Bridgeway dining a placed directly in fro- At 6:38 p.m. an un down next to R457 dietary aide (DA)-A R457's mashed por DA-A stated the ter potatoes was 93 de of the squash was proceeded to walk	wheelchair at a table in the rea. R457 had a tray of food ont of her and left unattended. Addentified staff member sat a Upon request of the surveyor, a took the temperature of tatoes and squash on her tray. The mashed egrees F and the temperature of degrees. DA-A then away and did not offer to					
	PROVIDER OR SUPPLIER  RIDGE HEALTH AND  SUMMARY STA (EACH DEFICIENC' REGULATORY OR L  Continued From pa food. She stated sh  R457's was fed col reheat or provide h  R457's Diagnosis F identified R457's di generalized muscle  R457's significant of indicated R457 had was sometimes ab and required exten nutritional Care Are 3/10/15, identified I activities of daily liv physical assistance  R457's care plan d required total assis meals.  R457's nutritional a indicated R457 relified  On 6/3/15, at 6:26 seated in a tilt back Bridgeway dining a placed directly in fr -At 6:38 p.m. an ur down next to R457 dietary aide (DA)-A R457's mashed po DA-A stated the ter potatoes was 93 de of the squash was proceeded to walk	PROVIDER OR SUPPLIER  RIDGE HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 91 food. She stated she would work on the concern.  R457's was fed cold food an the facility failed to reheat or provide hot food.  R457's Diagnosis Report dated 11/21/14, identified R457's diagnoses as dementia and generalized muscle weakness.  R457's significant change MDS dated 3/6/15, indicated R457 had severe cognitive impairment, was sometimes able to make herself understood and required extensive assist with meals. R457's nutritional Care Area Assessment (CAA) dated 3/10/15, identified R457's inability to perform activities of daily living (ADL)s without significant physical assistance affected her ability to eat.  R457's care plan dated 5/28/14, indicated R457 required total assistance from staff with her meals.  R457's nutritional assessment dated 5/28/15, indicated R457 relied on staff to feed her.  On 6/3/15, at 6:26 p.m. R457 was observed seated in a tilt back wheelchair at a table in the Bridgeway dining area. R457 had a tray of food placed directly in front of her and left unattended.  -At 6:38 p.m. an unidentified staff member sat	PROVIDER OR SUPPLIER  RIDGE HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 91 food. She stated she would work on the concern.  R457's was fed cold food an the facility failed to reheat or provide hot food.  R457's Diagnosis Report dated 11/21/14, identified R457's diagnoses as dementia and generalized muscle weakness.  R457's significant change MDS dated 3/6/15, indicated R457 had severe cognitive impairment, was sometimes able to make herself understood and required extensive assist with meals. R457's nutritional Care Area Assessment (CAA) dated 3/10/15, identified R457's inability to perform activities of daily living (ADL)s without significant physical assistance affected her ability to eat.  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A1 6:38 p.m. an unidentified staff member sat down next to R457. Upon request of the surveyor, dietary aide (DA)-A took the temperature of the mashed potatoes was 93 degrees F and the temperature of the squash was 90 degrees. DA-A then proceeded to walk away and did not offer to	PROVIDER OR SUPPLIER  RIDGE HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 91 (FAST'S was fed cold food an the facility failed to reheat or provide hot food.  R457'S Diagnosis Report dated 11/21/14, identified R457's diagnoses as dementia and generalized muscle weakness.  R457's significant change MDS dated 3/6/15, indicated R457 had severe cognitive impairment, was sometimes able to make herself understood and required extensive assist with meals. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06	/05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 364	R385 was observed eggs. R385's quarterly M R385 was cognitive was independent wow on 6/3/15, at 7:18 seated in his wheel R385 stated at time eggs, were served he had brought to times. On 6/3/15, at 8:34 was served to R385 occupational therapanother resident at eggs. R385 stated can you please put warm them for 45 sleave the table thereggs, warmed them R385. The Preventing For policy revised 12/20 potentially hazardo internal temperature for the destroy harmful bar as to when to discas specifically direct the	d to assist R457 with her meal eheat her food.  d to have been served cold  DS dated 4/11/15, indicated ely intact, was on dialysis and eith eating after set up only.  a.m. R385 was observed chair at the dining room table. Es the food, especially the cold and this was something the facility attention several  a.m. shortly after breakfast to he was overheard to ask the bist (OT) who was assisting the same table to warm his "as always the eggs are cold, them in the microwave to be conds." OT staff was seen a returned and took R385's in and brought them back to be cold to the appropriate es and hold the food at those e appropriate length of time to coteria. The policy directed staff and food items but it did not the staff as to how to ensure the the proper temperature for the	F 36	54			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245183	B. WING		06	/05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 431 F 431 SS=E	483.60(b), (d), (e) ILABEL/STORE DR  The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled.  Drugs and biological labeled in accordar professional princip appropriate access instructions, and the	DRUG RECORDS, EUGS & BIOLOGICALS  Inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug or and that an account of all maintained and periodically  als used in the facility must be not entered ones, and include the	F 4			7/12/15	
	facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugontrol Act of 1976 abuse, except when package drug distri	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can					
	This REQUIREMENT by:	NT is not met as evidenced					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		06/	05/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From page 94  Based on observation, interview and document review, the facility failed to ensure medications were stored properly on 2 of 7 nursing units (2 north west and 2nd floor central nurses station) which involved 7 of 7 residents (R209, R492, R315, R103, R643, R533, R300) residing on the 2 Northwest nursing unit who required insulin and 1 of 1 resident (R92) who had discharged from the facility. This had the potential to affect all 79 residents residing on 2 West.			F431- Insulin and medicati disposal are being properly Current residents have the affected by this alleged defi Medications are being prop Licensed nursing staff have re-educated regarding med and proper disposal.	potential to be ciency. erly stored. e been lication storage		
	8:28 a.m. to 8:50 a was observed sitting west nurses station to be filled with multiprescription labels were observed by were available for remove. Insulin performed in the fround of the stored in t	ate Agency staff sat at the		DON/Designee will audit the and medication rooms daily weeks, weekly x 4 weeks a for proper storage and disp medications.	M-F x 4 nd monthly x 3		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245183	B. WING _		06	/05/2015
	NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COL 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	R209 had 1 Novelor R492 had 1 Lantus R209 had 1 Lantus R209 had 1 Lantus R315 had 1 Lantus Pen R103 had 1 Novolor R643 had 1 Lantus R533 had 1 Novolor R300 had 1 Nov	ent and the directions for use. neld the following pens:  g Flex pen Flex pen Flex pen Flex pen and 1 Novolog Flex  g and 1 Levimure Flex pens and 1 Novolog Flex pen g Flex pen g Flex pen o.m. LPN-B stated the was to be in sight of the nurse es.  o.m. LPN-A confirmed she had on the desk. She stated she not to leave them out by her ted the morning became very ents had begun to "pile up." re to be kept secure.  a.m. the west building second station was observed to stic box of medication. The not equipped with any type of d prevent unlicensed staff, a from entering the nurses	F 43			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (7	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06/05/2015	
-	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	00,00,20.0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 465 SS=E	been discharged from medications include bottles of Azopt eye medication should with the resident up. The ADON confirm kept secure.  The Storage of Med 2017, indicated onling prepare and admin access to medication to be stored secure 483.70(h) SAFE/FUNCTION/AE ENVIRON  The facility must pr	orted to be for R92 who had com the facility. The ed Spirva capsules and two edrops. The ADON stated the have either been sent home on discharge or destroyed. The all medications were to be edication policy revised in April by persons authorized to ister medications were to have one and all medications were elly.  AL/SANITARY/COMFORTABL  Tovide a safe, functional, ortable environment for	F 431		7/12/15	
	by: Based on observareview, the facility from aintenance to res 366, 393, 394, 423 of 2 residents (R46 free of odors review concerns.  Findings include: On 6/4/15, from 9:0	ition, interview, and document ailed to provide appropriate ident rooms numbered (322, a. In addition failed to ensure 15) room was kept clean and wed for environmental		Rooms for resident 322, 366, 393, 3 423 have had ceiling tiles replaced. Resident 465 has had odors resolved. A whole house audit for ceiling tiles a odors has been completed. Repairs resolution has been completed when necessary.  Preventative measures have been per place for rooms identified as being requiring more than routine cleaning. All staff have been re-educated regal	d. and and e ut in	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/	05/2015	
	PROVIDER OR SUPPLIER  RIDGE HEALTH AND	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 465	director (MD), admi administration, distriction, distriction, distriction, administration, distriction, administration, distriction, administration, distriction, administration, and needed replacion. In room 366, the bathroom which and needed replacion. In room 393, two and needed replacion in room 423, but to the above concerns and needed replacion. In room 423, but to the above concerns and needed replacion in room 423, but to the above concerns and needed replacion. In room 423, but to the above concerns and needed replacion in room 423, but to the above concerns and needed replacion. In room 423, but to the above concerns and needed replacion in room 423, but to the above concerns and the above concerns and the received with the r	inistrator, regional nurse rict manager of the healthcare the director of housekeeping.  In following resident room  It is ceiling tiles were stained and in the bathroom ere was a broken ceiling tile in a needed replacing tiles were stained and in the bathroom ethoroom eth	F 4	.65	system for reporting environmental issues.  Director of Maintenance will audit 2 rooms/unit/week for conditions, od and cleanliness. Audit results will I reviewed at QA&A.	ors,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING			06/	05/2015
	PROVIDER OR SUPPLIER			5430	EET ADDRESS, CITY, STATE, ZIP CODE BOONE AVENUE NORTH V HOPE, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	offensive odor ren room. Trained me observed standing medications.  -At 9:54 a.m. regis observed to enter was heard to ask wheelchair. RN-C and left the room.  -At 9:55 a.m. obse R469's room and odor remained.  On 6/4/15, from 7 room continued to malodorous smell overpowering whe staff, residents an observed going be other rooms locate acknowledged R4 cleaned.  On 6/5/15, at 9:35 smell remained ar walking past the rourine and stated h R469's clothes or working in the unit have housekeepir	a.m. the same strong, nained just outside of R469's dication aide (TMA)-B was goutside the room setting up stered nurse (RN)-C was R469's room in which R469 for assistance to get into his indicated she would get help erved a nursing assistant enter shut the door. The malodorous and a many strong when walking outside and was an entering the room. Several different family members were ack and forth past R469's to get down the hallway. No staff 69's room needed to be a.m. the pervasive malodorous and several staff were observed from.  a.m. the MD, after he walked om door, verified the smell was get thought the odor was in the carpet as the vent was groperly. The MD stated "I will"	F 4	.65			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06/	05/2015	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 467 SS=E	carpet.  On 6/5/15, at 10:10 was going to be cle room were going to 483.70(h)(2) ADEQ VENTILATION-WIN  The facility must haventilation by mean	he was going to clean his  a.m. the MD stated the carpet aned and the clothes in the also be checked.  UATE OUTSIDE	F 4			7/12/15	
	by: Based on observative review, the facility for adequate ventilation (107, 245, 247, 249 odors had been defined from the facility was compared from the facility was compared from the facility was compared from the following room urine odor and the facility was and the following room from the following room.	00 a.m. to 10:00 a.m. a tour of upleted with the maintenance nistrator, regional nurse rict manager of the healthcare he director of housekeeping.  s had been detected to have a MD checked the ventilation of eir adjoining bathrooms and		Rooms 107, 245, 247, 249, 326, have had ventilation restored.  All rooms have had appropriate verified.  All staff have been re-educated renotifications of ventilation concern Ventilation motors are on a routing check for function. We have enlist assistance of a HVAC/Ventilation contractor to provide consult for the overall ventilation system.  Director of Maintenance will audit function and repair requests 2 unit to ensure ventilation concerns removed. Audit will be reviewed in	entilation egarding is. e weekly sted the ne motor t/week nain		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/05/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 467	room 245 and the vent which demon Room 249, MI bathroom was not bathroom vent was above the door in improper air flow.  Room 326, the above the door in improper air flow.  Room 350, the okay, the vent abodemonstrated imp  Room 366, the okay, the vent abodemonstrated imp  On 6/2/15, at 10:2 stated her mother' On 6/3/15, at 11:5 urine odor detecte and lingered down bridgeway unit.  On 6/4/15, at 9:15 verified room 249  On 6/4/15, at 9:45 bridgeway unit the residents' rooms or resident's bathroom on 6/4/15, at 10:20 had gone down rat southwest wing an resident doors well the venting duct we seem to see the venting duct were seem as	Lip to the vent above the door in Kleenex did not adhere to the strated improper air flow. Do confirmed the vent in the open all the way. Once the sopened it was okay. The vent room 249 demonstrated event in the bathroom and room 326 demonstrated event in the bathroom was event in the door in room 366 event in the room 107 which permeated the 100 wing hallway on the exam. the administrator and MD had a urine odor.  a.m. the MD verified on the re were no vents in the room the hallways, just in the	F 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		0	6/05/2015
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, Z 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 467	must have aborted the ventilation proje when the ventilation why it had not been because the duct w both ends, this only	age 101 ated it appeared the facility the project and not finished ect. The MD was unaware of a system had been installed or a finished. The MD stated work had been capped off on a allowed the ventilation system ent bathrooms and not in their	F 4	67		
	gone up on the root the fan. The MD co roof was hot and he the exhaust system be replaced. The M needed to be replaced	p.m. the MD stated he had f of the building and checked infirmed the fan motor on the electric determined that the motor of a had gone out and needed to ID verified the motor which ced would have affected the or the bathroom in between and 326.				
	(PD) described the 100 hallway in bridg wet carpet and use	a.m. the purchasing director odor permeating down the geway smelled like dead skin, d incontinence pads.  a.m. housekeeper (H)-A stated				
	the 100 hallway of b	oridgeway smelled like urine all the way down the hallway.				
	2014 log indicated had been upset with	CONCERNS TRACKING - on 8/5/14, family members h odors. In addition, on ad expressed concerns ell.				
		port [undated] indicated the ast been inspected on 5/31/15.				
	The Interior Genera	al Maintenance policy				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		06	/05/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 467	maintain a clean, o	age 102 If it was the facility's policy to comfortable environment for sociates and visitors.	F 4	67			

(X2) MULTIPLE CONSTRUCTION

PRINTED: 07/09/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245183 06/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5430 BOONE AVENUE NORTH** NORTH RIDGE HEALTH AND REHAB NEW HOPE, MN 55428 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. North Ridge Health and Rehab was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care... PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**Electronically Signed** 

07/01/2015

(X6) DATE

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

Facility ID: 00238

PRINTED: 07/09/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 06/03/2015 245183 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5430 BOONE AVENUE NORTH NORTH RIDGE HEALTH AND REHAB NEW HOPE, MN 55428 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 1 K 000 Marian.Whitnev@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. North Ridge Care Center is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. Because the original building and the 4 additions are of the same complying construction type, the facility was surveyed as 1 building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for fire department notification. The facility has a full fire sprinkler system. The facility has a capacity of 351 beds. At the time of the survey the census was 310.

CENTE	49 FOR MEDICARE	& MEDICAID SERVICES			0.11.5	0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		E SURVEY PLETED
		245183	B. WING _		06/	03/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000 K 018 SS=D	The requirement a NOT MET as evide NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas a those constructed wood, or capable ominutes. Doors in required to resist the impediment to the are provided with a the door closed. Dare permitted.	at 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD  orridor openings in other than as of vertical openings, exits, or a substantial doors, such as of 1¾ inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping outch doors meeting 19.3.6.3.6 9.3.6.3	K 00			7/12/15
	Based on observation had corridor doors requirements of NI 19.3.6.3.2. This deresidents.  Findings include:  During facility tour	is not met as evidenced by: Ition and interview, the facility that did not meet the FPA 101 LSC (00) Section Ificient practice could affect the between 10:00 AM and 1:30 , observation revealed that the	3	Preparation and or execution of correction does not constitu admission or agreement by the the accuracy of facts alleged conclusions set forth in the Stadeficiencies. The plan of correprepared and or executed sole it is required by the provisions and State Law.	te provider to r atement of ction is ely because	

CLIVILI	13 I ON MEDICANE	& MEDICAID SERVICES				110.	0330-003
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		245183	B, WING			06/0	03/2015
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE \$30 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 018	Bridgeway beauty sautomatically latch.  This deficient pract	shop dutch door leaves do not	K	018	Corrective Actions  Immediate Actions: Maintenance Director has repaired dutch door latch on the Bridgeway unit to ensure that the door leaves automatically latch in accordance NFPA 101 Life Safety Code standa 19.3.6.3.6.  Reoccurrence will be prevented by Maintenance Director has implement preventative maintenance protocol audit doors to ensure they are all functionally working in accordance NFPA 101 Life Safety Codes.  Maintenance Director is also notification maintenance order requests via an electronic and paper work order sy Maintenance staff have been educing door function.	South with and a to to ed of stem. ated	
K 038 SS=D	Exit access is arrar	FETY CODE STANDARD  nged so that exits are readily nes in accordance with section	K	038	The Maintenance Director will be responsible for the ongoing complithis correction. Compliance will be monitored via weekly audits. Audits reviewed by QA&A.	ance of	7/12/15

CENTER	RS FOR WEDICARD	E & MEDICAID SERVICES			ON	ID NO.	0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/0	3/2015
	PROVIDER OR SUPPLIER			54	TREET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 038	Continued From pa	age 4	ΚO	38			
	Based on observation facility failed to produce accordance with the 2000 NFPA 101, Spractice could affer Findings include:  On facility tour betton 06/03/2015, obto door handle leadin damaged and missing This deficient practice.	ween 10:00 AM and 1:30 PM servation revealed that the exit g from the laundry room is			Corrective Actions Immediate Actions:  Maintenance Director has replaced damaged and missing door handle laundry room door.  Reoccurrence will be prevented by:  Maintenance Director has implement preventative maintenance protocol audit all doors and door handles on campus to ensure they are all functivorking in accordance to NFPA 101 Safety Codes. Maintenance Directoralso notified of maintenance order requests via an electronic and paper order system. Maintenance staff has been educated regarding door hand requirements.	nted a to ionally Life or is er work ve	
K 043 SS=F	Patient room doors patient can open the using a key. (Spec	AFETY CODE STANDARD  s are arranged so that the ne door from inside without cial door locking arrangements ental health facilities.)	K	)43	The correction will be monitored by: The Maintenance Director will be responsible for the ongoing compliathis correction. Compliance will be a via weekly audits. Audit results will I reviewed at QA&A.	ance of audited	7/12/15

CENTE	42 LOK MEDICAKE	& MEDICAID SERVICES			OIVID	110,	1930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION (X3) 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			06/0	3/2015
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	=	(X5) COMPLETIO DATE
K 043	Continued From pa	n page 5		043			
	Based on observation has failed to maintaccordance with Li 18.2.2.4. This defiresidents.  Findings include:  On facility tour betton 06/03/2015, observing between the primary 200 windoes not unlock the egress control device perimeter door lock fire alarm reset.  This deficient practical accordance with the primary control of the primary reset.	is not met as evidenced by: tion and interview, the facility ain the door locks in fe Safety Code Section cient practice could affect the  ween 10:00 AM and 1:30 PM servation revealed that the g exterior exit door keypad e door. Testing of the special ices also revealed that the ks automatically relock upon  tice was verified by the e time of the inspection.			Corrective Actions:  Immediate Actions:  Maintenance Director repaired the Bridgeway South 200 wing exterior exidoor to ensure that it is functionally working in accordance with the Life Sa Code 18.2.2.4.  Reoccurrence will be prevented by:  Maintenance Director has implemente preventative maintenance protocol to audit exit doors to ensure they are functionally working in accordance to NFPA 101 Life Safety Codes.  Maintenance Director is also notified of maintenance order requests via an electronic and paper work order system Maintenance staff have been educated regarding requirements for functioning doors.  The correction will be monitored by:	fety d a f	
K 072 SS=F	NFPA 101 LIFE SA	AFETY CODE STANDARD	K	072	The Maintenance Director will be responsible for the ongoing complianc this correction. Audits will be conducte weekly, audit results will be reviewed to QA&A.	d y	7/12/15

CENTER	RS FOR WEDICARE	& MEDICAID SERVICES		_			0930-038
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION O1 - MAIN BUILDING 01		SURVEY PLETED
		245183	B. WING			06/0	3/2015
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
K 072	of all obstructions of use in the case of f furnishings, decora	re continuously maintained free or impediments to full instant ire or other emergency. No tions, or other objects obstruct ress from, or visibility of exits.	K	)72			
	Based on observa has egress corridor LSC 7.1.10. These with the convenient patients in an emer Findings include:  On facility tour betwon 06/03/2015, obswheeled storage in facility.  This deficient pract	s not met as evidenced by: tion and interview, the facility r obstructions which violates obstructions could interfere t and effective removal of regency situation.  In the corridors throughout the received was verified by the etime of the inspection.			Corrective Actions Immediate Actions:  Maintenance Director obtained a categorical waiver to allow wheeled storage in corridors throughout the far Reoccurrence will be prevented by:  North Ridge Health & Rehab has obtain a categorical waiver that allows for wheeled storage in corridors throughout the facility.  The correction will be monitored by:	ained	
K 076 SS=D	Medical gas storag	FETY CODE STANDARD e and administration areas are lance with NFPA 99, Standards cilities.	K	076	The Maintenance Director will be responsible for updates regarding the categorical waiver that allows for whe storage in corridors.	eeled	7/12/15

PRINTED: 07/09/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245183 06/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5430 BOONE AVENUE NORTH** NORTH RIDGE HEALTH AND REHAB NEW HOPE, MN 55428 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 076 | Continued From page 7 K 076 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3.000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: **Corrective Actions** Based on observation and interview, the facility failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice Immediate Actions: could affect the residents. Maintenance Director immediately removed the unnecessary oxygen tanks Findings include: stored in resident room 264. During facility tour on between 10:00 AM and 1:30 PM on 06/03/2015, observation revealed Reoccurrence will be prevented by: that there are (3) liquid oxygen tanks in resident Nursing Managers are required to audit room 264. resident rooms for unnecessary oxygen tank storage to ensure facility is in This deficient practice was verified by the accordance to NFPA 99 Standards for administrator at the time of the inspection. Health Care Facilities. Staff has been educated on proper oxygen storage protocol to ensure facility meets the NFPA 99 Standards for Health Care Facilities. This occurrence will be monitored by: Nursing Managers will be responsible for the ongoing compliance of this correction. DON/Designee will audit 2 rooms/week/unit. Audit results will be reviewed at QA&A.

	MENT OF DEFICIENCIES  AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245183	B. WING		·	06/0	03/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH			
NORTH	RIDGE HEALTH AND	REHAB	NEW HOPE, MN 55428					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
					÷			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 2, 2015

Mr. Ryan Chies, Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, Minnesota 55428

Re: Enclosed State Nursing Home Licensing Orders

Dear Mr. Chies:

A complaint investigation was completed on June 4, 2015. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

North Ridge Health And Rehab July 2, 2015 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Michelle Ness, Investigation Unit Supervisor Office of Health Facility Complaints, Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64970 St. Paul, MN 55164-0970

5t. Faul, MIN 55104-0970

Telephone: (651) 201-4217 Fax: (651) 281-9796

General Information: (651) 201-4201 or 1-800-369-7994

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

If you have questions or concerns you may call me at the number below.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

**Division of Compliance Monitoring** 

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE SURV COMPLETED	
		00238	B. WING		06/04/20	15
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/01/20	
NORTH I	RIDGE HEALTH AND	RFHAR	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE CON	(X5) MPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficient herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

winnesc	<u>ita Department of He</u>	<u>e</u> alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
			7. BOILDING			
		00238	B. WING		06/04	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE			
		NEW HOI	PE, MN 5542	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 1	2 000			
	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Investigation of context and identify the date in your and identify the state Licensing federal software. The assigned to Minnes Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of context and replaces the "Tour correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Context and in the statement, evidence by." Followare the Suggested Time period for Context and in the statement, evidence by." Followare the Suggested Time period for Context and its properties.	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  4 and 6/5/15, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, when they will be completed. The complaints H5183106 and so completed. The complaints at F353.  The ent of Health is documenting a Correction Orders using ag numbers have been sota state statutes/rules for the complainte is listed in the cent of Deficiencies" column To Comply" portion of the nis column also includes the in violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficienc column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period For Correction.  PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" nis s which after the s /eyors d of or  DING OF THIS  O DN FOR	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
NORTH I	RIDGE HEALTH AND	RFHAB	NE AVENUE E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 000	p a continuo a continu		2 000			
	FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.					
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 530	MN Rule 4658.0300	Subp. 4 Use of Restraints	2 530			
	decision to apply a comprehensive res restrictive restraint incorporated into the The comprehensive progressive removalless restrictive means obtain an informed in a physical or cheorder must be obtained restraint which specific umstances undused, including the in this part requires during the resident's strictly for the purposition.	e comprehensive plan of care. e plan of care must allow for all or the progressive use of ms. A nursing home must consent for a resident placed mical restraint. A physician's ined for a physical or chemical cifies the duration and er which the restraint is to be monitoring interval. Nothing a resident to be awakened s normal sleeping hours ose of releasing restraints.				
	by: Based on observati review, the facility failed to follow the failed to follow the failed to follow the facility swhich lin The facility also fail	on, interview and document ailed to identify the use of body suits as a restraint and acility's restraint policy for 2 of R74) observed wearing full nited access to one's body. ed to recognize the use of orakes as restraint devices				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 530	Continued From pa	ge 3	2 530			
	which prevented freedom of movement for 2 of 2 residents (R327, R138) observed with engaged w/c brakes which prevented freedom of movement.  Findings include:					
	R566's diagnoses a depression, cerebro hemiplegia (weakno	Report dated 1/22/15, identified as Alzheimer's disease, ovascular disease (stroke) with ess on one side), lack of eneralized muscle weakness.				
	R566's quarterly Minimum Data Set (MDS) dated 4/17/15, indicated R566 had severe cognitive impairment, required extensive assist with dressing and personal hygiene and had upper and lower extremity impairment on one side. In addition, R566's MDS assessment for restraint use indicated "none used" for bed rail, trunk, limb or other.					
	unit manager, and entered R566's roo assisted R566 from R566 was observed one piece body suit	p.m. registered nurse (RN)-E, nursing assistant (NA)-E m and using a mechanical lift his wheelchair to his bed. If wearing a light blue topped the which was zipped up the d R566 access to his body.				
	seated in his wheel	o.m. R566 was observed chair wearing the light blue ody suit which remained				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	SEHAR 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542	_	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 530	Continued From pa	ge 4	2 530			
	seated in his wheel	a.m. R566 was observed chair by the aviary dressed in viece body suit zipped up the				
	revealed it was oka	mary Report dated 2/10/15, y for R566 to be placed in a Ill times to prevent disrobing.				
	place R566 in a one	ated 2/17/15, directed staff to e piece garment at all times, disrobing and smearing of				
	4/1/15, thru 6/3/15,	dministration records from indicated R566 had been ce garment at all times.				
	,	o.m. NA-G confirmed R566 t which zipped up the back.				
	wore a one piece be back. RN-E stated zip up the back in o accessing part of the they had not identification with the backed zip restraint; however here backed zip	a.m. RN-E verified R566 ody suit which zipped up the the body suits were made to rder to keep the resident from leir body. RN-E confirmed ed the one piece body suits ped enclosure as a physical le understood they were a sthey had limited access to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND I	REHAB 5430 B	ADDRESS, CITY, S OONE AVENUI OPE, MN 5542	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 530	On 6/4/15, at 11:53 understood the one backed zipped encl restricted access to confirmed R566 had assessment complethe physical restrain	a.m. RN-F stated she piece body suits with the losure were restraints as they the residents' body. RN-F d not had a pre-restraint eted prior to implementation ont. RN-F stated she was not the content of the facility's				
	R74 utilized a full body suit which zipped up the back and prevented R74 access to body and the facility failed to recognize this as a restraint and follow their restraint policy and procedures related to the use.  R74's care plan dated 3/16/15, directed staff to put R74 in a one piece outfit at night and during the day as needed.					
	R74's diagnoses as (stroke), dysphasia	eport dated 3/19/14, identified s cerebrovascular disease (difficulty in swallowing), blood pressure), muscle culty walking.	1			
	indicated R74 had s and required extens toileting and person MDS assessment for	nange MDS dated 4/17/15, severe cognitive impairment sive assist with dressing, nal hygiene. In addition, R74 or restraint use indicated d rail, trunk, limb or other.	S			
	R74's Order Summ	ary Report dated 8/6/14,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015	
	PROVIDER OR SUPPLIER	REHAB 5430 BOO	ODRESS, CITY, S ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 530	revealed a physicia be worn at night an day.  R74's treatment ad	n order for a one piece suit to d as needed throughout the ministration records from	2 530				
	placed in a one pied for 4/24/15.	indicated R74 had been ce suit every evening except					
	On 6/3/15, at 12:30 p.m. NA-E was observed to enter R74's room. R74 was observed wearing a one piece, dark blue, neck to ankle body suit which was zipped up the back and prevented R74 access to her body. NA-E was observed to remove R74's body suit, change her incontinent brief, provide perineal-care and apply a clean brief while following infection control practices. While reapplying R74's one piece suit, NA-E noticed the one piece suit's legs were soiled. NA-E attempted to find another one piece suit in R74's closet and stated R74's other one piece suit must be in the laundry. NA-E proceeded to dress R74 in sweat pants and sweatshirt and stated he would put another one piece suit on R74 later once it was washed.						
	usually wore a one zip enclosure every her incontinent brie NA-E also verified I suit because he due	p.m. NA-E verified R74 piece body suit with a backed day because she picked at f and would tear it apart. R566 wore a one piece body g in his brief. NA-E verified wearing a one piece body suit p the back.					
	On 6/4/15, at 10:50	a.m. RN-E and social worker					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 530	(SW)-A both confirmed body suit with a back	ned R74 wore a one piece, sked zip enclosure. RN-E and they could see how this could	2 530			
	piece body suits wit were absolutely cor confirmed R74's ca one piece body suit had a pre-restraint on R74 or an inform	p.m. RN-F confirmed the one h the backed zip enclosures asidered a restraint. RN-F re plan had not addressed the as a physical restraint nor assessment been completed ned consent obtained from ntative with regards to				
	confirmed it was the the facility's restrain and R566's medica documentation of in a physical restraint	o.m. RN-E and RN-F eir expectation staff followed at policy. RN-F confirmed R74 I records lacked aformed consent for the use of and documentation of residents while in restraints.				
	which limited move recognize the use a	d with engaged w/c brakes ment and the facility failed to as a restraint device and traint policy and procedures.				
	R327's diagnoses in difficulty walking, re bipolar and had mo R327's Fall Care Ar 3/5/15, indicated R3	OS dated 5/22/15, indicated noluded muscle weakness, stless legs syndrome and derately impaired cognition. rea Assessment (CAA) dated 327 was at risk for falls, had noting self transferring and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING	· · · · · · · · · · · · · · · · · · ·	06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND I	5430 BO	ONE AVENUE	NORTH		
NONTILL	MIDGE HEALTH AND	NEW HO	PE, MN 5542	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 530	Continued From pa	ge 8	2 530			
	staff were directed to protocol. R327's Co 3/5/15, indicated R3 able to communicate	to monitor for falls per communication CAA dated 327 was heard of hearing, was te effectively using a pocket to let staff know when she				
	was at risk for falls,	ated 3/16/15, indicated R327 was unaware of safety needs nti-roll back brakes on the w/c.				
	dining room seated table. R327 was obpull self forward by herself but the left vengaged. When R3 backwards, the w/c back device was enw/c. R327 was obsestep over the foot ppocket talker in her ambulated, with a sfeet when the dietal asked another staff -At 8:32 a.m. R327 down the unit hallwand NA-C intervened and to use the walker or R327 responded shall NA-C proceeded to her room at which pasked another staff R327's w/c was whimedication cart neastated R327 needed was a fall risk. RN-E	a.m. R327 was observed in the in a w/c next to the dining served to repeatedly attempt gripping the table to wheel w/c brake was noted to be 27 attempted to wheel self would not move as an anti-roll agaged on the back of R327's erved to independently stand, edal and as she held the hand, she independently teady gait, approximately 30 ry manager intervened and member to get her w/c. was observed to ambulate ay to the nursing station where ad asked R327 if she wanted rw/c for mobility in which he wanted to use her w/c. ambulate with R327 back to boint NA-C turned around and member if they knew where the chart the nursing station. NA-C do to use the w/c because she who heard this conversation, non looking at the back of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 530	w/c an anti-roll brake installed. At 8:45 a.m. R327 at the dining room to observed engagedAt 9:02 a.m. NA-B R327's brakes, clear R327 out of the dinitive and would also use R327 was able to inbrakes, NA-B state to do so and added would be considered know who engaged.  On 6/4/15, at 10:43 encouraged the result when self transferring expect the staff to let the dining room. RN times the residents while eating, however esponsible to ensult when the residents when the residents to the release the bratening roles.	was observed seated in a w/c able. The w/c brakes were was observed to unlock anse R327's hands and wheel	2 530			
	(DON) stated she wand indicated if R32 independently she	o.m. the director of nursing was not so familiar with R327 27 was able to wheel herself would have expected staff to sengaged and was not sure if the brakes herself.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00238	B. WING		06/0	4/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
NORTH	RIDGE HEALTH AND	RFHAR	ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 530	Continued From pa	ge 10	2 530	,			
	which limited move recognize the use a implement their res R138's care plan for indicated R138 was	d with engaged w/c brakes ment and the facility failed to as a restraint device and traint policy and procedures.  or mobility initiated 3/7/15, a able to propel his wheelchair ne unit and directed staff to t and as needed.					
	R138's annual MDS dated 5/15/15, indicated R138 had moderate cognitive impairment, no physical behaviors, required extensive assistance of one staff for locomotion with the wheelchair, was independent with eating and had no restraints.						
	diagnoses that incli (stroke) with hemip on one side of the b	ce Sheet indicated R138 had uded cerebrovascular disease legia (weakness or paralysis body), difficulty walking, convulsions, dementia and					
	5/15/15, indicated F transportation was	aily Living (ADL) CAA dated R138's primary mode of the wheelchair and R138 was tly propel himself and also with					
		ord indicated R138 had a majority of falls having					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 530	Continued From pa	age 11	2 530			
	occurred during sta	aff assisted transfers. The ked documentation of physical				
	seated in a w/c at t independently eatir -At 5:48 p.m. upon was observed atter away from the table R138' w/c tipped sl move. R138 was obself in his w/c seat w/c back. The left vengaged therefore -At 5:53 p.m. R138 members in the dimove. RN-H was observed.	p.m. R138 was observed he dining room table ing the meal. completion of the meal, R138 mpting to push his w/c back in order to leave the table. ightly back, however did not beserved to intermittently shift while attempting to push the w/c brake was noted to be the w/c did not move. reported to a few staff hing room that he could not observed to release the w/c 138 out of the dining room.				
	device limited or pr a restraint. RN-H s R138's w/c brake w of any type of restra	w/c brakes to be locked that				
	locking w/c brakes prevented freedom	a.m. RN-H verified that at the dining table which of movement when the e to independently release, ed a restraint.				
	The Use of Restrai	nts policy, revision date				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 530	9/2012, indicated: Defined a phys method, or physical material or equipmeresident's body which one's body Directed staff to assessment prior to restraints Directed staff to the use of restraints benefits of all option including the use of Care plans for reflect interventions immediate medical underlying problem symptom(s) A resident restr	ical restraint as any manual or mechanical device, ent attached or adjacent to the ch restricted normal access to compete a pre-restraint or placing a resident in consent for swhich included the risks and as under consideration, is restraints and alternatives residents in restraints would a that addressed not only the symptom(s), but the symptom(s), but the sained would be monitored at nutes and the staff would	2 530			
	The director of nurs develop, review, an procedures to ensu identified, comprehiplanned to ensure trestraints. The direct designee could eduthe policies and procedures are straints.	Sing (DON) or designee could d/or revise policies and re potential restraints are ensively assessed and care hey are the least restrictive ctor of nursing (DON) or locate all appropriate staff on ocedures. The director of esignee could develop to ensure ongoing				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
71112 1 27111	or connection	BERTH TO WHOM HOMBER.	A. BUILDING:		0011111	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 530	Continued From page 13		2 530			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 540	0 MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment		2 540			
	conduct a compreh resident's needs, we capability to perform significant impairment nursing assessmer Minnesota Statutes 15, may be used as resident assessme comprehensive resused to develop, recomprehensive pla 4658.0405.  Subp. 2. Informatic comprehensive resinclude at least the A. medically demedical history;  B. medical state C. physical and D. sensory and E. nutritional state.	ion; ential; n potential; ttus; v; and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 540	This MN Requirements: Based on observation review, the facility of Set (MDS) assessor residents' dental standard reviewed for reflected the residents (R74, R50). Findings include:  R228's significant of (MDS) dated 5/22/1 had no dental issued residents.  R228's significant of indicated R228's had or partial dentures a fragments.  R228's Oral Health indicated R228 had root tips and option treatment such as: extractions or fill #1 partial and reline look R228's care plandard her own teeth.	ent is not met as evidenced ion, interview and document ailed to ensure Minimum Data nents accurately reflected the atus for 2 of 3 residents (R228 teeth/dental and accurately ints' restraint status for 2 of 2 66) reviewed for restraints.  Change Minimum Data Set 15, inaccurately indicated R228 es.  Change MDS dated 5/22/15, ad "no" broken or loosely fit full and "no natural teeth or tooth  Screening dated 4/21/2015, I an exam which noted multiple al recommendations for leave as is, take x-rays and 1 tooth and make new upper wers.  ated 5/2015, indicated she had a.m. R228 was observed with				
	teeth fell out and he	o.m. R228 stated her front er power of attorney knew I she did not know if she was				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00/0	4/2015	
NORTH I	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 540	Continued From pa	ge 15	2 540				
	going to get new teeth or not.						
	(LPN)-F verified sta	a.m. licensed practical nurse off knew R228 had missing 228 had lost three teeth around					
	MDS's were review coordinator. RN-E	a.m. the above identified ed with RN-E, the MDS verified the MDS information h were incorrect as R228 diding teeth.					
	R163's MDS dated reflect R163's denta	5/22/15, failed to accurately al status.					
	significant change I	DS dated 5/22/15, and MDS dated 10/6/14, indicated en or loosely fitting partial or					
	R163's care plan da "has her own teeth.	ated 5/28/15, indicated R163					
	On 6/2/15, at 8:23 a without the lower de	a.m. R163 was observed enture in place.					
	(FM)-A, stated R16	p.m. R163's family member, 3's lower denture did not fit ot fit for a couple of years.					
	On 6/5/15, at 10:18	p.m. R163 stated she did not					

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		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	BEHΔB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 540	wear her bottom de her mouth and did r On 6/5/15, at 1:53 p	entures as they "wobbled" in not fit her.  o.m. nursing assistant (NA)-U	2 540			
	On 6/5/15, at 2:06 p	t have bottom dentures. o.m. registered nurse (RN)-D an indicated R163 had her own				
	identified MDS docu	p.m. RN-E verified the above umentation and confirmed the were inaccurately coded.				
	Resident Assessme version 3.0 dated la "Steps for Assessmant - ask the resident, fawhether the resider or partials (If reside reported that the reor partials, but they facility, ask for a realif the resident had for loose fit.  The coding instructioned as loose if the was loose, the dent resident opened his moved when the recoding instructions natural teeth or tool	dentures or partials, examine ions directed a denture was the resident complained that it there visibly moved when the story or the denture sident tried to talk. The further directed to check "not the fragment(s) (edentulous)" if lentulous or lacked all natural				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00000	B. WING		00/0	4/0045
		00238			06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAR	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 540	Continued From page 17		2 540			
	R74's MDS dated 4 reflect the use of a	/17/15, failed to accurately physical restraint.				
	indicated R74's ass	ange MDS dated 4/17/15, sessment for restraint use ed" for bed rail, trunk, limb or				
	dressed in a one pi	p.m. R74 was observed ece, dark blue neck to ankle s zipped up the back and s to own body.				
	revealed a physicia	ary Report dated 8/6/14, n order for a one piece suit to d as needed throughout the				
		ed 3/16/15, directed staff to ece outfit at night and during				
	4/1/15, thru 6/3/15,	ministration records from indicated R74 had been ce suit every evening except				
	usually wore a one	p.m. NA-E verified R74 piece body suit with a backed day because she picked at tear it apart.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
_	PROVIDER OR SUPPLIER	SEHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542	-	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 540	(SW)-A confirmed F suit with a backed z SW-A agreed they s as a restraint.	a.m. RN-E and social worker R74 wore a one piece body tip enclosure. RN-E and saw how this could be viewed	2 540			
		p.m. RN-F confirmed the one the backed zip enclosures asidered a restraint.				
	R74's MDS was ina R74 utilized a physi	p.m. RN-E and RN-F verified accurate for restraint use as cal restraint (one piece body of been reflected on the the MDS.				
	R566's MDS dated reflect the use of a	4/17/15, failed to accurately physical restraint.				
	R566's assessment	OS dated 4/17/15, indicated tfor restraint use indicated d rail, trunk, limb or other.				
	observed to enter F from his wheelchair lift. R566 was obser topped one piece be	p.m. RN-E, NA-E were R566's room and transfer R566 into bed using a mechanical rved dressed in a light blue ody suit which was zipped up nted R566 access to his body				
	seated in his wheel	o.m. R566 was observed chair wearing the light blue ody suit which remained				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED	
		00238	B. WING		06/0	4/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	, 33.0		
NORTH I	RIDGE HEALTH AND	RFHAB	ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 540	Continued From page 19		2 540				
	zipped up the back.						
	seated in his wheel	a.m. R566 was observed chair by the aviary dressed in iece body suit zipped up the					
	revealed it was oka	mary Report dated 2/10/15, y for R566 to be placed in a all times for disrobing.					
	R566's care plan dated 2/17/15, directed staff to place R566 in a one piece garment at all times as available due to disrobing and smearing of bowel movement.						
	4/1/15, thru 6/3/15,	dministration records from indicated R566 had been ce garment at all times.					
		o.m. NA-G confirmed R566 t which zipped up the back.					
	wore a one piece b back. RN-E confirr one piece body suit enclosure as a phys	a.m. RN-E verified R566 ody suit which zipped up the ned they had not identified the is with the backed zipped sical restraint; however he ere a physical restraint as they is to his body.					
		3 a.m. RN-F stated she					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00238		B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 20	2 540			
		osure were restraints as they the residents' body.				
	MDS was inaccurate utilize a physical res	p.m. RN-E verified R566's te for restraints as R566 did straint (one piece body suit) en reflected on the restraint				
	Resident Assessment version 3.0 dated lathe "DEFINITIONS any manual method device, material or adjacent to the resistant remove eas movement or norm addition, the manual Assessment" and or Review the methodician orders, not determine if physician orders, not de	dical record, including urses notes, and NA notes to all restraints were used. e physical restraint definition, at to determine the effect the resident's normal function. resident can easily and the device, material, or resident cannot easily and the restraint, continue with the termine whether the device movement or the resident's				
	SUGGESTED MET	HOD OF CORRECTION:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING	<del></del>	06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 540	The director of nurs develop, review, an procedures to ensu are comprehensive physical restraints. to all appropriate st could be developed compliance.	sing (DON) or designee could d/or revise policies and re resident MDS assessments and include the use of Education could be provided aff and a monitoring system	2 540			
2 570	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,  This MN Requirements on observation of the facility fainclude intervention and incontinence care.	A comprehensive plan of yed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, oracticable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.  Lent is not met as evidenced on, interview and document ailed to revise the care plan to s regarding pressure ulcer are for 1 of 3 residents (R63) ssure ulcer and incontinence	2 570			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00238	B. WING	B. WING		06/04/2015	
	PROVIDER OR SUPPLIER	SEHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 22	2 570				
	Findings include:	. B					
	had diagnoses that partial paralysis of of cerebrovascular dis of language, affecti comprehension of sor write), generalize	gnosis Report indicated R63 included hemiplegia (total or one side of the body) due to sease, aphasia (an impairmenting the production or speech and the ability to readed muscle weakness, nentia and peripheral vascular					
	4/1/15, indicated R6 understood and had skills for daily decis indicated R63 requitwo staff for bed months and had functional of the upper and low impairment on one identified R63 as all	imum Data Set (MDS) dated 63 was rarely/never d severely impaired cognitive ion making. The MDS also red extensive assistance of obility, transfer and toilet use. Eated R63 was non-ambulatory limitations in range of motion wer extremities with side. The MDS further ways incontinent of bowel and risk for the development of					
	interventions regard incontinence care for incontinence as we	ated 4/10/15, lacked ding the frequency of or bowel and bladder Il as interventions to minimize ulcer development or					

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	A. BUILDING:		
		00238	B. WING		06/04/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE OPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 23	2 570			
	identified R63 had a shallow crater in	Report dated 6/1/15, a stage II (abrasion, blister or the skin) pressure ulcer to her uring 0.6 cm x 0.4 cm x 0 cm.				
	offered or assisted a.m. until 10:05 a.n	s observed to not have been with positioning from 7:05 n. and was not offered or tinence care from 7:05 a.m.				
	On 6/4/15, at 10:21 a.m. registered nurse (RN)-G verified the care plan lacked specific interventions regarding the prevention of pressure ulcers or incontinence care and stated it was the minimum expectation of the facility to turn and reposition residents as well as check and change for incontinence every 2 hours.					
	November 2012, id comprehensive car assessment of the indicated care plan about the resident a changed. The policipurposes of the car	emprehensive policy dated entified the basis of the re plan was a thorough resident that was ongoing and swere revised as information and the resident's condition by indicated one of the re plan was to reflect treatment and objectives in measurable				
	SUGGESTED MET	THOD FOR CORRECTION:				
		sing (DON) could develop and and procedures related to				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00238	B. WING		06/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
NORTH F	RIDGE HEALTH AND	RFHAB	NE AVENUE E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	training for all nursing timeliness of care passessment and as perform random au	ge 24  The DON could provide ng staff related to the lan revisions. The quality surance committee could dits to ensure compliance.  R CORRECTION: Twenty (21)	2 570			
2 800	Staffing requirements Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants to residents at all nursing all buildings if more involved. This inclusion and vacation replace.  This MN Requirements and vacation replace.  This MN Requirements are the facility for the faci	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and o meet the needs of the ses' stations, on all floors, and ore than one building is ides relief duty, weekends, sements.  The sent is not met as evidenced on, interview and document alled to ensure sufficient aff was available to meet the observed / interviewed (R71, R365, R376, R177) as well and staff who voiced lack of staff to assure e met timely. This had the il 351 residents that resided in	2 800			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 25	2 800			
	Complaints of inade from residents, fam Residents voiced or answer the call light do not meet or respondered on the call light do not meet or respondered on the call light do not meet or respondered on the call light observed on the call light overheard after being nursing assistant (Noneded help.  -At 5:54 p.m. again Observed a staff when the room, turn immediately came of the call light of the call light and another story of the same time NA-A trays down the same light and another story of the room call light in the call light of the call light	equate staffing were received ily members and staff. concerns that staff either do not its or turn off the call lights and cond to their needs.  I.M. R71's call light was ered nurse (RN)-D was not in R71's room tell an IA) in the hallway that R71  R71 put her call light on. no was passing the room trays in the call light off and out.  Find the call light on again. Practical nurse (LPN)-F go beling another resident.  Walked pasted the room. At IA was observed passing room in the hallway and walked past the light. Find NA-A both walked past the aff again went past the light. Find NA-A both walked past the aff again approached R71 ing to see if someone was r. er staff was observed go to be door then call light was off				
	-At 6:05 p.m. R71's LPN-F was observe medications as she -At 6:06 p.m. LPN-F observed to walk pa offered to assist he	call light was on again and ed in the hallway setting up stood by the medication cart. and NA-A both were ast R71's call light and never				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	SEHAB 5430 BOO	DRESS, CITY, S' DNE AVENUE PE, MN 55428	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	stated somebody we this time was obser angry and yelled "I bed."  -At 6:09 p.m. NA-L end of the hallway is same NA-P again we never offered to he and the signal was hallway.  -At 6:10 NA-L was of shut the call light of and went and stood was observed carry went into R71's rooden and this had gotten company took over short and overwork.  On 6/1/15, at 7:20 put the nursing floors we usually was not end with resident cares. It frequently displayed in the evening. She frequently displayed frequently displayed the company took over short and overwork.	vas going to assist her. R71 at red to be distressed and want somebody to put me to was observed standing at the by the nursing station. At the vent past R71's room and lp. R71's call light was still on audible when standing in the observed go to R71's room, if then came out of the room at at the nursing station. NA-Lying a towel and gown and m and shut the door. approached R71 stated this d sometimes she would be use the toilet or be put to bed. It would benefit them not the sked how long it would take for when she had put her call at minutes to over an hour worse since the new and thought the staff were	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 800	have enough staff r residents.  On 6/2/15, at 10:06	nembers to assist the  a.m. R285 stated she had	2 800			
	to answer call lights and a half hours the be wrapped. R285 answer call lights if assigned to work. Fethe worse for answer still talking to surve and R285 stated "o R285 stated she the	also stated it took staff forever and she had waited for one e previous night for her leg to further stated staff would not it was not their hall they were a 285 stated weekends were ering call lights. As R285 was yor RN-G entered the room h crap, I'm in trouble now." ought she was going to be ow" and confirmed she was				
	stated she frequent staff members do n requests timely. Sh family member, she staff to assist her fa but the staff were s taking her family m herself. She stated	a.m. family member (FM)-A aly visited the facility and the lot always respond to resident the stated when she visited here may put the light on for the amily member to the bathroom, low and she usually ended up ember to the bathroom the facility did not seem to o care for the residents				
	on the second floor when she had arriv morning shift, she h floor west building v nurses instead of fir second floor was st	a.m. RN-A who was working of the west building stated ed at the facility for the nad been informed the second would be working with three ve. She stated normally the raffed with one nurse on each on carts and a charge nurse				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	during the day. RN- of the areas, a train been assigned to p assigned wing. She would then be requ medications the TN such as injections a for the wing. She s was completing oth duties were not con wished. She indica frequently and the s their assignments to for the day.  On 6/3/15, at 10:00 to do her work load company took over and they were hiring don't stay. TMA-B times we work a lot calling you to work times they were floa also included the nu unit you are not fan was very hard to do and if someone was long time to do so in have to be careful t and have to keep c tell you the truth an they will tell you the resident care is sac staff problem."	A stated in order to cover all led medication aide (TMA) had ass medications on an elected the charge nurse ired to complete the IA was unable to complete and complete any treatments tated when the charge nurse er assignments, the charge inpleted as effectively as she ted this problem occurred staff were not made aware of antil they arrived at the facility.  When asked if she was able TMA-B stated since the new a lot of the original people quiting, however; the people just stated they worked a lot and at of doubles and they will be all the time. TMA-B stated at ated around the units which curses and when you go to a niliar with the resident care as you don't know the routine is passing medications it took a in a different unit because you onot get medication errors hecking and checking. I will dif you asked the other staff same. "I feel like sometimes crificed because of the short."	2 800			
	observed on. R290	a.m. R290's call light was 's room was located right rsing station and the call light				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
_	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	sound was audible standing at the stat -At 10:14 a.m. RN-nursing station as Nobserved standing -At 10:16 a.m. NA-I with call light still go the nursing desk ar observed and heard their hours of work -At 10:17 a.m. RN-was observed go in exit the room and siget out of bedAt 10:18 a.m. NA-I R290's room with a Con 6/3/15, at 11:32 could use more hel that really bothered she felt the residen residents to have a so is a nursing assisplit shift."  On 6/3/15, from 12 R627's call light was observed to wat towards the dining the room was obsehallway then went the -At 12:08 p.m. to 12 remained on. NA-B observed to stand overheard talking a were working and vidays off.	and even louder when	2 800			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	BEHAR 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	family member removerheard informing the toilet. NA-T responsive for you" then came room 240 and came then went to R627's toilet at 12:12 p.m.  R627's admission of R627 had memory extensive physical at toilet use and used  On 6/3/15, at 1:05 prequently did not how cover all of the area she was informed with the town of the but the toilet use and	ained in the room and was g NA-T R627 needed to use conded "let me find someone out of the room and straight to e out with another NA who is room to assist R627 to the MDS dated 4/30/15, indicated impairment, required assistance of two staff with the wheelchair for mobility.  D.m. RN-B stated the facility ave enough licensed nurses to as of the building. She stated when she came to work as to ilding she would be working short staffed on an regular				
	her father was not g (cath) in a timely man leaking and get sort sore in the groin, m R120 had a neurog straight catheterizing now a physician ord which clarified staff when R120 felt the stated, it took 45-50 to be straight cathe straight cath him. R would put the call lig come in, turn the car	o.m. R120's daughter stated getting straight catheterized anner therefore he would start e and right now R120 was ore so on the left. She stated enic bladder, had been g himself for eight years and der was obtained by the facility could straight cath R120 need to be. She further o minutes after he asked staff d before staff would return and 120's daughter stated she / he ght on and the staff would all light off and tell him they 20's daughter stated last night,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	04/2015	
	PROVIDER OR SUPPLIER	REHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 800	(6/2/15) R120 did no change of shift and cubic centimeters (cc's. R120's nurse verified R120's urinicathed.  R120's admission R130 had moderate required extensive transferring and recatheterization.  On 6/3/15, at 2:38 pwished to remain a licensed nurses and worked short staffe stated the nursing at the unstaffed work stated this caused tharder and they may completed timely.  On 6/4/15, at 6:05 a very heavy and we sometimes we have even take our breal staffed. They fire pecan't keep people to good staff for very lare not able to do a	ot get cathed until after the R120's urine output was 700 cc) and was normally 300-400 progress note dated 6/2/15, e output was 700 cc's. when MDS dated 4/25/15, indicated ely impaired cognition, assistance with toileting,					
		a.m. from the hallway, R365's ved on. At the time TMA-E					

6899

STATEMENT OF DEFICIONICS AND PLAN OF CORRECTION    Occupant   Destrict   Dest	winneso	ta Department of He	aim				
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  \$430 BOONE AVENUE NORTH  NEW HOPE, MN 55428   SUMMARY STATEMENT OF DEFICIENCIES  PRECINITY AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES  PRECINITY AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES  PRECINITY AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES BY TALL  PRECINITY AND REHAB  PRECINITY AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES BY TALL  PRECINITY AND REHABBY				` ′			
NORTH RIDGE HEALTH AND REHAB  NORTH RIDGE HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES  [MA) ID PREETX   EACH OFFICIENCY MUST RE PRECEDED BY FULL   PROVIDERS PLAN OF CORRECTION SECULD BE CROSS REPEBBERIES (EACH OFFICIAL SCHOLL) BE CROSS PERBERIES (EACH OFFICIAL SCHOLL) BE CROSS REPEBBERIES (EACH OFFICIAL SCHOLL) BE CROSS PERBERIES (EACH OFFICIAL SCHOLL) BE CROSS PA				A. BUILDING.			
NORTH RIDGE HEALTH AND REHAB   S430 BOONE AVENUE NORTH NEW HOPE, IMI 53428			00238	B. WING		06/0	4/2015
CALL	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800  Continued From page 32  was observed in the hallway, two doors down standing by the medication cart setting up medications.  -At 7-41 a.m. a NA was observed to walk past R365's room.  -At 7-44 a.m. the NA was observed to enter R365's room, turn the call light off, inform R365 "today is your shower" then left the room.  -At 7-47 a.m. R365 was observed lying in bed and stated about 10-15 minutes ago he had put his call light off and someone had been in his room, shut the call light off and been in his room, shut the call light off and sessist me to get up for breakfast. R365 stated he put his call light back on and one of the staff who had been to his room he did not even understand and that staff member left the room without R365 receiving assistance. R365 went on to state "I hope this light is going to the nursing station and the nurse sees someone is screwing up, this is what they do, I am always waiting for a long time for help and nobody comes or they would turn the light off, leave and not come back again. R365 stated he was now going to be late for breakfast. R365 sappeared sad, upset and closed his eyes.  -At 7:58 a.m. NA was observed to enter R365's room to assist which was more than 20 minutes since he had initially asked for assistance.  R365's quarterly MDS dated 5/9/15, indicated resident had moderately impaired cognition and required extensive assistance with folleting, transferring, bed mobility, dressing and personal hygiene and used the wheelchair for mobility.  On 6/4/15, at 8:05 a.m. R376's call light was	NORTH I	RIDGE HEALTH AND	RFHAR				
was observed in the hallway, two doors down standing by the medication cart setting up medications.  -At 7:41 a.m. a NA was observed to walk past R365's room.  -At 7:44 a.m. the NA was observed to enter R365's room, turn the call light off, inform R365 "today is your shower" then left the room.  -At 7:47 a.m. R365 was observed lying in bed and stated about 10-15 minutes ago he had put his call light of and told him they were coming back to assist me to get up for breakfast. R365 stated he put his call light back on and one of the staff who had been to his room he did not even understand and that staff member left the room without R365 receiving assistance. R365 went on to stafe "I hope this light is ging to ging to the nursing station and the nurse sees someone is screwing up, this is what they do, I am always waiting for a long time for help and nobody comes or they would turn the light off, leave and not come back again. R365 stated he was now going to be late for breakfast. R365 appeared sad, upset and closed his eyes.  -At 7:58 a.m. NA was observed to enter R365's room to assist which was more than 20 minutes since he had initially asked for assistance.  R365's quarterly MDS dated 5/9/15, indicated resident had moderately impaired cognition and required extensive assistance with tolleting, transferring, bed mobility, dressing and personal hygiene and used the wheelchair for mobility.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
standing by the medication cart setting up medications.  -At 7:41 a.m. a NA was observed to walk past R365's room.  -At 7:744 a.m. the NA was observed to enter R365's room, turn the call light off, inform R365  "today is your shower" then left the room.  -At 7:47 a.m. R365 was observed lying in bed and stated about 10-15 minutes ago he had put his call light on and someone had been in his room, shut the call light off and told him they were coming back to assist me to get up for breakfast. R365 stated he put his call light back on and one of the staff who had been to his room he did not even understand and that staff member left the room without R365 receiving assistance. R365 went on to state "I hope this light is going to the nursing station and the nurse sees someone is screwing up, this is what they do, I am always waiting for a long time for help and nobody comes or they would turn the light off, leave and not come back again. R365 stated he was now going to be late for breakfast. R365 appeared sad, upset and closed his eyes.  -At 7:58 a.m. NA was observed to enter R365's room to assist which was more than 20 minutes since he had initially asked for assistance.  R365's quarterly MDS dated 5/9/15, indicated resident had moderately impaired cognition and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used the wheelchair for mobility.  On 6/4/15, at 8:05 a.m. R376's call light was	2 800	Continued From pa	ge 32	2 800			
oncon/og on		standing by the memedicationsAt 7:41 a.m. a NA R365's roomAt 7:44 a.m. the NAR365's room, turn t "today is your show -At 7:47 a.m. R365 stated about 10-15 call light on and sor shut the call light of coming back to ass R365 stated he put of the staff who had even understand ar room without R365 went on to state "I h nursing station and screwing up, this is waiting for a long tir or they would turn t come back again. Fto be late for breakt upset and closed hi -At 7:58 a.m. NA waroom to assist which since he had initially R365's quarterly MI resident had moder required extensive at transferring, bed me hygiene and used to	was observed to walk past  A was observed to enter he call light off, inform R365 er" then left the room. was observed lying in bed and minutes ago he had put his meone had been in his room, f and told him they were list me to get up for breakfast. his call light back on and one been to his room he did not and that staff member left the receiving assistance. R365 hope this light is going to the the nurse sees someone is what they do, I am always me for help and nobody comes he light off, leave and not R365 stated he was now going fast. R365 appeared sad, is eyes. as observed to enter R365's h was more than 20 minutes y asked for assistance.  DS dated 5/9/15, indicated rately impaired cognition and assistance with toileting, obility, dressing and personal he wheelchair for mobility.				

-At 8:08 a.m. a NA was observed enter the room

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 800	and informed R376 left the room. NA tu-At 8:22 a.m. still no to assist R376.  On 6/4/15, at 10:21 requested the facility administrator and dindicated the facility logged call light use	she would find their NA and rned the call light off. bbody came back to the room a.m. when the surveyor ty call light logs the irector of nurses (DON) odd not have a system that and response times. The the facility call light audits but	2 800			
	staffing coordinator. The SC stated the find determined by residuation about the split ground units, as posted on the DON stated the how the groups were at the groups individuate needs. The DO with the nurse man to determine if this concerns. When SC when she was not at there were two other and shared the job, left. When asked with the department and manage the calls at When asked what he was low and if the finodded and stated when the census with the state of the stat	p.m. The DON and the (SC) were both interviewed. facility staffing pattern was dent census. When asked p shifts on 2 West and other the white boards in the units, nurse managers determined re to be split and they looked dually as well as the resident DN stated she would check agers regarding the split shifts was related to the staffing C was asked who did staffing at the facility, the SC stated or girls who worked evenings however, recently one had ho handled the sick calls, the ng office did and would notify I supervisor who would not re-arrange staff if need be nappened when the census acility staffed down, the DON "yes." The SC added, at times as low a NA would be floated re they were needed. Both the				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
71110 1 27111	or connection	ISEITTII TOTTI TOTTI TOTTI ISEIT.	A. BUILDING:			
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE PE, MN 5542			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 800	Continued From pa	ge 34	2 800			
	DON and the SC in supplemental agency When asked if there in the last 3 months going to find out any When asked what the DON stated it wasked the number of stated she would prasked if the turnove quality assurance (ODON confirmed states asked if staff had be concerns about the staff had not indicated work but had compoulted them in to he further stated the famultiple call-in's pole on facility core value had problems with sheen working at the non-profit and would levels which has chefor profit management though the facility has staffing was being a continued to have of family members regulated.	dicated the facility did not use by staffing (pool nursing). It were any employee injuries of the DON indicated she was did would provide information. The facility turnover rate was, was 43% as of 6/3/15. When of open positions, the SC ovide that information. When were rate had been reported to QA) at the last meeting, the ffing was discussed. When workloads, the DON stated the being able to finish their lained about the staffing so we selp problem solve. The DON workloads are inforcing their lained about the staffing so we selp problem solve. The DON was reinforcing their lained about the staffing so we staffing were educating staff who staffing were those that had a facility when the facility was a direflect the previous staffing anged since Mission Health and taken over. Even ad indicated the insufficient addressed, the facility complaints from residents and corting poor resident care oming, positioning and call wered timely among others exported to the surveyors				
	the staff would com come back half hou work in a place like	a.m. R376 stated sometimes e turn the call light off, leave ir later. R367 stated "I used to this as a nurse and I have hem they do come eventually.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/04	l/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	I have told them if a if I fall asleep it's ok I like to get out of b R376's quarterly MI R327 had intact coe	am in bed I want to get up and any for them to wake me up as ed early."  DS dated 4/10/15, indicated gnition, had no rejection of extensive assistance of one to	2 800			
	R190's FM-D stated facility there were cof two specific incide when R190's call light to get answered. FI the facility at approxime R190 indicated about 10 minutes. Find the NA R190 had be be answered, the NA R190 had be answered during to the dining room thand then there was during that time. Find this concern with the facility had I had also explained assured her the facility had I had also explained her the facility had I had	a.m. via a telephone interview, devery time she came the all lights on. FM-D stated one lents she recalled was last fall ght had taken over 45 minutes M-D stated she had arrived at kimately 5:30 p.m. and at that deher call light had been on for FM-D stated she waited until time she went to the nurses p and had come across a NA on. FM-D stated when she told been waiting for her call light to IA responded by saying "they during dinner." The NA further of assist residents' during to busy feeding people. The neal time, the aids were sent to help other residents to eat no one to help answer lights M-D stated she had discussed e unit manager who informed been having problems with his, the unit staffing pattern and illity was looking into the ded the second occurrence was in April when she had arrived D p.m. and had noticed the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	BEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	resident in the room had their call light of past the nurse's start member seated at ther. At 5:07 p.m. thon. FM-D stated where sident and asked stated he needed to stated she went to to the staff member staff member staff member staff member stated call light because s FM-D stated the start enter the residents resident how he was the room. The staff resident to the bath	n across the hall from R190 on. FM-D stated as she walked ation she observed a staff the desk with a meal in front of the resident's call light was still then she approached the him if he was ok, the resident of go to the bathroom. FM-D report the resident care need or seated at the desk and the dishe was not answering the he had other things to do. The aff member was observed to room at 5:14 p.m., ask the se, turn the call light off and left member never assisted the room.	2 800			
	observed onAt 10:38 a.m. NA-0 turn the call light off -At 10:41 a.m. R17 -At 10:43 a.m. NA-0 nursing station. NA- down he hallway ar walking talkie R177 continued to walk d observed walking to room, shut the light roomAt 10:45 a.m. when wanted someone to if her need had bee turned off two times told her they were g her. R177 stated sh -At 10:52 a.m. R17	a.m. R177's call light was  O was observed going into the, f and exited the room.  7 put the call light on again.  O was observed seated at the -O stood up, started walking and was heard stating on the r's call light was on. As NA-O own the hallway, NA-J was owards R177's room, enter the off and immediately exit the approached R177 stated she oput her to bed. When asked an met after her call light was as, R177 stated the staff had going to find her aide to assist the wanted to lay down.  7 remained seated in the stunched over and eyes				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/04/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NORTH F	RIDGE HEALTH AND I	RFHAR	ONE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	closedAt 10:56 a.m. R177 againAt 10:59 a.m. RN-I and asked R177 wh R177 stated again selected and asked R177 whose to enter R177's roor reopened it. R177 viseated in her wheeled in room the staff had told he so she was going so would be laid down.  On 6/5/15, at 11:08 had requested wheeled in her wheeled in room, TMA-D so the room prior with she wanted to lay down the room prior with she wanted to lay down the room had indicated so TMA-D indicated at mind when she had told R177 had asked down TMA-D indicated at mind wh	7's call light was observed on D was observed going to room nat she needed help with. She wanted to lay down. D and TMA-D were observed m, briefly shut the door then was observed to remain chairD and two NA's were nen came out of room. n approached R177 indicated er it was almost lunch time and tay up until after lunch and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	SEHAR 5430 BO	ONE AVENUE	NORTH		
NOITHIII.	IIIDGE HEAEIH AND	NEW HO	PE, MN 5542	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800			2 800			
	nursing assistant w depends the amour resident but I would call light and assist told staff had been hallways when call stated the staff was lights.	hey will go find who their as, the DON stated "It not of staff required to assist I expect them to answer the resident." When the DON was observed standing down the lights were on, the DON is supposed to answer the call				
	On 6/5/15, at 10:25 a.m. both NA-M and NA-N indicated the work load was heavy and all the time a group was split and they were not able to do their work timely which included repositioning the residents and this was a continuous problems at the facility and management was aware and was not doing anything. Both indicated this was not good for the residents when their needs were not met timely.					
	Layout for all the ur 3/5/15, 3/6/15, 3/6/15, 3/14 4/29/15, 5/6/15, 5/2 reviewed with the powerified on numerous were either absent not replaced instead had to be split the gin the sheets. In additional numerous days start shift, left early or call asked how resident to be met when start early she indicated level of acuity for the multiple shifts when not been replaced as	o.m. Daily Staffing Guide hits for randomly selected days /15, 3/15/15, 3/16/15, 4/12/15, 9/15, and 5/30/15, were ayroll & benefits staff who us shifts multiple staff who or had no call no show were d resident group assignments groups which was all indicated dition she verified on ff would either work part of the time in late for the shifts. When a cares/needs were supposed ff either came in late or left the supervisor determined the e units. She verified on a staff had left early and had and the groups had been split. Field on numerous shifts in rked short and no				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	replacements were worked on the floor one nurse. When a been counted as pr not able to respond manager would help asked about staff cashe indicated if the time it was easy to called in within a sh time it was hard at the replaced.  On 6/5/15, at 3:40 p would have expected lights were on, the ast expect her staff to a stand in the hallway things.  During review of the Tracking logs dated it was revealed 44 convolved either poor response during the positioning concern members. Although had been reached to	ge 39  done and nurse manager had when a nurse was short of sked if the nurse manager had oviding direct care she was but rather indicated the nurse of around the unit. When call-in's and replacing the staff staff had called in a head of replace the staff but when they ort time frame to shift start times to replace and would not be administrator stated she would answer call lights and not be a talking about their personal from 8/5/14, through 5/18/15, complaints complaints which is cares, poor call light eday or at night time, is from residents and family in the logs indicated resolution the complaints continued to a residents and units in the		DEFICIENCY		
	facility over time to by staff activity. In a facility annualized to 2014 rate was 44.6 (YTD) 2015 was 50	the survey weeks as observed addition during review of the urnover rates it was revealed 0 percent (%) and year to date				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00238	B. WING		06/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	RFHAB	NE AVENUE E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From page 40		2 800			
	revise policies, revi needs in order to en are provided. Educ staff. The administr	or designee could review and ew and adjust scheduling nsure the residents services eation could be provided to all ator or designee could a system in order to ensure				
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on observati interview, the facilit positioning was pro	ent is not met as evidenced on, document review and y failed to ensure appropriate vided during meal time for 3 of 7) residents reviewed for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING	<del></del>	06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Findings include:  R152 was observed evening meal during observation on 6/3/  R152's Diagnosis FR152's diagnoses at Alzheimer's diseased R152's quarterly Mi 3/6/15, indicated R1 impairment, require transfers and require up her meal tray. To Care Area Assessminating difficulty main impaired balance of Con 6/3/15, at 6:06 proceeded on the desk. R152's meal placed on the desk repeatedly twisting her food on the tray.  At 6:08 p.m. R152 off of the tray, held to take a few bites. waist in order to plasser.	d seated parallel to her githe evening meal 15.  Report dated 7/25/14, identified as esophageal reflux, and dementia.  Inimum Data Set (MDS) dated 152 had severe cognitive at extensive assist with red staff to assist with setting the Activities of Daily Living the Activities of	2 830			
	and while holding a it to her mouth. Ear food off of her tray waist and brought to food across her book. At 6:15 p.m. R152	forkful of mashed potatoes napkin under the fork brought ch time R152 took items of she needed to twist at the he eating utensil and morsel of dy and up to her mouth.  was observed to have turned he corner of the tray was hung.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	RFHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From part off of the desk.  -At 6:22 p.m. R152 cream cup over her under the cup.  R152's care plan disetting up her meal tray. In gradual non-signific days and that further the cup.  R152's meal intake 51-75% of her ever the cup.  R19's Diagnosis Reflection and difference and the cup.  R19's diagnoses as depression and difference and the cup.  R19's admission MR19's admission MR19 had severe copextensive assist with setting upon 6/3/15, at 6:11 prin the dining area are was positioned direction of the table was approm R19's chin. With difficult for her to early difficult f	was observed holding her ice lap with a napkin placed irected staff to assist R152 in tray.  ssessment dated 5/20/15, uired assistance with setting addition, R152 had showed a sant weight loss at 30, 90, 180 er weight loss was not desired. form indicated she consumed ing meal on 6/3/15.  seated at a table which was evening meal on 6/3/15.  sport dated 5/15/15, identified adementia, muscle weakness, iculty walking.  DS dated 5/15/15, indicated gnitive impairment, required h transfers and required staff	2 830			
	right arm (the arm/h	observed to have to raise her nand she used to feed herself) oulder in order to reach the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER	REHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	food on her tray.  R19's care plan diresetting up her meal R19's nutritional as indicated R19 was required assistance R19's meal intake f 0-25% of her evening R287 was observed during the evening R287's Diagnosis Fidentified R287's didysphasia (difficulty reflux and muscle v R287's quarterly MI R287 had severe comoderately impaire mechanically altere assist with setting to f Daily Living CAA difficulty maintaining impaired balance d On 6/3/15, at 6:26 p the right of the open back chair parallel to was seated across was placed on the company of the company	ected staff to assist R19 in tray.  sessment dated 5/20/15, 63 inches in height, and she with setting up her tray.  orm indicated she consumeding meal on 6/3/15.  diseated parallel to her meal meal on 6/3/15, diseated parallel to her meal meal on 6/3/15.  diseated parallel to her meal meal on 6/3/15, indicated ognitive impairment, division, was on a didie, and required staff to up her meal tray. The Activities identified R287 as having gray a sitting balance and uring transitions.  o.m. R287 was seated off to a dining area in a high winged to a large wooden desk. R287 from R152. R287's meal tray desk by therapeutic aide nued to be positioned facing ining area and parallel to her as observed during the meal 6:45 p.m. as having to twist at				
	her waist, bring the	6:45 p.m. as having to twist at food across her body and up At 6:31 p.m. registered nurse				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	RFHAR	ONE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 44	2 830			
	towards the desk, h parallel to her meal spilling Jello on her	slightly repositioned her chair nowever, R287 remained tray. R287 was observed clothing protector as she was llo across her body and to her				
	R287's care plan directed staff to assist R287 in setting up her meal tray.  R287's nutritional assessment dated 5/15/15, indicated R287 required assistance with setting up her meal tray.					
		form indicated she consumed ing meal on 6/3/15.				
	On 6/3/15, at 6:43 p.m. RN-E confirmed the table R19 was seated at was too high for her. In addition, the two residents (R152 and R287) seated at the wooden desk were positioned parallel and facing away from their meal trays.					
		ing, positioning during meals, ace were not provided.				
	SUGGESTED MET	HOD OF CORRECTION:				
	Committee to upda adequate positionin independent eating perform meal time of adequate positioning	ee could work with the QA te policies and procedures for g was provided to enhance. The facility could also observation audits to ensure g is maintained. The DON or ew results of the audits at the				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/04/2015	
	PROVIDER OR SUPPLIER	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 45	2 840			
2 840	MN Rule 4658.0520 Proper Nursing Car	) Subp. 2 B Adequate and e; Clean skin	2 840			
	B. Clean skin a odors. A bathing place resident's plan of cacondition requires the must be given a condition other day and more incontinent resident.	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every often as indicated. An must be checked at least				
	every two hours, and must receive perineal care following each episode of incontinence.  [ 144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally					
	agent of a resident in writing to waive p determining this into	tor, guardian, or health care who is not competent, agrees shysician involvement in erval, and this waiver is resident's care plan.				
	promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irrita	hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the tion. Rubber, plastic, or other must be kept clean, be				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER	REHAB 5430 BO	DDRESS, CITY, S' ONE AVENUE PPE, MN 55428	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 840	completely covered contact with the res	l, and not come in direct sident. Soiled linen and moved immediately from	2 840			
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide timely toileting 2 residents (R63) reviewed for				
	Findings include:					
	diagnoses that inclupartial paralysis of cerebrovascular disof language, affecti comprehension of sor write), generalize	eport indicated R63 had uded hemiplegia (total or one side of the body) due to sease, aphasia (an impairment of the production or speech and the ability to readed muscle weakness, nentia and peripheral vascular				
	4/1/15, indicated Re understood and had skills for daily decis indicated R63 requistaff for transfer an indicated R63 was functional limitation upper and lower ex one side. The MDS	imum Data Set (MDS) dated 63 was rarely/never d severely impaired cognitive ion making. The MDS also ired extensive assistance of 2 d toilet use. The MDS also non-ambulatory and had s in range of motion of the tremities with impairment on 5 further identified R63 as of bowel and bladder and was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER		ODRESS, CITY, S ONE AVENUI	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From page 47		2 840			
	at risk for the devel	opment of pressure ulcers.				
	Catheter Care Area 10/15/14, indicated bowel and bladder, use the toilet, was a dementia. The CA	ntinence and Indwelling Assessment (CAA) dated R63 remained incontinent of did not verbalize the need to aphasic and had some A indicated staff assisted R63 d managed/changed er protocol.				
	R63's Bladder Incontinence Evaluation dated 12/31/14, identified R63 was totally dependent for ADLs and wore adult briefs at all times. The evaluation indicated the care plan had been updated.					
	was at risk for skin incontinence, weak hemiplegia and dire treatments as order and symptoms of u. The Care Plan also extensive assist of care plan lacked into	ated 4/10/15, identified R63 breakdown related to ness, immobility, aphasia, and ected staff to complete skin red and to monitor for signs rinary tract infection. I identified R63 required two staff for toilet use. The terventions regarding or bladder incontinence.				
	R63 had a stage II thickness skin loss or both. The ulcer is clinically as an abra	Report dated 6/1/15 identified pressure ulcer (partial involving epidermis, dermis, s superficial and presents asion, blister, or shallow crater) measuring 0.6 centimeters m.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAB	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From page 48		2 840			
	On 6/3/15, from 7:0 continuous observa-At 7:05 a.m. R63 vat a table in the 1S'-At 7:56 a.m. break for R63At 8:32 a.m. R63 vat a table in the 1S'-At 7:56 a.m. break for R63At 8:32 a.m. R63 vat her meal. Voluntee asked if she would V-A then transporter room to the 2nd flo-At 8:54 a.m. R63 vat 8:56 a.m. R63 vat 10:04 a.m. R63 room and was obseindependently in heat 10:05 a.m. nursentered R63's room R63 was leaning in -At 10:06 a.m. NA-adjusted R63 so sh NA-J confirmed the incontinence since but would be doing -At 10:11 a.m. R63 room for a musical -At 10:24 a.m. NA-activity and request incontinence which -At 10:27 a.m. NA-during the day and incontinence cares check on R63 ever required two staff at On 6/3/15 at 2:38 at Con 6/3/15 at	ation revealed the following: was seated in her wheelchair W dining room. Ifast was delivered and set up and independently completed r (V)-A approached R63 and like to have her hair done. If R63 directly from the dining or beauty shop. If was observed having her hair If shop. If was assisted back to her If room. If and adjusted her posture as If wheelchair. If confirmed they had just If was assisted to the dining or beauty shop. If and NA-J If and NA-J If and NA-J If and adjusted her posture as If wheelchair. If confirmed they had just If was assisted to the dining of they got her up that morning, If so later. If was assisted to the dining activity. If approached R63 during the If the did to check her for If R63 refused. If stated R63 preferred to sit up would often refuse If NA-J stated they were to If ye hours. If NA-J stated R63 If the following the If ye had not checked R63 during the If ye had not check her for If ye had not checked R63 during the If ye had not check her for If ye had not checked R63 during the If ye had not c				
	On 6/3/15 at 2:38 a.m. registered nurse (RN)-G confirmed R63 currently had a stage II pressure					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING	<del></del>	06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAR 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	ulcer to her right glushould have been of incontinence at least frequently and incolleast been offered/a  On 6/4/15, at 10:21 plan lacked specific incontinence care a expectation of the faprovide incontinence resident every 2 hours and bladder incontininterventions and princluded check residence and princlude	a.m. RN-G verified 63's care interventions regarding and stated it was the minimum acility to check, change and e care to an incontinent	2 840	DEFICIENCY)		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905			
	Subp. 4. Positionin	g. Residents must be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 905	of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir the physician has of the physician ha	body alignment. The position to change their own position it least every two hours, if time after the resident has the night, unless the physiciar at repositioning every two ne period is unnecessary or ridered a different interval.  ent is not met as evidenced ion, interview and document ailed to act upon a physician's and occupational therapy tment for 1 of 3 residents	2 905	DEFICIENCY)		
	indicated R228's di non-Alzheimer's de and hip fracture. The MDS indicated impaired decision n dependent on two s	change MDS dated 5/22/15, agnoses included mentia, arthritis, osteoporosis R228 had memory loss, naking skills and was totally staff for transfers and was ne MDS indicated R228 had				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	NORTH RIDGE HEALTH AND REHAB 5430 BC NEW HC			NORTH 8		
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	IVE ACTION SHOULD BE COMPLE ED TO THE APPROPRIATE DATE	
2 905	Continued From page 51 impairment in range of motion on one side in lower extremity and used a wheelchair.		2 905			
	Assessment (CAA) R228 was at risk of complications of im incontinence and do R228's physical lim weakness, limited r	Daily Living (ADL) Care Area dated 5/29/2015, indicated functional decline due to mobility such as contractures, epression. The CAA indicated itations consisted of ange of motion, poor palance, visual impairment and				
	The 2/14/15, Fall Report indicated R228 had gait imbalance, impaired memory, non-compliant, weakness/fainted and had ambulated without assistance.					
	The medical record right hip fracture on	indicated R228 sustained a 2/14/15.				
	physician's order in physical therapy (P services. On 5/19/1 x-ray the hip for hea order was clarified	order dated 5/18/15, dicated R228 was to receive T)/occupational therapy (OT) 5, an order was received to realing. On 5/20/15, the PT/OT with an "Ok" for full weight the order was never received tment.				
	was weak and had	evised 5/27/15, indicated R228 a recent history of right hip ssist of two staff for transfers latory.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 52	2 905			
	was observed to when NA-T and another NA-T and the toile the toilet, both NA's	p.m. nursing assistant (NA)-T neel R228 to the bathroom. NA were observed to transfer t. When R228 was done using swere observed to transfer wheelchair and wheeled her n.				
	On 6/4/15, at 11:10 a.m. registered nurse (RN)-D verified R228 had a physician's order for PT to evaluate and treat R228, however, was unable to find any additional information in R228's medical record as to whether the order was fully process or not.					
	stated there was so	a.m. physical therapist (PT)-O ome miscommunication and ed R228 but would get right on				
	On 6/5/15, at 8:45 a.m. PT-L, stated the 5/18/15, physician order to evaluate and treat R228 should have been completed the day it was written or the next day.					
	recall writing down physician regarding for the physician (a had not heard anyth (6/4/15-during surve the order was lost in ot received the order PT-N stated when the therapy evaluation considered comple their schedule whice	a.m. PT-N stated he could some questions for the R228's weight bearing status round 5/18/15) to answer and hing further until yesterday ey). PT-N stated he thought in communication as they had der in the therapy department, there was an order written for and treatment the orders were ted when it would show up on h was made out by the ation Director/COTA. PT-N				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	stated R228 was or evaluation today (6/20 On 6/5/15, at 9:33 a Rehabilitation Direct got the 5/18/15, PT R228. She stated norder to the therapy was never received PT-N had left quest answer during roun in the computer system for a physician resp week she stated she case.  On 6/5/15, at 3:50 pp DON were interview DON stated they we treat to be acted on administrator stated had occurred.  SUGGESTED MET  The director of nurreview and revise the related to interdisciped Education could be each resident receives ervices. The DON monitoring system to	a.m. the Assistant stor/COTA stated she never evaluate and treat order for ursing should have faxed the department and the order. She stated she was aware ions for R228's physician to ds and she had been looking stem for the next couple days onse, however by the next e had forgotten about R228's o.m. the administrator and	2 905			
21025	MN Rule 4658.0615	5 Food Temperatures	21025			
	Potentially hazardo	us food must be maintained at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature corapid and progressi toxigenic microorga.  This MN Requirements: Based on observative review, the facility frensure food was set temperature for 5 or R257, R234, R515) regarding food quark (R457 R385) who we food.  Findings include:  R365's quarterly Mi	heit (four degrees centigrade) grees Fahrenheit (66 degrees re. "Potentially hazardous red subject to continuous time ontrols in order to prevent the regrowth of infectious or anisms.  The proper subject to continuous time ontrols in order to prevent the regrowth of infectious or anisms.  The proper subject to continuous time on the red in the proper subject to develop a system to reved at the proper subject to receive to the red it is not met as evidenced at the proper subject to receive cold it is not met as evidenced at the proper subject to receive cold in the red in the r	21025			
	6/2/15, at 9:23 a.m. cold.  R117's quarterly MI R117 had intact cog a.m. R117 stated the explained the food between 45 minute stated her table was served and the food R257's quarterly MI	265 had intact cognition. On R365 stated the eggs were DS dated 5/8/15, identified gnition. On 6/2/15, at 10:34 he food was usually cold. She service distribution took is to an hour to complete. She is one of the last tables to be distribution. On 6/2/15, identified gnition. On 6/2/15, at 10:57				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE			
	I	NEW HOP	PE, MN 5542			
(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) COMPLETE DATE
21025	Continued From pa	ge 55	21025			
	a.m. R257 stated the	ne food was cold. She stated ast table served during the ler dining room and the food				
	R234 had intact co	DS dated 4/10/15, identified gnition. On 6/2/15, at 11:33 ne food was sometimes cold.				
	R515 had intact cog R515 stated the eg					
	R515 stated the eggs were cold and the vegetables were cold and mushy.  On 6/3/15, at 11:20 a.m. the main kitchen area dietary service was observed with the registered dietician (RD).  -At 11:23 a.m. Cook (C)-A was observed to remove the hot meal items from the oven and check the temperatures. The hot meal choices consisted of tuna melts, chicken patties and mashed potatoes. The tuna melts were 180 degrees Fahrenheit (F), the chicken patties were 160 degrees F and the mashed potatoes were 180 degrees F.  -At 11:33 a.m. C-A loaded the steam table pans into an insulated cart and dietary aide (DA)-A was observed to push the cart out of the main kitchen. DA-A transported the food to the west building, first floor dining room.  -At 11:45 a.m. DA-A placed all of the hot food items onto the hot cart serving system. DA-A then rechecked the temperatures of the hot food items. The mashed potatoes were noted to be 150 degrees F, the chicken patties were 140					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE			
0/0.15	CLIMMA DV CTA		PE, MN 5542		ON	()(5)
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	Continued From pa	ge 56	21025			
	the 29 residents residining roomAt 12:37 p.m. the I residents. DA-A rechot food. The chick 130 degrees F and 134 degrees. The Fa serving of the chipotatoes. The RD citems were correct, stated the facility dithey monitored the service to ensure a maintained through process and had no residents had expresidents.	ast tray was served to the checked the temperature of the en patties were noted to be the mashed potatoes were RD and the survey staff tasted cken patty and mashed confirmed the taste of the food but the food was not hot. She d not have a system in which food at the end of the meal dequate temperatures were out the meal distribution of been made aware the essed concerns regarding cold the would work on the concern.				
	R457's was fed coloreheat or provide he	d food an the facility failed to ot food.				
		Report dated 11/21/14, agnoses as dementia and weakness.				
	R457's significant change MDS dated 3/6/15, indicated R457 had severe cognitive impairment, was sometimes able to make herself understood and required extensive assist with meals. R457's nutritional Care Area Assessment (CAA) dated 3/10/15, identified R457's inability to perform activities of daily living (ADL)s without significant physical assistance affected her ability to eat.  R457's care plan dated 5/28/14, indicated R457 required total assistance from staff with her					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	BEHΔR 5430 BO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21025	meals.		21025			
		ssessment dated 5/28/15, ed on staff to feed her.				
	On 6/3/15, at 6:26 p.m. R457 was observed seated in a tilt back wheelchair at a table in the Bridgeway dining area. R457 had a tray of food placed directly in front of her and left unattendedAt 6:38 p.m. an unidentified staff member sat down next to R457. Upon request of the surveyor, dietary aide (DA)-A took the temperature of R457's mashed potatoes and squash on her tray. DA-A stated the temperature of the mashed potatoes was 93 degrees F and the temperature of the squash was 90 degrees. DA-A then proceeded to walk away and did not offer to provide R457 with a tray of warm food or warm up the food on her tray. The unidentified staff member proceeded to assist R457 with her meal without offering to reheat her food.					
	R385 was observed eggs.	d to have been served cold				
	R385 was cognitive	DS dated 4/11/15, indicated ely intact, was on dialysis and ith eating after set up only.				
	seated in his wheel R385 stated at time eggs, were served	a.m. R385 was observed chair at the dining room table. es the food, especially the cold and this was something he facility attention several				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	74/2013
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	Continued From pa	ge 58	21025			
	was served to R385 occupational therap another resident at eggs. R385 stated can you please put warm them for 45 s leave the table ther eggs, warmed them R385.  The Preventing For policy revised 12/20 potentially hazardor internal temperature temperatures for the destroy harmful bacas to when to discas specifically direct the support of the process of the support of the process of the support	a.m. shortly after breakfast 5 he was overheard to ask the bist (OT) who was assisting the same table to warm his "as always the eggs are cold, them in the microwave to seconds." OT staff was seen a returned and took R385's an and brought them back to be oddorne Illness-Food Handling 1009, directed the staff to cook us food to the appropriate es and hold the food at those e appropriate length of time to octeria. The policy directed staff ard food items but it did not the staff as to how to ensure the the proper temperature for the				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop policies an potentially hazardor temperature to avois service manager or appropriate staff on procedures. The form	od service manager or relop monitoring systems to				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty -one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER	BEHAR 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	(a) A nursing home maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, interest. The Department of extechnical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to ens proper tuberculin sl millimeters (mm) an interpretation (nega Tuberculosis Scree Findings include: Personnel records indicated a hire dat (TB) screening was addition the TB screening was addition to the screening was additionally to the screening was	and document review, the ure 3 of 6 employees had kin test (TST) induration/nd documentation ative or positive) reviewed for ning State regulations.  for registered nurse (RN)-K e of 5/4/15, and a tuberculosis completed on 4/28/15. In eening sheet indicted RN-K ep TST on 4/28/15, and the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	results were read a interpretation of reareceived the second were read on 5/7/15 documentation of in Personnel records of (TR)-B indicated a latuberculosis (TB) so 4/13/15. In addition indicted TR-B received to 1/27/15, and the "Negative" interpret lacked documentation indicted M-B received to 1/27/15, and the result were lacked documentation indicted M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indicated M-B received to 1/27/15, and the result were lacked documentation indica	s 0 mm with a "Negative" ding - on 4/30/15. RN-K then d step TST on 5/5/15, results 5, as 0 mm, however lacked atterpretation.  for therapeutic recreation staff nire date of 4/16/15, and a creening was completed on the TB screening sheet wed the first step of her TST results were read as ation of reading. However ion of the induration.  for maintenance staff (M)-B e of 2/12/15, and a creening was completed on the TB screening sheet ed the first step TST on sults were read as a ation of reading - on 1/30/15. The second step TST on the read on 2/19/15, as er both results lacked	21426			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAR 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Tuberculosis, Empl revised April 2013, "a. If the reaction to the facility will admi weeks after the first begin duty assignm negative) unless produced Although the policy results interpretatio induration was suppolicy did not indicate ensuring the personand complete.  Regulation for Tube Health Care Setting "TST documentation the test (i.e., month millimeters of induration that the set (i.e	oyee Screening for policy directed: I the first skin test is negative, nister a second skin test 1 to 2 test. The employee may ents after the first skin test (if phibited by state regulations" directed the staff to read the n, it did not indicate the result posed to be included. The te who was responsible for nnel records were accurate exculosis Control in Minnesota as dated July 2013, directed n should include the date of day, year), the number of ation (if no induration, and interpretation (i.e.,	21426			
21565	MN Rule 4658.1325 Medications Self Ac	5 Subp. 4 Administration of Imin	21565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21565	Subp. 4. Self-adm self-administer med resident assessment care as required in 4658.0405 indicate is a written order from This MN Requirement by:  Based on observation review, the facility for practice of self administration (a inhalm medication) for 1 or	ge 62 inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.  ent is not met as evidenced on, interview and document ailed to assess for the safe ninistration of nebulizer ation treatment of respiratory f 1 resident (R270) observed a nebulizer treatment /	21565			
	and electronically s directed albuterol- I / 3 milliliters (ml) so inhale orally via net COPD. The Order of self-administer this  R270's significant M dated 5/15/15, indicincluded chronic ob (COPD) and demention of the company of t	Orders and Information dated igned by physician 5/4/15, pratropium 2.5-0.5 milligrams lution vial (Duoneb) 3 ml oulizer every four hours for did not indicate R270 could medication nor any others.  Minimum Data Set (MDS) eated R270's diagnoses estructive pulmonary disease ntia.  Acted 5/22/15, indicated R270 ems related to yelling out, ins/oxygen secondary to sions and narcissistic				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	5430 BOO	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAR	E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21565	to administer R270' however did not addid administration of modern administration of modern administration of modern administration of modern and running with nebulizer chamber. At 6:13 a.m. licens was observed to whom R270's room and candinistering paint and 6:23 a.m. when self-administration of medication, LPN-E After LPN-E review orders, she verified self-administer med R270 required a SAC completed to determine the completed to determine the complete administration and required a SAC complete administer modern and candid the complete administer modern and candidation and candidat	r. The care plan directed staff is medications as ordered, dress R270's self edication ability.  a.m. R270 was observed in his back on the edge of the bed hed out to the floor, sleeping. It mask was resting loosely on bulizer machine was turned in liquid medication noted in the R270 was did not easily noise.  I was did not easily noi	21565	DEFICIENCY)		
	(DON) stated this w R270 required a se	o.m. the direct of nursing vas poor practice and verified lf administration assessment r prior to self administering				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING	<del></del>	06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21565	December 2009, di self-administer their Attending Physiciar Interdisciplinary Ca determined that the capacity to do so sa SUGGESTED MET The director of nurthe policy and proceself-administration education to the state to identify and assec capability to particip	cation policy revised rected "Residents may rown medications only if the n, in conjunction with the re Planning Team, has by have the decision-making afely.  THOD OF CORRECTION:	21565			
21610	MN Rule 4658.1340 and Preparation Are Subpart 1. Storage must store all drugs under proper tempe only authorized nursaccess to the keys.  This MN Requirements: Based on observation review, the facility for the second statements of the second statements.	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have	21610			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAR TO THE STATE OF THE STATE	ONE AVENUE PE, MN 5542	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21610	north west and 2nd which involved 7 of R315, R103, R643, 2 Northwest nursing 1 of 1 resident (R92	floor central nurses station) 7 residents (R209, R492, R533, R300) residing on the g unit who required insulin and 2) who had discharged from ad the potential to affect all 79	21610			
	8:28 a.m. to 8:50 a. was observed sitting west nurses station to be filled with multiprescription labels of were observed by the were available for some remove. Insulin perbe stored in the from	ontinuous observations from m. a plastic divided container g on the second floor north. The container was observed tiple insulin pens with on them. No staff members he station and the insulin pens taff, residents and visitors to n needles were observed to nt section of the box. sidents and family members he unit.				
	At 8:40 a.m. the Stanurse's station near	ate Agency staff sat at the rathe insulin pens.				
	was observed to wa up the container of	ed practical nurse (LPN)-A alk to the nurse's desk, picked insulin pens and place it in the LPN-A then left the desk area.				
	observed with LPN- was equipped with	o.m. the insulin container was B. Each of the insulin pens a pharmacy label which ent and the directions for use.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING	····	06/0	04/2015
	PROVIDER OR SUPPLIER	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21610	R209 had 1 Novelo R492 had 1 Lantus R209 had 1 Lantus R315 had 1 Lantus pen R103 had 1 Novolo	g Flex pen Flex pen Flex pen Flex pen Flex pen g and 1 Levimure Flex pens and 1 Novolog Flex g Flex pen	21610			
	On 6/2/15, at 3:05 p.m. LPN-B stated the container of insulin was to be in sight of the nurse or locked at all times.  On 6/2/15, at 3:10 p.m. LPN-A confirmed she had left the insulin pens on the desk. She stated she					
	Supervisors but state busy and the reside She stated they were On 6/3/15, at 7:20 a floor central nurses contain a small plas nurses station was system which would visitors or residents station and removin On 6/3/15, at 9:10 a	not to leave them out by her ted the morning became very ents had begun to "pile up." re to be kept secure.  a.m. the west building second station was observed to stic box of medication. The not equipped with any type of d prevent unlicensed staff, of from entering the nurses and the medication.  a.m. the basket of medication ask without staff members				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	4/2013
NORTH F	RIDGE HEALTH AND I	RFHAR 3.33 - 3.3	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From page 67		21610			
	central nurses static assistant director of medication were no been discharged fro medications include bottles of Azopt eye medication should he with the resident up	o.m. the second floor west on was observed with the finurses (ADON). The ted to be for R92 who had om the facility. The ed Spirva capsules and two drops. The ADON stated the have either been sent home on discharge or destroyed. ed all medications were to be				
	The Storage of Medication policy revised in April 2017, indicated only persons authorized to prepare and administer medications were to have access to medications and all medications were to be stored securely.					
	The director of nurs development and in procedures to ensu appropriately. The designee could then	HOD OF CORRECTION: sing or her designee could explement policies and re that medications are stored director of nursing or her explement monitor the licensed staff for policies and procedures.				
	TIME PERIOD FOR one (21) days	R CORRECTION: Twenty -				
21685	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			
	Subp. 2. Physical p	plant. The physical plant,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re routine maintenanc This MN Requirement by: Based on observation review, the facility for maintenance to res 366, 393, 394, 423) of 2 residents (R46)	ge 68  rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.  ent is not met as evidenced on, interview, and document ailed to provide appropriate ident rooms numbered (322, In addition failed to ensure 15) room was kept clean and wed for environmental	21685			
	the facility was com director (MD), admi administration, districtions arrived group, and.  The MD verified the concerns:  In room 322, two and needed replacitions in room 393, two and needed replacitions in room 394, two and needed replacitions in room 394, two and needed replacitions.	ere was a broken ceiling tile in n needed replacing to ceiling tiles were stained ng in the bathroom to ceiling tiles were stained				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND I	RFHAR TO THE STATE OF THE STATE	ONE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21685	On 6/4/15, at 10:00 had not received we for the above concern the	a.m. the MD confirmed he ork orders requesting repairs erns identified.  ance schedule for p keep for resident rooms was all Maintenance policy the facility would be repair at all times to include and fixtures.  strong musty offensive odor d to reduce the odor.  d 4:30 p.m. during the initial y malodorous smell was noted m.  o a.m. until 3:10 p.m. a was noted just outside R469's ication aide (TMA)-B was outside the room setting up the ered nurse (RN)-C was R469's room in which R469 or assistance to get into his ndicated she would get help		DEFICIENCY)		
		ved a nursing assistant enter nut the door. The malodorous				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	room continued to hall malodorous smell woverpowering when staff, residents and observed going back other rooms located acknowledged R46 cleaned.  On 6/5/15, at 9:35 a smell remained and walking past the room of the room o	20 a.m. until 12:00 p.m. R469's have the same strong when walking outside and was a entering the room. Several family members were sk and forth past R469's to down the hallway. No staff 9's room needed to be  a.m. the pervasive malodorous diseveral staff were observed om.  a.m. the MD, after he walked m door, verified the smell was thought the odor was in the carpet as the vent was properly. The MD stated "I will prome clean it."  a.m. a staff member with a chine entered R469's room he was going to clean his  a.m. the MD stated the carpet and and the clothes in the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	Continued From page 71		21685			
	SUGGESTED MET	THOD OF CORRECTION:				
	work with the direct a maintenance prog walls, floors, ceiling fixtures are manage clean, homelike endesignee could edu the program, and c	sing (DON) or designee could for of maintenance to develop gram to ensure damaged gs, and bedroom and bathroom ed/repaired to maintain a safe, vironment. The DON or ucate all appropriate staff on ould develop monitoring ongoing compliance.				
	TIME PERIOD FOR Twenty-One (21) D					
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			
	reporter who has revulnerable adult is lor who has knowled has sustained a phreasonably explained information to the condividual is a vulne the individual is adreporter is not required.	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior is:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is	as admitted to the facility from the reporter has reason to ble adult was maltreated in the knows or has reason to believe as a vulnerable adult as defined 2, subdivision 21, clause (4).				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21980	(b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reason been made to the component of the component	required to report under the ection may voluntarily report at a section requires a report of dimaltreatment, if the reporter on to know that a report has sommon entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has reporter or a facility, at any in investigation by a lead reporter or a facility, at any in investigation by a lead reporter or a facility, at any in investigation by a lead reporter or a facility, at any in investigation by a lead reporter or report or reporter or	21980			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00238	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 73	21980			
	Findings include:					
	indicated R138 fell transfer from the will R138 lost his balan. The report indicated and the left side of indicated the direct nursing supervisor note on the incident R138's care plan with staff assist was need ambulation. The profactors were identification report also indicate was notified on 5/7/physician was notified.	lated 5/7/15, at 7:40 p.m. during a one staff assisted heelchair to the toilet when ce and fell against the wall. d R138 bumped his left arm his head. The report also or of nursing (DON) and the were notified. The nursing t report dated 5/8/15, indicated as updated to indicated two edd for transfers and edisposing physiological ied as weakness/fainted. The d R138's responsible party (15, at 7:50 p.m., and the led on 5/8/15, at 2:04 p.m. lacked indication of State as required.				
	printed 6/4/15, indic included hemiplegia body) due to cerebi convulsions (seizur muscle weakness,	ce Sheet and Diagnosis List cated R138's diagnoses a (paralysis on one side of the rovascular disease (stroke), es), difficulty in walking, dementia without behavioral ssive disorder and anxiety.				
	R138 was at high ri the 90 days prior. indicated R138 had ambulated with pro	on dated 5/6/15, indicated sk for falls and had 1-2 falls in The fall risk evaluation no cognitive changes, blems and a device, his gait he required physical ize.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 74	21980			
		ote dated 5/8/15, indicated f pain in ribs from the fall.				
		ote dated 5/10/15 at 2:41 p.m., applained of pain in his chest on				
	p.m. indicated R138	ote dated 5/10/15, at 10:30 3 complained of left side pain, rea. No bruising or swelling				
	An order by the nurse practitioner (NP) dated 5/11/15, directed an x-ray of the right and left ribs and chest x-ray for diagnosis of pain.					
		lated 5/11/15, indicated R138 res of the left third, fourth, and				
	indicated a chest x- fractures of 3 ribs. placed to the assist (ADON) to report the report was reviewed R138 was spoken the fractures occurred to previous week and	ote dated 5/11/15, at 9:40 p.m. cray result included rib. The note indicated a call was ant director of nursing the injury (fracture) and the fall d. The report also indicated to and he reported the when he had fallen the reported his pain level as 10 which indicated almost				
	B138's NP progress	s note dated 5/12/15, indicated				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	CONSTRUCTION		E SURVEY PLETED
		00238	B. WING	<u>-</u>	06/	04/2015
	PROVIDER OR SUPPLIER	BEHAR 5430 BOC	DRESS, CITY, ST DNE AVENUE PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21980	rib fractures. In add a 10 pound weight were too low and the had just been decreed. The note ordered R138's blochecks twice daily for the staff for transfers a indicated R138 had unsteady with posit MDS indicated R138.	injury and noted R138 had left lition, the NP noted R138 had loss and his blood pressures he blood pressure medication eased and labs had been also indicated the NP had od pressures and heart rate	21980			
	5/15/15, indicated If falls due to balance changes and receive medication. The Cassistance with transhort distances in If	rea Assessment (CAA) dated R138 was potentially at risk for a problems during position ving an antidepressant AA indicated R138 required asfers and would ambulate his room with staff assist and but the wheelchair was his ansportation.				
	indicated R138 rep neck." The note ind what was going on, helped him the prev wrong with his neck	ote dated 5/29/15, at 7:45 a.m. orted, "someone busted up my dicated when R138 was asked he talked about how no one vious night, something was and he wanted an x-ray. indicated R138 was told the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21980	charge nurse would	nge 76 Id be notified to schedule an or would be informed.	21980			
	indicated R138 con neck, running along R138 stated he felt morning and said the way as to cause pa	ote dated 5/29/15, at 8:54 a.m. inplained of pain in the lower grupper shoulder blade region. pain when moved by NA that hat he was moved in such a lin in his neck. The progress assessed the location of				
	of the State agency with resultant rib fra medical record lack	ord lacked any documentation or notification related to the fall actures. In addition, R138's ked any documentation related neck pain and rough				
	revised 2/9/15, indicand directed staff to protocol, review the attempt to determine possible root cause or remove any pote care plan further directions.	an initiated 6/12/14, and cated R138 was at risk for falls of follow the facility's fall enformation on past falls and ne cause of falls, recordes of the fall, and then to alterential causes, if possible. The rected staff to educate the distaff regarding the causes.				
	(ADLs), initiated 3/7 indicated R138 req	or activities of daily living 7/15, and revised 5/8/15, uired the assistance of two ped mobility and toilet use.				
	R138's care plan da	ated 4/24/15, indicated R138				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	BEHAB 5430 BO	ODRESS, CITY, S ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21980	had the potential for was able to call for able to reposition so communicate how experiencing and with pain.  R138's care plan for indicated R138 required staff for ambulation 4 ends, hemicane)	r pain related to arthritis and assistance when in pain, was elf, ask for medication,				
	updated as recently was to ambulate wi 300 feet with the as quad cane on the ri indicated R138 was extensive assistant transfers with the q	re plan printed 12/20/13, and as 1/15/15, indicated R138 th restorative nursing up to esistance of one staff using the ght side. The care plan at risk for falls, required the of 1 to 2 staff for pivot and cane and assistance and due to weakness, pain and				
		odated on 12/5/14, indicated I the care card was updated.				
	by nursing assistan use of two staff for the quad cane for a for toilet use. The F 3/9/15, indicated R <sup>3</sup> transferring. A note	are Card (the care plan used ts) printed 6/4/15, directed the transfers, two staff assist with mbulation and two staff assist desident Care Card printed 138 required two staff for by the registered nurse 6/14, indicated R138's resident				

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PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21980  Continued From page 78  care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NORTH RIDGE HEALTH AND REHAB  S430 BOONE AVENUE NORTH NEW HOPE, MN 55428    (X4) ID			00238	B. WING		06/0	4/2015
NORTH RIDGE HEALTH AND REHAB  NEW HOPE, MN 55428  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21980 Continued From page 78  care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for	NAME OF	PROVIDER OR SUPPLIER				_	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21980  Continued From page 78  care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for	NORTH	RIDGE HEALTH AND	RFHAR		=		
care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETE DATE
The undated nursing assistant (NA) group sheet provided by RN-H indicated the NAs were to refer to the Care Card for transfers and toilet use guidance. The group sheet did not indicate how R138 was to ambulate or if he could ambulate.  The facility Minnesota Department of Health Tracking Form for vulnerable adult (VA) reports made by the facility lacked documentation which indicated R138's incident of 5/7/15, rib fractures and the report of neck pain alleged to be caused by treatment by staff.  On 6/3/15, at 2:17 p.m. R138 stated some staff were rough in the morning because they were in a hurry. R138 also stated he was more sore in the morning and at times, felt staff were disrespectful and ignored his needs. R138 also stated he was not afraid of staff and did not feel the staff purposefully tried to hurt him. R138 confirmed he had had broken bones and bruises from falls.  On 6/4/15, at 2:09 p.m. RN-H stated since prior to 12/5/14, R138 had required the assist of two staff. RN-H stated the facility reported falls with	21980	care card dated 12/R138 with two staff care plan was not for of 12/5/14, when Risonly one staff assis R138's care card hat 12/5/14, directing the transfer.  The undated nursin provided by RN-H into the Care Card for guidance. The grown R138 was to ambult to the Care Card for guidance. The grown R138 was to ambult to the facility indicated R138's indicated R138'	75/14, directed staff to transfer assist and also indicated the ollowed during R138's incident 138 fell during a transfer with t. RN-H stated this indicated ad been changed prior to he use of two staff assist for assistant (NA) group sheet ndicated the NAs were to refer r transfers and toilet use up sheet did not indicate how ate or if he could ambulate.  Ota Department of Health rulnerable adult (VA) reports a lacked documentation which cident of 5/7/15, rib fractures eack pain alleged to be caused ff.  O.m. R138 stated some staff norning because they were in stated he was more sore in times, felt staff were inored his needs. R138 also of staff and did not feel by tried to hurt him. R138 and broken bones and bruises p.m. RN-H stated since prior and required the assist of two				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	in odd spots and all allegations of abuse the State agency. If fractures were proboccurred that week was unaware if the State agency. RN-Frelated to the neck reported to the State	ge 79 sercations as well as e, neglect and mistreatment to RN-H stated R138's rib ably related to the fall that had during a transfer, however incident was reported to the H verified the allegations pain should have been e agency, immediately.	21980			
	(DON) stated she were sident care cards care card was the in NA's to use. The DODON with all falls as were related to his verified R138's care the incident and the have been reported required. In additionallegation of neck pwas not reported the pain had diminished was to protect the restaff member from	would expect staff to follow the when providing cares as the advidual resident care plan for ON stated staff called the and stated R138's fractured ribs fall on 5/7/15. The DON e plan was not followed during a fall with a fracture should to the State agency, as an, the DON verified R138's ain and mistreatment by staff e next day because R138's d. The DON stated the nurse esident first, pull the alleged the floor and report the ate agency right away.				
		unwitnessed right hip fracture d to report and investigate the l.				
	R228's diagnoses in dementia, arthritis a indicated R228 had	S dated 2/6/15, indicated ncluded, non-Alzheimer's and osteoporosis. The MDS memory loss, impaired ills, required limited assist with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
NAME OF	PROVIDER OR SUPPLIER		ODRESS, CITY, S			
NORTH	RIDGE HEALTH AND	RFHAB	PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21980	walking and transfe wheelchair for mobile R228's significant or indicated R228's dia non-Alzheimer's de and hip fracture. The MDS indicated impaired decision in dependent on two signon-ambulatory. The impairment in range lower extremity and R228's Nurse Programment in range lower extremity and R228's Nurse Programment in range lower extremity and living on right side by The note indicated screamed when rightfurther revealed R2 rotated therefore a physician and supe The 9:29 a.m. nurse x-ray showed hip from the room, was combalance, impaired had weakness/faint R228's predisposing ambulating without The report indicated	erring and used a walker and ility.  change MDS dated 5/22/15, agnoses included mentia, arthritis, osteoporosis  R228 had memory loss, naking skills, was totally staff for transfers and was the MDS indicated R228 had to of motion on one side in a used a wheelchair.  Tess note dated 2/14/15, at R228 was found on the floor, etween the bathroom door. R228 was yelling out and the leg was touched. The note 28's right leg was shorter and telephone call placed to rvisor.  The progress note indicated acture.  Teport indicated R228 had a fall onfused, incontinent, had gait did memory, was non-compliant ed. The report indicated g situation factors were				
		ies Fall Log report on 6/4/15, Il/fractured hip was not on the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB 5430 BOO	DDRESS, CITY, S DNE AVENUE PE, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From pareport.	ge 81	21980			
	would not be on the report was not com following R228's ca RN-D added, it was an incident such as staff were following RN-D also verified investigation related	p.m. RN-D stated R228 Fall log because an incident pleted because the facility was re plan at the time of the fall. not facility practice to report R228's hip fracture because the resident's care plan. the facility did not complete and to R228's fall and fracture following the care plan.				
	were interviewed. T not their policy to re R228's fall and hip	o.m. the administer and DON The administrator stated it was eport an incident such as fracture because staff were re plan at the time of the fall.				
		ractured rib of unknown origin d to timely report the incident r, as required.				
	indicated on 5/3/15 sided pain, R152 do ordered and reveal	on Report dated 5/4/15, , R152 had complained of right enied falling, an X-Ray was ed an acute right 7th fractured he report form titled, date				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING	<del></del>	06/0	04/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	administrator and m	ge 82 nedical director notification nmary of Investigation section	21980			
	R152's incident occ	eport-undated indicated curred/or was noted on 5/4/15, dent was "unknown."				
		with the State agency was fore was not reported juired.				
	were interviewed. T VA report was not re RN supervisor shou required. The admir	o.m. the administer and DON the administrator verified the eported timely and stated the ald reported the incident as nistrator stated the RN was given disciplinary action provided.				
	Abuse to the State A Entities/Individuals suspected violation mistreatment, negle source, or abuse (in	nd procedure for Reporting Agencies and Other revised 2006, directed if a or substantiated incident of ect, injuries of an unknown ncluding resident to resident , the facility will promptly notify				
	Signs and Sympton 2006, indicated neg provide goods and avoid physical harm	nd procedure for Recognizing ns of Abuse/Neglect revised glect was defined as "failure to services as necessary to n, mental anguish, or mental identified some signs of				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00238	B. WING		06/	04/2015
	PROVIDER OR SUPPLIER	BEHΔB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21980	abuse or neglect incof care and caregive personal care and regive perso	cluding inadequate provision er indifference to resident's needs.  and procedure for Reporting anagement revised 9/12, responsibility of the ptly report any incident or of neglect or resident abuse, unknown source, and theft or resident property to facility policy and procedure directed mediately report any rincidents of abuse to their buse coordinator and/or addition the administrator or ediately notified of suspected of abuse regardless of the	21980			
	The administrator, of designee could revito vulnerable adult administrator, DON facility staff on the preporting and invess mistreatment and / The administrator, I develop monitoring compliance is attain	CHOD OF CORRECTION:  director of nursing (DON), or ew and update policies related abuse and neglect. The or designee could educate all policies and procedures for tigating allegations of or injuries of unknown origin. DON or designee could systems to ensure ongoing ned and maintained.  R CORRECTION: Twenty one				

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PRINTED: 06/25/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	04/2015
NAME OF PRO	VIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
NORTH RID	GE HEALTH AND I	REHAB	ONE AVENUE			
		NEW HO	PE, MN 5542		TION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Su face per ess produce es produc	eporting - Maltrear  abd. 14. Abuse polity, except home ersonal care attendersonal care at a statement of minimize the risk amply with any rule omulgated by the (b) Each facility, in the polity and personal care at a sessment of: (1) buse by other individuals. For the purpor "abuse to that a lults. For the purpor "abuse" including the facility, of a personal care at a lults. For the purpor "abuse" including the facility, of a personal care at a lults. For the purpor "abuse to that a lults are a lults and personal care at a lults and p	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care al care attendant services elop an individual abuse each vulnerable adult ceiving services from them. Ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the person and other vulnerable poses of this paragraph, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	04/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAR	ONE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
22000	of a vulnerable adu misconduct or phys such information fro authority or through another facility, ano	ge 85  It's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by ther health care provider, or g assessments of the	22000			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed operationalize their abuse prohibition policy and procedures related to timely reporting to the State agency and / or investigate allegations of abuse, neglect, injuries of unknown origin and accidents with serious injury for 3 of 5 incidents reviewed which involved 3 of 3 residents (R138, R228, R152).					
	Findings include:					
	indicated R138 fell transfer from the will R138 lost his baland. The report indicated and the left side of indicated the director nursing supervisors note on the incident R138's care plan will staff assist was need ambulation. The present the staff assist was need ambulation.	lated 5/7/15, at 7:40 p.m. during a one staff assisted neelchair to the toilet when ce and fell against the wall. d R138 bumped his left arm his head. The report also or of nursing (DON) and the were notified. The nursing t report dated 5/8/15, indicated as updated to indicated two eded for transfers and edisposing physiological ed as weakness/fainted. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAR 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	report also indicated was notified on 5/7/ physician was notification, The incident report agency notification,  R138's undated Farprinted 6/4/15, indicincluded hemiplegial body) due to cerebro convulsions (seizur muscle weakness, disturbance, depressional A Fall Risk Evaluati R138 was at high rithe 90 days prior. Indicated R138 had ambulated with professional assistance to stability R138's Progress not the second stability of the sec	d R138's responsible party 15, at 7:50 p.m., and the ed on 5/8/15, at 2:04 p.m. lacked indication of State as required.  ce Sheet and Diagnosis List cated R138's diagnoses a (paralysis on one side of the rovascular disease (stroke), es), difficulty in walking, dementia without behavioral ssive disorder and anxiety.  on dated 5/6/15, indicated sk for falls and had 1-2 falls in The fall risk evaluation no cognitive changes, blems and a device, his gait he required physical	22000	DEFICIENCY)		
		ote dated 5/10/15 at 2:41 p.m., aplained of pain in his chest on				
	p.m. indicated R138	ote dated 5/10/15, at 10:30 3 complained of left side pain, rea. No bruising or swelling				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/	04/2015
-	PROVIDER OR SUPPLIER	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
22000	An order by the nur 5/11/15, directed ar and chest x-ray for A radiology report d	se practitioner (NP) dated  1 x-ray of the right and left ribs	22000			
	indicated a chest x- fractures of 3 ribs. placed to the assist (ADON) to report the report was reviewed R138 was spoken the fractures occurred to previous week and	ote dated 5/11/15, at 9:40 p.m. ray result included rib The note indicated a call was ant director of nursing the injury (fracture) and the fall d. The report also indicated to and he reported the when he had fallen the reported his pain level as 10 which indicated almost				
	R138 had falls with rib fractures. In add a 10 pound weight were too low and the had just been decreased. The note	s note dated 5/12/15, indicated injury and noted R138 had left lition, the NP noted R138 had loss and his blood pressures to blood pressure medication eased and labs had been also indicated the NP had od pressures and heart rate or one week.				
	assessment dated a moderate cognitive of care and require staff for transfers at	mum Data Set (MDS) 5/15/15, indicated R138 had deficit, displayed no rejection d extensive assistance of two nd ambulation. The MDS also balance problems and was				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE				
(VA) ID	SHIMMA DV STA	TEMENT OF DEFICIENCIES	PE, MN 5542	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETE DATE	
22000	Continued From pa	ge 88	22000				
	unsteady with position changes. In addition, the MDS indicated R138 had almost constant pain rated at 10 out of 10, which indicated almost unbearable pain.						
	5/15/15, indicated F falls due to balance changes and receive medication. The Cassistance with transhort distances in h	rea Assessment (CAA) dated R138 was potentially at risk for problems during position ring an antidepressant AA indicated R138 required asfers and would ambulate his room with staff assist and but the wheelchair was his ansportation.					
	R138's Progress note dated 5/29/15, at 7:45 a.m. indicated R138 reported, "someone busted up my neck." The note indicated when R138 was asked what was going on, he talked about how no one helped him the previous night, something was wrong with his neck and he wanted an x-ray. The progress note indicated R138 was told the charge nurse would be notified to schedule an x-ray and the doctor would be informed.						
	indicated R138 con neck, running along R138 stated he felt morning and said the way as to cause pa	ote dated 5/29/15, at 8:54 a.m. inplained of pain in the lower grupper shoulder blade region. In pain when moved by NA this nat he was moved in such a in in his neck. The progress assessed the location of					
		ord lacked any documentation notification related to the fall					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00238	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	NORTH RIDGE HEALTH AND REHAB NEW HO			E NORTH 28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 89	22000			
	medical record lack	actures. In addition, R138's ked any documentation related neck pain and rough				
	revised 2/9/15, indicand directed staff to protocol, review the attempt to determin possible root cause or remove any pote care plan further directions.	an initiated 6/12/14, and cated R138 was at risk for falls of follow the facility's fall enformation on past falls and ne cause of falls, record es of the fall, and then to alterential causes, if possible. The rected staff to educate the distaff regarding the causes.				
	R138's care plan for activities of daily living (ADLs), initiated 3/7/15, and revised 5/8/15, indicated R138 required the assistance of two staff for transfers, bed mobility and toilet use.					
	had the potential fo was able to call for able to reposition so communicate how	ated 4/24/15, indicated R138 r pain related to arthritis and assistance when in pain, was elf, ask for medication, much pain he was what increased or alleviated the				
	indicated R138 req staff for ambulation 4 ends, hemi cane)	or mobility initiated 3/7/15, uired the assistance of two with a quad cane (a cane with with a goal for R138 to the quad cane and assist of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00238	B. WING		06/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	REHAR	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	updated as recently was to ambulate wi 300 feet with the as quad cane on the ri indicated R138 was extensive assistant transfers with the queded varied daily confusion.  R138's care plan up R138 had a fall and R138's Resident Caby nursing assistant use of two staff for the quad cane for a for toilet use. The R139/15, indicated R15/15, indicated R15/15, indicated R15/15, indicated R15/15/15, indicated R15/15/15/15, indicated R15/15/15/15, indicated R15/15/15/15, indicated R15/15/15/15/15/15/15/15/15/15/15/15/15/1	ge 90  re plan printed 12/20/13, and as 1/15/15, indicated R138 th restorative nursing up to sistance of one staff using the ght side. The care plan at risk for falls, required se of 1 to 2 staff for pivot uad cane and assistance and determined to determine the care card was updated.  The care plan used the care card was updated.  The care plan used the care card was updated.  The care card was updated.  The care plan used the transfers, two staff assist with ambulation and two staff assist with the care card printed the staff for by the registered nurse sold, indicated R138's resident (5/14, indicated R138's resident the collowed during R138's incident 138 fell during a transfer with the RN-H stated this indicated the collowed during R138's incident the collowed during a transfer with the RN-H stated this indicated and been changed prior to the use of two staff assist for the could ambulate.	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	The facility Minnesor Tracking Form for with made by the facility indicated R138's into and the report of new by treatment by state of the morning and at disrespectful and ig stated he was not at the staff purposeful confirmed he had he from falls.  On 6/4/15, at 2:09 stated since prior to the assist of two state reported falls with munknown cause, broadtercations as well neglect and mistreat RN-H stated R138's related to the fall the during a transfer, he incident was reported should have been rimmediately.	ota Department of Health vulnerable adult (VA) reports lacked documentation which cident of 5/7/15, rib fractures eck pain alleged to be caused ff.  o.m. R138 stated some staff norning because they were in stated he was more sore in times, felt staff were mored his needs. R138 also fraid of staff and did not feel ly tried to hurt him. R138 ad broken bones and bruises  p.m. registered nurse (RN)-H or 12/5/14, R138 had required aff. RN-H stated the facility najor injuries, bruises of uises in odd spots and as allegations of abuse, atment to the State agency. It is fractured that week owever was unaware if the ead to the State agency. RN-H ons related to the neck pain eported to the State agency,	22000			
	(DON) stated she was resident care cards	o.m. the director of nursing would expect staff to follow the when providing cares as the adjuictual resident care plan for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	NA's to use. The DODON with all falls at were related to his verified R138's care the incident and the have been reported required. In addition allegation of neck pwas not reported th pain had diminished was to protect their staff member from allegation to the Staff member in dementia, arthritis a indicated R228's diagnoses in dementia, arthritis a indicated R228's diagnoses in dementia, arthritis a indicated R228's significant of indicated R228's diagnon-Alzheimer's de and hip fracture. The MDS indicated impaired decision in dependent on two significant in range in the MDS indicated impaired decision in dependent on two significant in range in the MDS indicated impaired in range in range in range in the MDS indicated impaired in range in r	ON stated staff called the nd stated R138's fractured ribs fall on 5/7/15. The DON e plan was not followed during a fall with a fracture should to the State agency, as n, the DON verified R138's ain and mistreatment by staff e next day because R138's d. The DON stated the nurse esident first, pull the alleged the floor and report the ate agency right away.  unwitnessed right hip fracture d to report timely to the State gate the incident as required.  S dated 2/6/15, indicated included, non-Alzheimer's and osteoporosis. The MDS memory loss, impaired ills, required limited assist with rring and used a walker and ility.  hange MDS dated 5/22/15,	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015
	PROVIDER OR SUPPLIER	SEHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
22000	R228's Nurse Programment of the note indicated lying on right side book The note indicated screamed when who note further reveale and rotated therefore physician and super The 9:29 a.m. nurse x-ray showed hip from the room, was combalance, impaired had weakness/faint R228's predisposing ambulating without The report indicated unattended, and care of fall.  Review of the facility indicated R228's fareport.  On 6/4/15, at 12:30 would not be on the report was not comfollowing R228's care RN-D added, it was an incident such as staff were following RN-D also verified the and investigation results.	ress note dated 2/14/15, at R228 was found on the floor, etween the bathroom door. R228 was yelling out and en right leg was touched. The ed R228's right leg was shorter re a telephone call placed to rvisor. The progress note indicated acture.  Report indicated R228 had a fall onfused, incontinent, had gait d memory, was non-compliant, ed. The report indicated g situation factors were	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00238	B. WING		06/04/2015	
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND RI	5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
were interviewed. The not their policy to rep R228's fall and hip from following R228's care R152 sustained a fragency, as required.  R152's undated Transindicated R152 had concerned and revealed arteriosclerosis and concerned and revealed rib. The section of the administrator and mewas blank. The Summas also blank.  The Investigation Re R152's incident occu 5/4/15, and location concerned and recommendation of the section of the administrator and mewas blank.	m. the administer and DON le administrator stated it was lort an incident such as acture because staff were le plan at the time of the fall.  Inctured rib of unknown origin to report timely to the State  Inster / Discharge report diagnoses of Alzheimer's led pain, coronary depression.  In Report dated 5/4/15, R152 had complained of right lined falling, an X-Ray was did an acute right 7th fractured le report form titled, date ledical director notification mary of Investigation section  In port-undated indicated lined / or was noted on lor incident was "unknown."  In the State agency was are was not reported	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/	06/04/2015	
	PROVIDER OR SUPPLIER	SEHAB 5430 BO	DDRESS, CITY, S'ONE AVENUE PE, MN 55428	NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
22000	On 6/5/15, at 3:00 p were interviewed. T VA report was not re RN supervisor show required. The admit supervisor involved and education was The facility policy at Abuse to the State Entities/Individuals suspected violation mistreatment, negle source, or abuse (in abuse) be reported	o.m. the administer and DON the administrator verified the eported timely and stated the uld reported the incident as nistrator stated the RN was given disciplinary action	22000				
	Signs and Sympton 2006, indicated neg provide goods and avoid physical harm illness. The policy or neglect including	nd procedure for Recognizing ns of Abuse/Neglect revised glect was defined as "failure to services as necessary to n, mental anguish, or mental identified some signs of abuse inadequate provision of care erence to resident's personal					
	Abuse to Facility Maindicated it was the employees to prom suspected incident including injuries of misappropriation of management. The employees must im	and procedure for Reporting anagement revised 9/12, responsibility of the ptly report any incident or of neglect or resident abuse, unknown source, and theft or resident property to facility policy and procedure directed mediately report any rincidents of abuse to their					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		06/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER		STATE, ZIP CODE			
NORTH I	RIDGE HEALTH AND	REHAR	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	administrator. In ac DON must be imme	buse coordinator and/or ddition the administrator or ediately notified of suspected of abuse regardless of the	22000			
	The administrator of procedures regardial alleged abuse/neadministrator could policies and procedures.	THOD OF CORRECTION: could develop policies and ng reporting and investigating eglect/mistreatment. The educate all staff on those lures. The administrator could ng system to ensure ongoing				
23240	(21) days.	R CORRECTION: Twenty-one  5 Ventilation Requirements:	23240			
23240	Existing Constructor  Existing facilities m ventilation in the kit collection room, soi areas, except if the semiprivate, and is	ust have mechanical exhaust chen, laundry, soiled linen led utility rooms, and toilet toilet area is private or provided with window ion must be provided	20240			
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview and document ailed to maintain functional / n in resident rooms numbered				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		00238	B. WING		06/0	4/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					1 00/0	.,_0.0	
		5430 BOO	NE AVENUE				
NORTH I	RIDGE HEALTH AND	REHAR	PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
23240	Continued From pa	ge 97	23240				
	·	), 326, 350, 366), where urine					
	Findings include:						
	the facility was comdirector (MD), administration, distributed administration, distributed and the following room urine odor and the facility and the following room and the facility and the fac	hroom vent was okay, no vent hroom vent was okay, MD p to the vent above the door in Gleenex did not adhere to the trated improper air flow. confirmed the vent in the open all the way. Once the opened it was okay. The vent oom 249 demonstrated vent in the bathroom and oom 326 demonstrated vent in the bathroom was re the door in room 350					
	okay, the vent above demonstrated impro- On 6/2/15, at 10:25	vent in the bathroom was the the door in room 366 oper air flow.  a.m. family member (FM)-A troom smelled like urine.					
		a.m. there was a very strong					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		06/0	4/2015	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
23240	Continued From pa	ge 98	23240				
		l in room 107 which permeated the 100 wing hallway on the					
	On 6/4/15, at 9:15 a verified room 249 h	a.m. the administrator and MD ad a urine odor.					
	bridgeway unit there	a.m. the MD verified on the e were no vents in the in the hallways, just in the is.					
	had gone down ran southwest wing and resident doors were the venting duct wo capped off at both allway. The MD st must have aborted the ventilation proje when the ventilation why it had not been because the duct whoth ends, this only	a.m. the MD confirmed he dom rooms on the two domnoe of the vents above the eworking. The MD confirmed ork in the ceiling had been ends on this two southwest ated it appeared the facility the project and not finished ext. The MD was unaware of a system had been installed or a finished. The MD stated work had been capped off on a allowed the ventilation system ent bathrooms and not in their					
	gone up on the root the fan. The MD co roof was hot and he the exhaust system be replaced. The M needed to be replace	p.m. the MD stated he had for the building and checked nfirmed the fan motor on the electermined that the motor of a had gone out and needed to ID verified the motor which ced would have affected the or the bathroom in between and 326.					
		a.m. the purchasing director odor permeating down the					

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 501251140.				
		00238	B. WING		06/0	4/2015	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
23240	Continued From pa	ige 99	23240				
		geway smelled like dead skin, d incontinence pads.					
	the 100 hallway of b	a.m. housekeeper (H)-A stated oridgeway smelled like urine all the way down the hallway.					
	2014 log indicated of had been upset with	CONCERNS TRACKING - on 8/5/14, family members h odors. In addition, on ad expressed concerns ell.					
		port [undated] indicated the ast been inspected on 5/31/15.					
	[undated] indicated maintain a clean, co	al Maintenance policy it was the facility's policy to omfortable environment for ociates and visitors.					
	The director of main and revise procedu maintenance and moventilation system. These procedures a	THOD OF CORRECTION:  Intenance (DM) could review res related to regular nonitoring of the exhaust The DM could train all staff on and how to report concerns. itor for continued compliance.					
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one					

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