MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

January 13, 2017

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

Re: North Ridge Health And Rehab Independent Informal Dispute Resolution
CMS Certification Number (CCN): 245183
Project # S5183025

Dear Ms. Guindon:

In a request dated April 18, 2016, North Ridge Health And Rehab requested removal of deficiencies cited at F314, F333 and F353 as a result of a complaint investigation and recertification survey completed on March 21, 2016 by the Health Regulation Division, Licensing and Certification section of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated November 18, 2016. The revised CMS 2567 is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz

Holly Kranz

CC: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Maria King, Assistant Program Manager
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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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. 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. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint, H5183122 was completed. The complaint was substantiated. Deficiency(ies) issued at F353, F282, F312 and F333. An investigation of complaint, H5183121 was completed. The complaint was substanitated. Deficiency(ies) issued at F353, and F312. An investigation of complaint, H5183110 was completed. The complaint was not substantiated. An investigation of complaint, H5183112 was completed. The complaint was not substantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157		5/3/16

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

Electronically Signed | 04/15/2016

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.

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F 157	Continued From page 1 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to notify family of the development of pressure ulcer on resident heels for 1 of 1 resident (R35). In addition, the facility failed to notify the medical doctor (MD) of the missed antibiotic for 1 of 1 resident (R305).	F 157	Preparation, submission and implementation of thie plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies	

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F 157	Continued From page 2 Findings include: R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed: - 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed was elevated 45 degrees. R35 had oxygen in place via nasal cannula. - 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about turning or repositioning before leaving room to get breakfast tray. R35 remained in same position as observed at 7:05 a.m. - 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's left heel and left without repositioning R35 off bottom. - 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35. During interview on 3/17/16, at 10:58 a.m. family member (F)-A said that in the last three weeks she [R35] had gotten so bad. "Three weeks ago she knew everything. They told me she had a bed sore on her bottom." F-A said, "No one told me about blisters on her heels." The facility provided a letter dated 3/22/16, from F-A which indicated "I was also aware of the pressure areas on her heels as the staff updated me regarding these concerns."	F 157	and licensing violations stated herein. This plan of correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance. F 157 R35 family has been notified. R305 MD has been notified. Each resident who has a accident resulting in injury with potential for requiring physician intervention, a significant change in status, a need to alter treatment significantly, or a decision to transfer or discharge, will have family and MD notification and is potential at risk related to this alleged deficiency. Licensed staff have been reeducated regarding notification of changes. Don/designee will audit 2 residents per unit per week to ensure that notification has occurred. Results of audit will be reviewed by QAPI	

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F 157	Continued From page 3	F 157		

During interview on 3/24/16, at 9:05 a.m. F-A stated, "They called me the next day after you spoke with me and told me about all of her ulcers."

R305 was observed on 3/16/16, at 10:57 a.m. to be very short of breath with audible wheezing and usage of accessory muscles. R305 was unable to complete initial interview due to shortness of breath. R305 was sitting upright in a wheelchair with oxygen on via nasal cannula. There was a nebulizer machine sitting on the table next to R305.

R305 was seen by the nurse practitioner on the evening of 3/16/16, and wrote orders for Keflex (antibiotic) 250 milligrams (mg) three times a day by mouth for seven days for bronchitis. The order read, "Start stat [immediately, without delay]!" albuterol nebulizer (neb-breathing treatment) 2.5 mg twice a day for five days stat every two hours and as needed (PRN) and "Prednisone (steroid that reduces inflammation) 10 mg stat" then every a.m. for four days.

The Geriatric Services of Minnesota Progress Notes dated 3/16/16, indicated (R305) "alert, up and dressed cough bothering her, does want antibiotic. Lungs with diminished breath sounds and audible wheezes. Assessment was 'bronchitis, not actively dying'." The plan was to treat with antibiotics, prednisone, and nebulizer treatments.

Review of the March 2016 Medication Administration Record (MAR) did not indicate the Keflex was given as ordered on 3/16/16.

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F 157	Continued From page 4	F 157		

Prednisone 10 mg stat was given at 6:06 p.m.

On 3/17/16, at 8:30 a.m. the trained medication aide (TMA)-A asked RN-G about R305's order for Keflex three times a day. TMA-A said "None has been given and it is not due until noon."

During interview on 3/17/16, at 2:12 p.m. RN-G said, "The order was inputted incorrectly. It was set up to start at noon, so I corrected it to 9:00 a.m." RN-G verified that Keflex had not been given on 3/16/16.

During interview on 3/18/16, at 10:03 a.m. nurse practitioner (NP) said, "I was called on the fifteenth and was told she looked like she was dying so I ordered Morphine (a narcotic). When I saw her on the sixteenth she was up in her chair having difficulty breathing but not dying, so I ordered nebs, prednisone and an antibiotic. 'STAT does not mean start the next day. It means as soon as possible.' No one notified me that there was an issue getting the antibiotic. Delays in giving stat medications are not acceptable."

Northridge 1 SW Omnicell (Southwest automated medication dispensing system) Inventory faxed to facility on 3/18/16, at 10:23 a.m. was provided as a list of medications available in the facility for emergencies. Cephalexin (Keflex) 250 mg was on the list.

During interview on 3/18/16, at 10:55 a.m. RN-H said, STAT meant as soon as possible. "There was an issue with scheduling the medication. If we start it in the evening she might not get all of her doses. There was no supply of the antibiotic until the morning. If we order a medication from the pharmacy STAT they can get it for us in four

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F 157	Continued From page 5 hours." RN-H was not sure if Keflex was in the emergency kit. On 3/18/16, at 12:06 p.m. RN-E nurse manager said STAT meant now. "Sometimes we cannot get the medications from the pharmacy. I expect staff to notify the medical doctor if they cannot give a STAT medication." Administering Medications Policy revised 2010, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed."	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		5/3/16

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F 225	Continued From page 6 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report and thoroughly investigate an incident involving 1 of 1 (R104) intoxicated resident documented to be threatening others with a knife. Findings include: R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5 pm. Hx [history] of alcohol abuse...Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note indicated R104's hospice agency and primary physician were notified of the incident and, "Received order to search resident's room and remove any alcohol found and continue to	F 225	F225 R104 Behavioral episode was reported and thoroughly investigated. Current resident have the potential to be affected by this alleged deficiency. Alleged violations are thoroughly investigated and measures put in place to prevent potential abuse during the investigation. Results of investigations are reported to the administrator or his designee and the State agency within 5 working days of the incident. Staff have been reeducated regarding reporting and investigating. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by QAPI	

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F 225	Continued From page 7	F 225		

monitor residents' VS [vital signs] and place on 15 min [minute] check for safety. Writer and NAR (nursing assistant) searched resident's room and found no liquor...Ok to monitor VS q [every] 1 hour for the next 2 hours then check VS q shift x 24 hours. Monitor for s/sx [signs and symptoms] of alcohol intoxications every shift and hold narcotics as needed. Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN (as needed) of resident room and room checks hourly and PRN for prohibited substances," "MD (medical doctor) orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify interventions to assist when R104's was actively drinking alcohol, what to do if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe related to R104's alcohol consumption.

R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. The care plan also included: R104 "prefers to hoard objects under w/c (wheelchair) cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and was "offered alternative storage of items and

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F 225	Continued From page 8	F 225		

declined." The care plan did not identify what staff should do if sharp objects were observed in R104's possession, or how to ensure the safety of other residents.

R104's significant change MDS dated 2/1/16, indicated R104 diagnoses included hepatic (liver) failure, cirrhosis, and severe cognitive impairment.

On 3/18/16 at 10:29 a.m. RN-K was asked about the 3/8/16 Progress Note regarding the resident's alcohol use and swinging of a knife, and RN-K stated she was not aware of the incident, and would not be informed every time R104 had been drinking. RN-K also stated that if a resident was identified as a danger to self or others, an immediate report would be made to the supervisor, assistant director of nursing (ADON), and DON, and staff would ensure the safety of the resident. RN-K stated that the progress note from 3/8/16 was a "unique situation" but if it was reported, a full investigation should be completed.

On 3/18/16 at 10:45 a.m., the DON was asked about the Progress Note dated 3/8/16, regarding R104's alcohol consumption and knife. The DON stated she did not recall the incident, but stated the ADON had been on-call that evening. The DON further stated she'd never been informed at any time of R104 swinging a knife at other people and would have expected to be informed if that had happened. The DON confirmed there was no incident report completed for the incident of 3/8/16, and no report was made to the SA. The DON also verified that having knifes or sharp objects was a "habit" of R104 that had been identified on R104's care plan.
At 12:51 p.m. on 3/18/16, the DON, ADON,

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F 225	Continued From page 9	F 225		

licensed social worker (LSW)-B and RN-H requested to discuss the Progress Note documentation from 3/8/16, at 5:49 p.m. with the surveyor. The DON stated RN-H had charted inaccurate information in R104's medical record because what RN-H had been charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member. RN-H then stated she'd charted what the ADON had told her when she was asked to come to R104's floor to assist due to R104's intoxication. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was what she was told by the ADON on the way down to R104's floor. The ADON then denied that, and stated she did not know where RN-H "got this information." The ADON and LSW-B stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician. The DON again stated the charting on 3/8/16, at 17:49 p.m. by RN-H was not accurate. "Hearsay" was charted and that was why she was not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and her expectation was staff was to chart accurate information. The DON additionally confirmed that had this incident occurred she would have expected the information to be reported to the administrator, law enforcement

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F 225	Continued From page 10 and the state agency (SA). RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN-H confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. based on what the ADON was now reporting. However, RN-H confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information at the time the chart entry was made. RN-H stated in any situation like that she would have informed her supervisor, but since her the ADON was her supervisor and had been the one to report the information RN-H did not follow up. RN-H stated by the time she got to R104's unit, R104 was not a threat to anyone and they did not send R104 to the emergency room. An interview with the administrator on 3/21/16, at 7:50 a.m. revealed he was contacted on the evening of 3/8/16, regarding R104 being "under the influence" and the resident had a box cutter. The administrator stated the ADON informed him R104 was upset, had a box cutter in his hands but denied R104 was threatening anyone. When asked about the 3/8/16, progress note in R104's medical record, the administrator stated what was charted in the progress note was not what he was told that evening. He stated the note was charted inaccurately and the nurse did not observe that type of behavior from R104. The administrator stated he expected staff to chart accurately and if that was what occurred that he should have been	F 225		

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F 225	Continued From page 11 informed. The administrator stated RN-H was given direction from the ADON, and it would have been a good idea for the ADON to review what was written. When asked why the progress note was not followed up and no information was provided further in the medical record, the administrator stated the facility "Can't go back and erase what was written" and was unsure about making a correction. The administrator also indicated that police would have been called if R104 had a weapon and was threatening people and reports would have been filed to the appropriate agency. A facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals, dated 3/16 indicated: All suspected incidents of abuse will be immediately reported to the stated agency. Additionally, the policy indicated under the definition of "verbal abuse" as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 intoxicated resident (R104) reported to be	F 226	F226 R104 Behavioral episode was reported to the state agency and administrator.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 threatening others with a knife was immediately reported to the administrator and the State agency (SA). Findings include: A facility policy titled Abuse Prevention Program, dated 3/16, and indicated, residents have the right to be free from abuse and neglect. A facility policy titled Reporting Abuse to Facility management- Revised 9/12, directed staff to report any suspected abuse to the administrator. The policy indicated the following definition: "neglect" the failure to provide the goods and services necessary to avoid physical harm. Additionally, the policy indicated under the definition of "verbal abuse" as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families. A facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals, dated 3/16, indicated: All suspected incidents of abuse will be immediately reported to the SA. R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5 pm. Hx [history] of alcohol abuse...Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note indicated R104's hospice agency and primary physician were notified of the incident and, "Received order to search resident's room and	F 226	Current residents have the potential to be affected by this alleged deficiency. Allegations of mistreatment, neglect, abuse of residents and misappropriation of resident□s property will be immediately reported to the administrator and State agency. Staff have been reeducated regarding implementation of the abuse and neglect policy and procedure. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 13	F 226		

remove any alcohol found and continue to monitor residents' VS [vital signs] and place on 15 min [minute] check for safety. Writer and NAR (nursing assistant) searched resident's room and found no liquor...Ok to monitor VS q [every] 1 hour for the next 2 hours then check VS q shift x 24 hours. Monitor for s/sx [signs and symptoms] of alcohol intoxications every shift and hold narcotics as needed. Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN [as needed] of resident room and room checks hourly and PRN for prohibited substances," "MD orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify interventions to assist when R104's was actively drinking alcohol, what to do if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol.

R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c [wheelchair] cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and R104 was "offered alternative storage of items and declined."The care plan did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14	F 226		

not identify R104's possession of sharp objects or knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.

R104's significant change MDS dated 2/1/16, indicated R104 diagnoses included hepatic (liver) failure, cirrhosis, and severe cognitive impairment.

On 3/18/16, at 10:29 a.m. registered nurse (RN)-K was asked about the 3/8/16, Progress Note in R104's medical record and stated she was not aware of the incident and that she did not need to be informed of every time that R104 had been drinking. RN-K also stated that if somebody was a danger to self or others an immediate report would be made to the supervisor, ADON and DON and staff would ensure the safety of the resident. RN-K stated that the progress note from 3/8/16 referred to a "unique situation" but if it was reported a full investigation should be completed.

The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. and the DON indicated she did not recall the incident but the ADON was on-call that evening. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated that she believed the incident involved a box cutter, not a knife. The DON verified the box cutter did have a sharp blade end, however stated that she was not aware of R104 swinging it at others and that no one was threatened or harmed. The DON could not verify who the "other people" were and was unaware if any other staff or residents were involved with the situation. The DON confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 15	F 226		

there was no incident report completed for the incident of 3/8/16 and no report was made to the state agency (SA). The DON also stated that having knifes or sharp objects was a "habit" of R104 and that was identified on R104's care plan. At 12:51 p.m. on 3/18/16, the DON, ADON, licensed social worker (LSW)-B and RN-H requested to discuss the progress note written on 3/8/16, at 5:49 p.m.

The DON began to discuss RN-H charted inaccurate information in R104's medical record for the Progress Note as RN-H charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member. RN-H stated she charted what the ADON had told her when she was asked to come to R104's floor to assist, as R104 was intoxicated. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was what she was told by the ADON on the way down to R104's floor. The ADON then denied that, and stated she did not know where RN-H "got this information." The ADON and LSW-B stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician. The DON again stated the charting on 3/8/16, at 17:49 p.m. by RN-H was not accurate. "Hearsay" was charted and that was why she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 16	F 226		

not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and her expectation was staff was to chart accurate information. The DON additionally confirmed that had this incident occurred she would have expected the information to be reported to the administrator, law enforcement and the state agency (SA).

RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN-H confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. based on what the ADON was now reporting. However, RN-H confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information at the time the chart entry was made. RN-H stated in any situation like that she would have informed her supervisor, but since her the ADON was her supervisor and had been the one to report the information RN-H did not follow up. RN-H stated by the time she got to R104's unit, R104 was not a threat to anyone and they did not send R104 to the emergency room.

An interview with the administrator on 3/21/16, at 7:50 a.m. revealed he was contacted on the evening of 3/8/16, regarding R104 being "under the influence" and the resident had a box cutter. The administrator stated the ADON informed him R104 was upset, had a box cutter in his hands but denied R104 was threatening anyone. When asked about the 3/8/16, progress note in R104's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17 medical record, the administrator stated what was charted in the progress note was not what he was told that evening. He stated the note was charted inaccurately and the nurse did not observe that type of behavior from R104. The administrator stated he expected staff to chart accurately and if that was what occurred that he should have been informed. The administrator stated RN-H was given direction from the ADON, and it would have been a good idea for the ADON to review what was written. When asked why the progress note was not followed up and no information was provided further in the medical record, the administrator stated the facility "Can't go back and erase what was written" and was unsure about making a correction. The administrator also indicated that police would have been called if R104 had a weapon and was threatening people and reports would have been filed to the appropriate agency. A facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals, dated 3/16 indicated: All suspected incidents of abuse will be immediately reported to the stated agency. Additionally, the policy indicated under the definition of "verbal abuse" as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify and implement appropriate interventions including the potential utilization of internal and external resources for 1 of 1 resident (R104) with an identified concern related to alcohol intoxication and aggression. Findings include: R104's significant change Minimum Data Set dated 2/1/16, indicated R104 diagnoses included hepatic (liver) failure, cirrhosis, and R104 had severe cognitive impairment. R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5 pm. Hx [history] of alcohol abuse...Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note indicated R104's hospice agency and primary physician were notified of the incident and, "Received order to search resident's room and remove any alcohol found and continue to monitor residents' VS [vital signs] and place on 15 min [minute] check for safety. Writer and NAR (nursing assistant) searched resident's room and found no liquor...Ok to monitor VS q [every] 1 hour for the next 2 hours then check VS q shift x 24 hours. Monitor for s/sx [signs and symptoms]	F 250	F250 R104 is receiving medically related social services including utilization of internal and external resources as appropriate. Current resident with a history of ETOH abuse have the potential to be affected by this alleged deficiency. Residents with ETOH use/abuse are receiving medically related social services including utilization of internal and external resources as appropriate. LSW□s have been reeducated regarding provision of medically related social services including utilization of internal and external resources. Lead Social worker/designee will audit up to 2 residents per unit, per week. Results of audits will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 19	F 250		

of alcohol intoxications every shift and hold narcotics as needed. Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN [as needed] of resident room and room checks hourly and PRN for prohibited substances," "MD [medical doctor] orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify interventions to assist when R104's was actively drinking alcohol, what to do if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol.

R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c [wheelchair] cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and R104 was "offered alternative storage of items and declined."The care plan did not identify R104's possession of sharp objects or knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 20	F 250		

R104's undated Kardex Report directed staff under the "Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" and that R104 was "aware of the risks." The Kardex further identified "MD orders to hold narcotic medications for lethargy and updated MD PRN for substance abuse. Psych [psychiatrist] orders received." Additionally, the Kardex included "monitor for use of ETOH, NAR [nursing assistant registered] to report to nurse. Nurse if observed to have signs of impairment to ETOH, call MD for orders." The "Behavior" section of the Kardex identified R104 "was at risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons." The hourly checks were not documented anywhere in the medical record.

A vulnerability assessment was requested for R104. On 3/21/16, at 10:32 a.m. the director of nursing (DON) stated "Our social workers don't do a specific VA [vulnerable adults] assessment because all residents when they are admitted are VA." The DON further stated the "asterisks denote some vulnerability on the care plan."

An interview on 3/17/16, at 7:45 a.m. with nursing assistant (NA)-E revealed that "a while ago" R104 "had a big problem with drinking" and had "behaviors when drinking, he likes to swear. I think, he thinks he needs more help than he does and he gets an attitude. I'm not sure how he is getting alcohol, I haven't heard lately. He used to leave sometimes when he had a power chair to the liquor store down the road. " At 11:25 a.m. registered nurse (RN)-I stated that she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 21	F 250		

aware of R104's alcohol use and stated the last time R104 had used alcohol was "maybe two weeks ago." R104 had "gone out and come back drunk." R104's physician was updated and an order was obtained to hold medications at those times and to monitor for intoxication. When asked about R104 leaving the facility, RN-I stated "He signs out up front at the desk sign out, he is able to do that and he goes and sits out front of the facility." RN-I also stated R104 used Metro Mobility for transportation, arranged his own rides and went to the bank and went shopping. At 9:34 a.m. NA-F revealed R104 refused help a lot when he had been using alcohol and noted R104 "drank liquor last week" and he "curses a lot and is very aggressive when he's been drinking." NA-F was unable to provide a date and time to R104's alcohol consumption. At 2:22 p.m. licensed practical nurse (LPN)-B revealed R104 "drinks all the time" and "gets drunk." LPN-B revealed the physician ordered methadone (used as a pain reliever) cannot be given if R104 has been drinking. LPN-B stated she had "been here seven months and this is an ongoing issue." LPN-B stated R104 had been using alcohol on her shift "for a couple months" and noted R104 to be using alcohol "multiple times per week." LPN-B further revealed that she "wouldn't be surprised" if R104 was "drunk" and he "just leans over and sleeps on the armrest" of his w/c. When asked about the specific interventions for R104 when intoxicated and how/where to document issues, LPN-B replied "I don't know, I would hope it would be my TAR [treatment record] and to monitor for intoxication." When asked what else she was directed to do when R104 has been using alcohol, LPN-B replied "nothing, just monitor-15 min checks, he will usually pass out in his wheelchair." LPN-B went on to say that if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 22	F 250		

R104 was "belligerent, pushing, slapping, yelling or swearing" she would call the charge nurse or supervisor. LPN-B stated she had never had to call the hospital due to R104's alcohol use. When asked where R104 obtained alcohol LPN-B stated "There's a lot of suspicions that one liquor store delivers close by the front door and that one supervisor happened to be in the front area once and confiscated it before it was open. I've never seen a visitor outside of facility and never seen him leave the facility."

On 3/18/16, at 8:37 a.m. RN-J revealed she was aware of R104's drinking and "it's been awhile since I have seen him do it." When asked what was done when R104 was using alcohol, RN-J replied "usually" a room search was completed, no pain medications were given and the physician or hospice was notified. When asked how often room searches were completed RN-J replied "I don't know of a room search, usually if suspected drinking, that's just my guess." At 8:48 a.m. NA-G revealed R104 used to drink "most of the time" and would come back from lunch "always drunk." NA-G would tell the nurse and the nurse would take R104 back to his room. NA-G stated she has not witnessed that recently, "its maybe been a month now" but she would tell the nurse and then management would be informed. At 8:54 a.m. NA-H revealed R104 was often found by staff in the dining room "after he has been drinking and smells of alcohol." NA-H stated the last time that occurred was "a week and a few days ago." NA-H stated he told the nurse about R104 smelling of alcohol and the nurse brought him back to his room. NA-H stated he was not sure where R104 got the alcohol or where he drank it. NA-H stated he was unsure if R104 left the facility property as he never followed R104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 23	F 250		

down the elevator and was unsure of where he went when he was off of the nursing unit. At 10:13 a.m. licensed social worker (LSW)-A indicated she "sometimes checks his room for alcohol if staff thinks he is intoxicated. We complete random checks if we suspect intoxication; I have never found alcohol. " When asked how often checks are completed LSW stated it "just depends, nurses do it too" when asked what it "depends" on she stated she was "not sure what it depends on." LSW-A went on to say she thought R104 left the building and "goes out with Metro Mobility- not with any supervision, he tells the Health Unit Coordinator [HUC] and he usually signs out. He tells the HUC or charge nurse, as long as he is signed out he can leave." When asked if there was an assessment to determine if a resident could leave the facility unsupervised, LSW-A responded that it was based off a nursing assessment, and that she was not aware of any assessment or requirement for anyone to leave. LSW-A stated she had asked about the facility's alcohol policy and had "not received an answer on one." At 10:29 a.m. RN-K was interviewed and when asked about R104's alcohol use, RN-K replied that it was a "typical thing" for R104. RN-K went on to say staff was directed to complete random room searches for alcohol, hold narcotics and monitor the resident if he appeared intoxicated. When asked who was responsible for the room searches, RN-K replied that "typically social services" was responsible. RN-K indicated the facility staff found vodka bottles outside of the facility in planters and indicated these were R104's bottles. RN-K also stated staff was unable to identify where or how R104 obtained alcohol but he was "friends with everyone" at the facility and the connected assisted living facility. When asked if there was any interventions in place to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 24 prohibit R104's alcohol use, RN-K stated R104 was encouraged to participate in more activities on the unit and that Alcoholics Anonymous (AA) had been discussed but declined by R104. RN-K was aware R104 often had knives in his possession and presented two knives described as steak knives, that she had removed from R104's possession that she kept locked up in her office. RN-K stated the knives were identified on R104's care plan and R104 had been talked to multiple times about it. In addition, R104 was at risk for skin breakdown because R104 punctured his wheelchair cushion with the sharp objects. On 3/18/16 at 11:50 a.m. the DON confirmed she was aware of R104's alcohol use. When asked where R104 obtained alcohol, the DON indicated the facility staff was unaware of where R104 obtained his alcohol and R104 left the building unsupervised and arranged his own transportation. The DON stated R104 purchased the alcohol himself and she was aware of a liquor store that delivered to the home. The DON further stated R104 had been offered support to discontinue drinking such as AA meetings, however that was not identified in R104's medical record. The DON also stated that having knifes or sharp objects was a "habit" of R104 and that was indicated on R104's care plan. The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. and the DON indicated she did not recall the incident. The assistant director of nursing (ADON) was on-call that evening. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated she believed the incident involved a box cutter, not a knife.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 250	Continued From page 25	F 250		

At 12:51 p.m. on 3/18/16, the DON, ADON, licensed social worker (LSW)-B and RN-H requested to discuss the progress note written on 3/8/16, at 5:49 p.m.

The DON began to discuss RN-H charted inaccurate information in R104's medical record for the Progress Note as RN-H charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member. RN-H stated she charted what the ADON had told her when she was asked to come to R104's floor to assist, as R104 was intoxicated. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was what she was told by the ADON on the way down to R104's floor. The ADON then denied that, and stated she did not know where RN-H "got this information." The ADON and LSW-B stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician. The DON again stated the charting on 3/8/16, at 17:49 p.m. by RN-H was not accurate. "Hearsay" was charted and that was why she was not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and her expectation was staff was to chart accurate information. The DON additionally confirmed that had this incident occurred she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 26	F 250		

would have expected the information to be reported to the administrator, law enforcement and the state agency (SA).

RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN-H confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. based on what the ADON was now reporting. However, RN-H confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information at the time the chart entry was made. RN-H stated in any situation like that she would have informed her supervisor, but since her the ADON was her supervisor and had been the one to report the information RN-H did not follow up. RN-H stated by the time she got to R104's unit, R104 was not a threat to anyone and they did not send R104 to the emergency room.

There was no documentation to support LSW-B's interaction with R104 on 3/8/16, or documentation the removal of the box cutter from R104's possession. No new interventions were added to R104's care plan following the incident. Although R104 had a significant issue with alcohol consumption, aggressive tendencies when intoxicated, and created a potential threat to residents, visitors and staff when intoxicated, there were no individualized interventions in place to ensure the safety of R104 and other residents. In addition, staff was unaware of the interventions currently in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care (POC) for 2 of 7 residents (R511, R429) who were identified as smokers. Findings include: R511 was observed on 3/14/16, at 8:10 p.m., was outside smoking a cigarette. He was using oxygen via nasal cannula, running at four liters. A Progress Note dated 1/5/16, indicated R511	F 279	F279 R511 and R429 have comprehensive care plans that include smoking. Current resident who smoke while residing at the community have the potential to be affected by this alleged deficiency. Residents who choose to smoke have comprehensive care plans that include smoking. Licensed staff have been educated regarding comprehensive care plans that include smoking. Lead Social worker/designee will audit up	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 28 told activity aide (AA)-O, "I just want to go outside and smoke." R511's significant change Minimum Data Set (MDS) dated 1/15/16, indicated he was cognitively intact and required staff assistance for all activities of daily living. R511's care plan dated 2/5/16, did not address smoking. During an interview on 3/14/16, at 8:13 a.m., the administrator stated all residents sign an agreement on admission that they acknowledge the facility is smoke free. He stated if residents go outside to smoke they have been identified as able to smoke independently. During an interview on 3/14/16, at 8:26 p.m., the director of nursing (DON) stated R511 did not have a smoking assessment completed. She stated he had not been identified as a resident who smoked. She further stated, all residents sign a smoking agreement as part of their admission. A Smoking assessment was completed on 3/14/16, after the administrator and DON were notified of R511 smoking with his oxygen in use. The assessment indicated R511 needed reminders not to smoke with his oxygen running, however, smoking safety was not added to R511's care plan. During an interview on 3/15/16, at 10:37 a.m., R511 stated he had not been outside to smoke prior to the previous night. He further stated he did not know where he got the cigarette. R511 stated he was told on admission if he wanted to smoke he would have to go outside.	F 279	to 2 smoking residents per unit per week for comprehensive smoking care plans. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 29	F 279		

During an interview on 3/15/16, at 2:03 p.m., nursing assistant (NA)-T stated she was unsure if R511 smoked. She stated she knew he went outside but did not pay attention to whether or not he was smoking.

During an interview on 3/15/16, at 2:06 p.m., licensed practical nurse (LPN)-C stated R511 was asked about smoking on admission and stated he did not smoke. She stated she had never seen him smoke but stated he does spend his time out in the common area by the front door.

During an interview on 3/15/16, at 2:16 p.m., AA-O stated R511 told her he wanted to go outside and smoke. She stated she "did not remember" if she had told anyone.

During a subsequent interview on 3/15/16, at 3:23 p.m., the administrator stated the facility had identified smoking as a concern. He stated the student administrator had been completing audits and determining when residents are going outside to smoke. He stated residents will outside to enjoy the weather and then decide to smoke. He stated, "This is a major concern for us."

While R511 was observed smoking a cigarette with his oxygen running, and had expressed a desire to smoke, the facility assessed a need for reminders regarding smoking with oxygen but there was no evidence R511's care plan was updated to include smoking safety.
R429 was admitted 2/17/16, with admission diagnoses of repeated falls, medication mismanagement, traumatic brain injury (TBI) with seizures. R429 signed smoking contract 2/17/15.

A smoking assessment was completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 30	F 279		

2/19/16, the assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette, and did not state if the resident was safe to smoke or had limitations. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community smoking rules description.

On 3/14/16, a smoking care plan was initiated (after surveyor intervention) and indicated resident chooses to smoke despite facility no smoking policy. The goal will be encouraged to comply with no smoking policy. The resident would be encouraged to decrease smoking. Interventions were to offer nicotine patch if R429 chooses and the smoking assessments quarterly. R429 did not have an identified care plan for smoking in the medical record.

At 9:59 on 3/15/16, stated she had cigarettes and lighter in jacket pocket (jacket draped over w/c, no evidence of burns), smokes down the road away.

On 3/15/16, at 10:07 a.m. observation of the TCU entrance, had more than 75 cigarette butts on the ground on 3/15/16. There was a garbage with a plastic liner covered but with open sides, and a large green bin of sidewalk salt.

On 3/18/16, at 10:30 a.m. the DON stated the facility started smoking focus group and talked to smokers. They noted that, "we didn't have ashtrays out. The facility was revamping policy about no smoking, people know it's a no smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 31 facility, and sign contract agreeing not to smoke and then go out to smoke anyway. The assessments were done on people who identify themselves as smokers on admission assessment, nurses do assessment on safe smoking. A new task force on smoking was developed. We are still in the process of planning and care planning." The facility had residents smoking at the main entrance and at the TCU entrance, but lacked any safe smoking receptacles to put out cigarettes and put cigarette butts safely into.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 32 by: Based on observation, interview and document review, facility failed to revise the care plans for 2 of 2 residents (R35, R62) to reflect changes in care required with development of pressure ulcers and decline in condition. In addition, the facility failed to revise the plan of care (POC) for 1 of 5 residents (R104) who were identified to be currently using alcohol and carried a knife under the wheelchair (w/c) cushion. Findings include: R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed: - 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed was elevated 45 degrees. R35 had oxygen in place via nasal cannula. - 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about turning or repositioning before leaving room to get breakfast tray. R35 remained in same position as observed at 7:05 a.m. - 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's left heel and left without repositioning R35 off bottom. - 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35. The heels were left flat on the mattress after the treatment had been completed. The heels were not placed in a position to relive	F 280	F280 R35 is discharged. R62 and R104 have had their care plans revised to reflect current status. Current resident with skin breakdown or who have a history of etoh abuse have the potential to be affected by this alleged deficiency. Residents who have skin ulcerations or consume alcohol have been reviewed and care plans revised as appropriate. Licensed staff have been educated regarding care plan revisions for residents with skin alterations and residents who consume alcohol. DON/designee will audit up to 2 residents per unit per week to ensure appropriate revisions of care plan. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 33	F 280		

pressure.
-9:32 a.m. R35 was being fed breakfast and still not one offered to reposition her.

The annual Minimum Data Set (MDS) dated 2/5/16, indicated R35 was modified Independence with decision making. R35 required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35 had a history of falls in the last 90 days and was identified as at risk for the development of pressure ulcers. R35's MDS indicated R35 had diagnosis of heart failure, anemia, peripheral vascular disease, arthritis, dementia, and dysphagia (difficulty swallowing).

R35's Pressure Ulcer Care Area Assessment (CAA) dated 2/12/16, indicated R35 had risk for pressure ulcers related to being incontinent of bladder, below normal weight, and needing assist with bed mobility. CAA also indicated skin was intact and free of breakdown. CAA indicated R35 had a ROHO cushion (air filled cushion to reduce pressure on bottom while sitting) in chair and would care plan interventions to minimize risk factors for skin breakdown,

R35's Urinary CAA dated 2/12/16, indicated R35 was frequently incontinent of bladder and needed assist with toileting, managing clothing, peri care and incontinent pad. R35's CAA indicated facility would care plan interventions to manage incontinence when it occurs and reduce potential for complications related to incontinence.

Pressure ulcer care plan dated 3/3/16, identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 34	F 280		

that "R35 has the potential for skin breakdown/bruising r/t [related to] fragility/aging, incontinence, Prednisone [a steroid medication] use- has chronic senile purpura of both limbs and muscle wasting. The resident also had a diagnosis of peripheral vascular disease with the right great toe being ischemic, lower extremity edema, and history of ulceration. "Resident with skin breakdown on buttock r/t refusal to turn and reposition, end of life." The care plan instructed staff: "Creams/ointments/tx [treatments] as ordered, encourage side to side positioning - resident reluctant but encourage, encourage to sit with legs elevated as she allows, R35 has a ROHO cushion in WC pressure reduction mattress on bed. Check cushion inflation q [every] shift, observe skin daily with cares report concerns to licensed nurse, and skin check weekly on bath day by licensed nurse, treatments per MD/NP orders." While the care plan identified R35 as having skin breakdown on the buttocks, it did not address heel ulcers or Kennedy Ulcer. The care plan did not address the location or stages of ulcers. The care plan was not revised to include interventions to reduce pressure on the on heels.

On 2/29/16, the treatment sheet noted to keep heels dry and offload heels while blisters were intact. The care plan lacked direction for the staff on how to relieve pressure on the heels while in bed.

The Visual Bedside Kardex Report sheet dated 3/17/16, (after surveyor intervention) instructed staff to encourage R35 to allow side to side positioning, R35 "can turn and reposition using bilateral grab bars. Staff assist of two every 2 hours and PRN, per preference. Family is aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 35	F 280		

of resident refuse to turn and reposition. The risks and benefits was provided to resident and family." In addition, staff were to check and change R35 every two hours and as needed, Keep heels dry and off load pressure while blisters are intact. However the sheet lacked direction for the staff on how to relieve pressure on the heels while in bed.

A Progress Note dated 3/5/16, at 1:00 p.m. "Oh please don't move me. I'm hurting so much. My legs are hurting bad. Don't make me turn please." The note indicated staff were to continue to encourage turning/ repositioning every two hours as resident allowed to reduce pressure on buttocks. The medical record lacked any information of relieving pressure on the heels.

During interview on 3/17/16, at 12:46 p.m. with RN-E and RN-J, RN-E said "When I spoke to you Monday and today to the best of my knowledge [R35] had three pressure ulcers; one on her coccyx and two on her heels. [RN-G] told me [R35] had a new stage three wound on left lateral posterior upper thighs." RN-E said that when a new wound is found it is our facility protocol is to use risk assessment to document the wound. RN-E verified the care plan did not indicate R35 had current pressure ulcers nor was hospice on the care plan until after survey had started. RN-J stated R35's significant change in condition happened in March.

During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said the nurses look at the skin weekly. The ADON said the process is the nurse manager enters documentation regarding wounds on the pressure /non pressure ulcer report. ADON stated, "I would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 36	F 280		

expect to a nurse to document finding a new wound and alert nurse manager and nursing supervisor, notify hospice physician and family and put it on the 24 hour report. The nurse should pass it on in report including new open areas."

R62's Weekly Skin Report dated 12/31/15, indicated he had a pressure ulcer on his right buttock that was resolved. The care planned interventions at that time directed staff to complete weekly skin checks and encourage R62 to avoid positioning on coccyx. The care plan further indicated R62 was able to reposition himself in bed, however, his quarterly assessment dated 11/27/15, indicated he required extensive assistance from two staff. There was no evidence of weekly skin assessments between 12/31/16 and 1/27/16, at which time, a facility Weekly Skin Condition Report indicated a new pressure ulcer to R62's right buttock.

R62's care plan dated 1/14/16, indicated he was at risk for pressure ulcers, admitted to the facility with a pressure ulcer on his coccyx and had a history of re-opening pressure ulcers.

R62's care plan was updated on 2/9/16, however, no new interventions were implemented even though R62 had developed a new pressure ulcer. The care plan continued to direct staff to encourage R62 to avoid pressure to his coccyx even though his MDS indicated he required extensive assist of two staff for bed mobility.

R62's quarterly MDS dated 2/26/16, indicated he had no cognitive impairment, required extensive assist of two staff for bed mobility and transfers, and had a stage IV pressure ulcer (Full thickness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 37	F 280		

skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers).

During an observation on 3/16/16, at 3:06 p.m., R62 was lying in bed on his back watching television. During observations on 3/17/16, at 7:22 a.m., 7:50 am, and 8:44 a.m., R62 remained in his room lying in bed.

During an interview on 3/17/16, at 11:08 a.m., nursing assistant (NA)-K stated she was unaware of R62's skin condition. She stated, "I think there is an open area on his bottom." She further stated, R62 had no scheduled cares and stated if he needed anything he would put his light on.

During an interview on 3/17/16, at 11:11 a.m., licensed practical nurse (LPN)-C stated, R62 has a couple of open areas to his bottom and has daily dressing changes. She stated during his dressing changes he is able to hold on to the grab bar, she further stated staff are supposed to go in and offer repositioning every two hours. However, there was no care planned interventions directing staff to do that. LPN-C stated RN-M was responsible for the care plan.

During an interview on 3/17/16, at 11:17 a.m., registered nurse (RN)-M stated, R62 had a stage IV pressure ulcer when he moved to the unit. She stated the wound had healed on 12/31/16, and opened up again on 1/20/16.

During an interview on 3/17/16, at 3:07 p.m., the director of nursing (DON) stated, R62 "is pretty good at repositioning himself." She stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 38	F 280		

changed position in bed but was not sure if he was able to offload. While R62 was at increased risk for pressure ulcers and required staff assistance for repositioning, the facility did not implement interventions to ensure offloading of pressure from R62's bottom. Further, while previous pressure ulcers had healed and re-opened, the care plan was not revised with new interventions to prevent worsening of existing pressure ulcers or prevention of new pressure ulcers.

R104's significant change MDS assessment dated 2/1/16, indicated R104 had diagnoses that included hepatic failure and cirrhosis. The MDS also revealed R104's cognition was severely impaired.
R104's progress note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5pm. Hx [history] of alcohol abuse ... Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 [one to one] for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note identified R104's hospice agency and medical doctor (MD) were notified of the incident, an order was obtained to search R104's room for liquor, but none was found, and staff identified they would, "Monitor for s/sx [signs and symptoms] of alcohol intoxication every shift and hold narcotics as needed." Further, the note identified, "Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 39	F 280		

R104's care plan identified R104 had "end stage liver disease, hx [history] of ETOH [alcohol], r/t cognitive impairment, hx of coffee ground emesis, hx of ETOH. Often refuses lactulose and is aware of the risks and benefits. R104 "has a history of abnormal labs. " Interventions include " frequent safety checks hourly and PRN [as needed] of resident and room checks hourly and PRN for prohibited substances. Resident is aware of the risks. MD [medical doctor] orders to hold narcotic medications for lethargy. Update MD PRN for substance abuse. Psych orders received. Revisit and remind of activities that may interest, 1:1 visits and chaplain support PRN. "
The care plan failed to identify R104's current alcohol use, what interventions staff should attempt if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol.
R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c cushion including sharp objects like scissors" R104 "is aware of the risks and benefits" and R104 was "offered alternative storage of items and declined. "
The care plan did not identify R104's possession of knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.
R104's Kardex Report directed staff under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 40	F 280		

"Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" also included "frequent room checks hourly and PRN for prohibited substances" and that R104 was "aware of the risks". The Kardex further identified " MD orders to hold narcotic medications for lethargy and updated MD PRN for substance abuse. Psych orders received. " Additionally, the Kardex included "monitor for use of ETOH, NAR to report to nurse. Nurse if observed to have signs of impairment to ETOH, call MD for orders. " The "Behavior" section of the Kardex identified that R104 "was at risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons".

Information identified on the Kardex Report under the "Safety" section was not identified on R104's care plan.

A vulnerability assessment was requested for R104. On 03/21/2016 at 10:32 a.m. the DON stated that " Our social workers don't do a specific VA assessment because all residents when they are admitted are vulnerable adults" and stated that "asterisks denote some vulnerability on the care plan. "

An interview with RN-K on 3/18/16 at 10:29 a.m. revealed that RN-K was asked about the 3/8/16 progress note in R104's medical record stated that she was not aware of the incident and that she did not need to be informed of every time that R104 had been drinking. RN-K was also aware that R104 often has knives in his possession and then presented to the surveyor two knives (RN-K described as steak knives) that she had removed from R104's possession that she keeps locked up in her office. RN-K stated that this information is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 41	F 280		

on R104's care plan (regarding R104 having knives) and R104 has been talked to multiple times about it and is at risk for skin breakdown because R104 punctures his wheelchair cushion with the sharp edges.
The DON confirmed that she was aware of R104's alcohol use. When asked where R104 obtains alcohol, the DON indicated that the facility staff is unaware of where R104 obtains his alcohol and that R104 leaves the building unsupervised and arranges his own transportation. The DON stated that R104 purchases alcohol himself and that she is aware of a liquor store that delivers. The DON also stated that having knifes or sharp objects was a "habit" of R104 and that this was indicated on R104's care plan.
An interview with the Director of Nursing (DON) on 3/18/16 at 11:30 a.m. revealed that there was no assessment completed to determine if R104 was able to leave the building unsupervised however indicated that his placement in the facility (on the second floor) indicated that he was able to leave the facility unsupervised and that the nurses know who is able to leave the facility safely. The DON stated R104's alcohol use was identified on his care plan. When asked where this was on R104's care plan the DON displayed the care plan and pointed to the focus of "end stage liver disease, hx of ETOH, r/t cognitive impairment, hx of coffee ground emesis, hx of ETOH. Often refuses lactulose and is aware of the risks and benefits. R104 "has a history of abnormal labs". Interventions include "frequent safety checks hourly and PRN of resident and room checks hourly and PRN for prohibited substances. Resident is aware of the risks. MD orders to hold narcotic medications for lethargy. Update MD PRN for substance abuse. Psych

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 42	F 280		

orders received. Revisit and remind of activities that may interest, 1:1 visits and chaplain support PRN". The DON indicated that with what was listed as interventions that "any reasonable and prudent nurse" would know that he is currently using alcohol and what to do if R104 was intoxicated at the facility. The DON further stated that R104 has been offered support to discontinue drinking such as AA meetings, however this was not identified in R104's medical record. The DON further indicated that room checks should be completed hourly (as identified on R104's care plan) by the nursing assistants (NA's) but that nurses could complete this as well. The DON confirmed that she expects staff to be aware and follow R104's care plan. The DON confirmed that the facility did not have an alcohol policy.

POLICY

A policy entitled Care Plans-Comprehensive dated November 2012 indicated that "the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians orders. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change." The policy further indicates that

"each resident's comprehensive care plan is designed to:

a. Incorporate identified problem areas;

b. Incorporate risk factors associated with identified problems;

c. Build on the resident's strengths;

d. Reflect the resident's expressed wishes regarding care and treatment goals if applicable;

e. Reflect treatment goals, timetables and objectives in measurable outcomes;

f. Aid in preventing or reducing declines in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 43 resident's functional status and/or functional levels; g. Enhance the optimal functioning of the resident". A facility policy labeled Care Plans-Comprehensive, dated November 2012, indicated The Care Panning/Interdisciplinary team is responsible for the priodic review and updating of care plnas: when there has bee a significant change in the residents condition, and when the desired outcome is not met.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R439) was repositioned as directed by the care plan; the facility failed to provide personal hygiene care for 1 of 1 resident in the sample (R35) who was dependent upon staff for personal cares according to the plan of care; and the facility failed to provide ambulation assistance to improve or maintain each resident's ability for 1 of 1 resident (R179) according to the plan of care. Findings include: Repositioning: R439 was admitted to the facility on 9/15/15, after	F 282	F282 R439 and R179 are receiving services by qualified persons per care plan. R35 has been discharged. Current resident have the potential to be affected by this alleged deficiency. Residents are receiving services by qualified persons per care plan including personal hygiene, turning and repositioning and ambulation assistance. Nursing staff have been educated regarding the provision of personal hygiene, turning and repositioning and ambulation assistance. DON/designee will audit will audit 2 residents per unit per week to ensure	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 44 extensive hospitalizations in acute care hospitals and long term acute care hospitals. 439's admission diagnosis from the Face Sheet included paraplegia [functional], pressure ulcer of sacral region Stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers), type II diabetes and morbid obesity, and major depression. The initial care plan dated 9/28/15, indicated R439 had pressure ulcers and potential for pressure ulcers development related to disease process, prolonged immobility. There was no discussion on the care plan of where the pressure ulcers were or any stages listed. The initial goal dated 9/28/15, indicated R439's pressure ulcer will show signs of healing and remain free from infection. The initial interventions dated 9/28/15, indicated, " Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Inform the resident and family/caregivers of any new area of skin breakdown. Pressure relieving/reducing device in bed/chair. Treat pain as per orders prior to treatments/turning etc. to ensure comfort. Educate R439/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. " On 3/17/16, continuous observations from 5:45 a.m. until 8:00 a.m. the resident was not repositioned, or approached to be repositioned.	F 282	appropriate provision of care by qualified persons. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 45	F 282		

At 6:24 a.m. registered nurse (RN)-P, knocked and entered room for blood glucose test. At 7:08 a.m. RN-B entered room without knocking, then called R439 by name, she left the room within 15 seconds of entering and placed something in the treatment cart garbage. At 11:16 a.m. RN-B stated she had entered his room the first time to get his blood sugar and the second time to give insulin. At 8:03 a.m. resident R439 was interviewed and stated he had not been turned on the night shift. At 8:05 a.m. RN-N was notified that the resident had not been turned during the time of continuous observation, and that the resident had stated he had not been turned all night. RN-N stated "He should be turned every two hours. "

On 3/18/16, at 9:08 a.m. R439 was interviewed and stated he had returned to facility last night from North Memorial Medical Center where he had been assessed in the emergency department. When asked when he had last turned, R439 responded last night at 8:30 p.m. At 9:52 a.m. notified RN-N, that resident stated not turned since 830 p.m. RN-N stated the charge nurse had shown him in point of care (POC - nursing assistant care tracking system), that R439 refused to turn. RN-N opened the POC charting and stated last turned at 11:09 p.m. There was no documentation for the night shift. RN-N stated the aide should inform the nurse when R439 refused (because aides cannot document more than yes or no). RN-N did verify the resident should be given the risks and benefits of refusal of repositioning and the risks and benefits and refusal should be documented each time he refused. A review of the nursing notes lacked documentation that R439 refused to turn. RN-N stated, " After you talked to me, I put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 46	F 282		

the orders for NA to continue repositioning on the care plan, I told nurses to document if he refused. " At 11:04 a.m. RN-N, stated he had interviewed R439 who told him "They [staff] do not reposition him at night."

The facility was able to print out the last 30 days of NA charting for bed mobility, turning and repositioning which revealed that out of four opportunities per shift (12 opportunities per day), a total of 360 opportunities there were 84 actual documentation as follows:
- On 2/20/16, 2/2816, 3/5/16, 3/8/16, 3/11/16, and 3/17/16, the night shift NA did not document anything on R439 for turning and repositioning.
- On 2/21/16, 2/26/16, 3/4/16, 3/9/16, 3/10/16, and 3/18/16, the NA documented " NO " once, for turning and repositioning.
- On 2/27/16, 2/29/16, 3/9/16, 3/14/16, and 3/15/16, the NA charting indicated the resident refused to turn once per shift, however there was no evidence that the NA informed the nurse who was then expected to re-approach R439 or document the risks and benefits of refusal to turn in the nursing Progress Notes.

On 3/18/16, at 10:24 p.m. the director of nursing (DON) stated she spoke to the evening supervisor and R439 frequently refused to be turned at night.
-At 10:41 a.m. the DON verified expectation that aides would follow the care plan.

Toileting:
R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed:
- 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 47	F 282		

was elevated 45 degrees. R35 had oxygen in place via nasal cannula.
- 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about toileting needs. R35 remained in same position as observed at 7:05 a.m.
- 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's and did not offer to check and change R35.
- 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35.
-9:32 a.m. R35 was being fed breakfast and still not one offered to reposition her nor did the staff check and change her.

The annual Minimum Data Set (MDS) dated 2/5/16, indicated R35 was modified independence with decision making. R35 required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35 had a history of falls in the last 90 days and was identified as at risk for the development of pressure ulcers. R35's MDS indicated R35 had diagnosis of heart failure, anemia, peripheral vascular disease, arthritis, dementia, and dysphagia (difficulty swallowing).

R35's Urinary CAA dated 2/12/16, indicated R35 was frequently incontinent of bladder and needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 48	F 282		

assist with toileting, managing clothing, peri care and incontinent pad. R35's CAA indicated facility would care plan interventions to manage incontinence when it occurs and reduce potential for complications related to incontinence.

Care plan revised 2/15/16, indicated R35 had a Self Care Performance Deficit related to pain, weakness/anemia, congestive heart failure, chronic obstructive pulmonary disease. Care plan was revised on 3/15/16, after the survey started to include "resident is currently enrolled on North Memorial Hospice. Decline expected." The care plan interventions written 3/15/16, instructed staff: R35 is checked and changed by staff every two hours and PRN.

Care sheet dated 3/17/16, instructed staff to check and change R35 every two hours and as needed, Keep heels dry and off load pressure while blisters are intact.

During interview on 3/17/16, at 9:50 a.m. NA-J stated, "I am to turn [R35] after every two hours. I check her for incontinence in the morning at the beginning of the shift and then at the end of the shift. I turned her around 6:00 a.m. when I got here." NA verified had not offer to reposition or do incontinence care R35 since 6:00 a.m.

During interview on 3/17/16, at 9:52 a.m. RN-G stated "She is supposed to be turned every two hours. I think that it is the same for checking her for incontinence every two hours."

During interview on 3/17/16, at 11:55 a.m. RN-G said, "After you left the floor [NA-J] and I spoke and he went in and changed her. She was wet but did not have any stool until we did the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 282	Continued From page 49	F 282		

dressing change. I verified it had been over three hours since he last changed her."

During interview on 3/18/16, at 1:29 p.m. RN-E said, "I expect them to at least offer to reposition a resident in accordance to her care plan. I expect them to do check and change or toilet and in accordance to the care plan."

During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said "I would expect them to follow the check change or toileting care plan."

Ambulation:

R179's physical therapy (PT) discharge therapy note dated 7/31/15, indicated R179 had met his therapy goals and PT services were discontinued with instructions for nursing rehabilitation on the unit to ambulate R179 to meals.

R179's care plan, last revised on 8/8/15, indicated R179 was to ambulate to all meals with a front wheeled walker and assist of one staff.

R179's Kardex (nursing assistant assignment sheet) dated 3/10/16, indicated R179 was to walk to meals with a front wheeled walker (an assistive walking device) and wheelchair to follow.

During observations on 3/16/16, at 11:04 a.m. R179 was observed to wheel self in the hallway. At 11:07 a.m. staff were observed to wheel R179 into the dining room. There were no offers by staff to ambulate R179 to the dining room.

On 3/17/16, at 7:53 a.m. nursing assistant (NA)-A was observed to assist R179 with morning cares. NA-A applied a transfer belt around R179's waist and assisted R179 as he utilized a front wheeled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 50	F 282		

walker to transfer self from the bed and onto a shower chair. At 9:00 a.m. R179 wheeled self to the dining room for breakfast. There were no offers by staff to ambulate R179 to the dining room.

When interviewed on 3/17/16, at 11:21 a.m. NA-A verified R179 was not walked to meals. NA-A further stated it had been several weeks since R179 had walked to the dining room.

On 3/17/16, at 11:35 a.m. registered nurse (RN)-A stated she was not aware if R179 was on a walking program and needed to check the Kardex. After checking R179's Kardex, RN-A verified R179 was to be walked to meals. RN-A stated she had worked on the unit for six months and had never seen R179 walked to meals. RN-A further stated that NA assigned to R179 was responsible for ambulating R179.

During interview on 3/18/16, at 11:13 a.m. unit nurse manager RN-E stated NA assigned to R179 was responsible for ambulating R179. RN-E further stated the expectation was for staff to follow resident's care plan, document any refusals and report to the nurse.

During interview on 3/18/16, at 11:30 a.m. the facility's director of nursing (DON) stated she expected staff to follow resident's care plan, if resident refuses cares NA are to report to the nurse and nurse to document in the resident's medical record.

The facility's Rehabilitative Nursing Care Policy revised 4/2007, indicated that the facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 282	Continued From page 51 optimal level of self-care and independence. The policy directed rehabilitative nursing care to be performed daily for residents who require such services.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation assistance to improve or maintain each resident's ability for 1 of 1 resident (R179) reviewed for ambulation with activities of daily living (ADL's). Findings include: R179's physical therapy (PT) discharge therapy note dated 7/31/15, indicated R179 had met his therapy goals and PT services were discontinued with instructions for nursing rehabilitation on the unit to ambulate R179 to meals. R179's care plan, last revised on 8/8/15, indicated R179 was to ambulate to all meals with a front wheeled walker and assist of one staff. R179's current Minimum Data Set (MDS) dated 1/29/16, indicated R179 was diagnosed with dementia, had mild cognitive impairment and required one staff assistance for bed mobility, transfers, dressing, toileting and ambulation. R179's Physical Functioning Assessment: dated	F 311	F311 R179 is has been reevaluated by physical therapy and is receiving ambulation services per recommendation. Current resident receiving restorative ambulation programs have the potential to be affected by this alleged deficiency. Appropriate residents are ambulated. Nursing staff have been educated regarding ambulating residents. DON/designee will audit 2 residents per unit per week to ensure appropriate residents ambulate. Results of audit will be reviewed by QAPI.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 311	Continued From page 52	F 311		

1/28/16, indicated R179 required assistance of one staff with ambulation.

R179's Kardex (nursing assistant assignment sheet) dated 3/10/16, indicated R179 was to walk to meals with a front wheeled walker (an assistive walking device) and wheelchair to follow.

During observations on 3/16/16, at 11:04 a.m. R179 was observed to wheel self in the hallway. At 11:07 a.m. staff were observed to wheel R179 into the dining room. There were no offers by staff to ambulate R179 to the dining room.

On 3/17/16, at 7:53 a.m. nursing assistant (NA)-A was observed to assist R179 with morning cares. NA-A applied a transfer belt around R179's waist and assisted R179 as he utilized a front wheeled walker to transfer self from the bed and onto a shower chair. At 9:00 a.m. R179 wheeled self to the dining room for breakfast. There were no offers by staff to ambulate R179 to the dining room.

When interviewed on 3/17/16, at 11:21 a.m. NA-A verified R179 was not walked to meals. NA-A further stated it had been several weeks since R179 had walked to the dining room.

On 3/17/16, at 11:35 a.m. registered nurse (RN)-A stated she was not aware if R179 was on a walking program and needed to check the Kardex. After checking R179's Kardex, RN-A verified R179 was to be walked to meals. RN-A stated she had worked on the unit for six months and had never seen R179 walked to meals. RN-A further stated the NA assigned to R179 was responsible for ambulating R179.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 311	Continued From page 53 During interview on 3/18/16, at 11:13 a.m. the unit nurse manager RN-E stated the NA assigned to R179 was responsible for ambulating R179. RN-E further stated the expectation was for staff to follow resident's care plan, document any refusals and report to the nurse. During interview on 3/18/16, at 11:30 a.m. the facility's director of nursing (DON) stated she expected staff to follow resident's care plan, if resident refuses cares NA are to report to the nurse and nurse to document in the resident's medical record. The facility's Rehabilitative Nursing Care Policy revised 4/2007, indicated that the facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The policy directed rehabilitative nursing care to be performed daily for residents who require such services.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to provide personal hygiene care for 1 of 1 resident in the sample (R35) who was dependent upon staff for personal	F 312	F312 R35 has been discharged. Current residents who are incontinent of bowel and bladder have the potential to be affected by this alleged deficiency.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 312	Continued From page 54 cares. Findings include: R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed: - 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed was elevated 45 degrees. R35 had oxygen in place via nasal cannula. - 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about toileting needs. R35 remained in same position as observed at 7:05 a.m. - 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's and did not offer to check and change R35. - 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35. -9:32 a.m. R35 was being fed breakfast and still not one offered to reposition her nor did the staff check and change her. The annual Minimum Data Set (MDS) dated 2/5/16, indicated R35 was modified independence with decision making. R35 required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35	F 312	Dependent residents who are incontinent are receiving care. Nursing staff have been educated regarding the provision of incontinent care for dependent residents. DON or designee will audit 2 dependent residents per unit per week for the provision of incontinent care Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 312	Continued From page 55	F 312		

had a history of falls in the last 90 days and was identified as at risk for the development of pressure ulcers. R35's MDS indicated R35 had diagnosis of heart failure, anemia, peripheral vascular disease, arthritis, dementia, and dysphagia (difficulty swallowing).

R35's Urinary CAA dated 2/12/16, indicated R35 was frequently incontinent of bladder and needed assist with toileting, managing clothing, peri care and incontinent pad. R35's CAA indicated facility would care plan interventions to manage incontinence when it occurs and reduce potential for complications related to incontinence.

Care plan revised 2/15/16, indicated R35 had a Self Care Performance Deficit related to pain, weakness/anemia, congestive heart failure, chronic obstructive pulmonary disease. Care plan was revised on 3/15/16, after the survey started to include "resident is currently enrolled on North Memorial Hospice. Decline expected." The care plan interventions written 3/15/16, instructed staff: R35 is checked and changed by staff every two hours and PRN.

Care sheet dated 3/17/16, instructed staff to check and change R35 every two hours and as needed, Keep heels dry and off load pressure while blisters are intact.

During interview on 3/17/16, at 9:50 a.m. NA-J stated, "I am to turn [R35] after every two hours. I check her for incontinence in the morning at the beginning of the shift and then at the end of the shift. I turned her around 6:00 a.m. when I got here." NA verified had not offer to reposition or do incontinence care R35 since 6:00 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 312	Continued From page 56 During interview on 3/17/16, at 9:52 a.m. RN-G stated "She is supposed to be turned every two hours. I think that it is the same for checking her for incontinence every two hours." During interview on 3/17/16, at 11:55 a.m. RN-G said, "After you left the floor [NA-J] and I spoke and he went in and changed her. She was wet but did not have any stool until we did the dressing change. I verified it had been over three hours since he last changed her." During interview on 3/18/16, at 1:29 p.m. RN-E said, "I expect them to at least offer to reposition a resident in accordance to her care plan. I expect them to do check and change or toilet and in accordance to the care plan." During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said "I would expect them to follow the check change or toileting care plan."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 314	Continued From page 57 Based on observation, interview and document review, the facility failed to provide care including monitoring and assessment, to prevent deterioration of pressure ulcers for 1 of 4 residents (R439) reviewed who had presssure ulcers. The failure to provide adequate care resulted in actual harm for R439 whose pressure ulcers deteriorated. In addition the facility failed to prevent development of pressure ulcers for 1 of 4 residents (R62). Findings include: R439 was interviewed on 3/16/16, at 8:35 a.m. and stated "The night shift does not turn me." R439 stated he had reported that to the head nurse, and several aides were no longer allowed to care for him. R439 was admitted to the facility on 9/15/15, after extensive hospitalizations in acute care hospitals and long term acute care hospitals. R439's admission diagnosis from the Face Sheet included paraplegia [functional], pressure ulcer of sacral region, Stage IV (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers), type II diabetes and morbid obesity, and major depression. The admission Care Area Assessment (CAA) dated 9/27/15, indicated R439 was admitted with stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) to the sacrum/coccyx and two stage III pressure areas (Full thickness	F 314	F314 R35 has been discharged. R62 and R439 are receiving treatment and services to prevent/heal pressure sores. Current residents with pressure ulcers or risk risk of pressure ulcers have the potential to be affected by this alleged deficiency. Residents are receiving treatment of pressure ulcers and prevention of pressure ulcers. Nursing staff have been educated regarding the prevention and treatment of pressure ulcers. DON/designee will audit 2 residents per unit per week to ensure that care is provided to treat pressure ulcers or prevent pressure ulcers. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 58	F 314		

tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) to left and right buttocks. The areas had developed during prolonged hospitalization with multiple medical complications. A colostomy (intestinal diversion) and Foley catheter (urine collection system in the bladder) was initiated during the hospitalization as well as wound vac (mechanical wound management) to manage/treat pressure areas. A plastics [plastic surgery] doctor (MD) was following R439 and was considering a flap closure of the pressure ulcer (surgical covering of pressure ulcer to promote healing),and the follow-up scheduled for 10/1/15. A wound MD was following R439 while here and CAA indicated to see the Physician Progress Notes for measurements and debridement since admit. A Nutrition CAA had triggered as R439 had lost 150 pounds over the past six months, which was nutritionally significant, increased metabolic needs secondary to pressure areas.

The initial care plan dated 9/28/15, indicated R439 had pressure ulcers and potential for pressure ulcer development related to disease process and prolonged immobility. There was no discussion on the care plan of where the pressure ulcers were or any stages listed. The initial goal dated 9/28/15, indicated R439's pressure ulcer would show signs of healing and remain free from infection. The initial interventions dated 9/28/15, indicated staff were to assess/record/monitor wound healing. They were to measure length, width and depth where possible. assess and document status of wound perimeter, wound bed and healing progress. Staff were directed report improvements and declines to the MD. "Inform

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 59	F 314		

the resident and family/caregivers of any new area of skin breakdown. Pressure relieving/reducing device in bed/chair. Treat pain as per orders prior to treatments/turning etc. to ensure comfort." R439 required supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Staff were to educate R439/family/caregivers as to causes of skin breakdown which included transfer/positioning requirements; importance of taking care during ambulating /mobility, good nutrition and frequent repositioning.

The Physician Progress Notes from 9/16/15, going forward were reviewed and were as followed:
- On 9/16/15, initial progress note since admission to facility. R439 was admitted for management of Sacrococcygeal Stage IV pressure ulcer with possible osteomyelitis (infection in the bone) and respiratory failure requiring tracheostomy and lower paraplegia. Chronic pain due to sacral pressure ulcer, now on Fentanyl patch (extended release pain control) with Dilaudid (oral pain control) for break through pain. A colostomy and Foley catheter were started to promote wound healing ."Nursing reports patient has been cooperative with cares since admission. Patient with chronic sacral ulcer stage IV which was developed during extended and complicated hospitalization, being managed by a wound vac and followed by plastic surgery. Air mattress to assist with wound healing. Plan to continue physical therapy [PT] and occupational therapy [OT]."
- On 9/17/15, VOHRA (a wound company that specializes in wounds) Wound specialist progress note: "Consult requested for pressure ulcers. Stage IV wound of sacrum with moderate serous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 60	F 314		

exudate. Stage IV pressure ulcer of the sacrum 7 cm [centimeters] x 11.5 cm x 0.5 cm moderate serous exudate, 100% granulation tissue, dressing negative pressure three times per week (wound vac). Stage III pressure ulcer of the right ischium 4 cm x 4 cm x 1.5 cm with moderate serous exudate, thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. Wound debrided via surgical excision and subcutaneous tissue removed along with necrotic tissue. Post debridement depth 1.6 cm. Dressing Foam once daily, Santyl (helps clean wound) once daily. Stage III pressure ulcer of the left ischium 4 cm x 5.5 cm x 2 cm with moderate serous exudate. Thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. Wounds debrided via surgical excision and subcutaneous tissue removed along with necrotic issue. Post debridement depth 2.1 cm. Dressing, foam once daily, Santyl once daily, Calcium Alginate (provide antimicrobial action to prevent infection, absorb exudates and maintain a moist environment to promote rapid healing) once daily.
- On 9/21/15, nursing home (NH) progress note: seen by plastics team on 9/17/15, (transported to appointment) suggested a different wound vac. "Patient requested to be up 1-2 hours a day for meals and mental health, stated 'feels like he is in jail.' Requested shower on wound vac change days, charge nurse promised they will work around when more staff would be available to help. Sacrococcygeal wound connected to wound vac, left and right ischial (the lowest of the three major bones that make up each half of the pelvis) wounds covered with dressings, unable to assess. [R439] had a normal mood and affect, and behavior was normal. Bedrest except up 1-2 hours per day for a meal or leisure ."
- On 9/24/15, Wound specialist progress note:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 314	Continued From page 61 "Stage IV pressure ulcer of the sacrum 10 x 11.5 x 1.5 cm moderate serous exudate, 100% granulation tissue, dressing negative pressure three times per week (wound vac) deteriorated to generalized decline of patient. Optimize nutrition. Stage III pressure ulcer of the right ischium 5 cm x 5 cm x 0.5 cm with moderate serous exudate, thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. No change. Stage III pressure ulcer of the left ischium 4 x 6 x 0.6 cm with moderate serous exudate. Thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. Improved, decreased depth ." - On 9/30/15, VOHRA Wound specialist progress note read, "Stage IV pressure ulcer of the sacrum 8.2 x 14.8 x 1.6 cm moderate serous exudate, 100% granulation tissue, dressing negative pressure three times per week (wound vac). No change. Stage III pressure ulcer of the right ischium 5.0 cm x 4.2 cm x 0.2 cm, improved, decreased depth. Stage III pressure ulcer of the left ischium 4 x 6 x 1.4 cm, improved, increased granulation." - On 10/1/15, Plastic Surgery Clinic, doctor (D)-B: "[R439], last seen 1 month ago. Referral to D-A was never made, under the care of wound providers at facility. Sacral wound looked substantially improved with a nice granulating bed with no debris and no fibrinous material," and "Unfortunately in the last month, he had a significant progression and worsening of his ischial tuberosity pressure wounds. With a comment of the lack of pressure ulcer care which contributed to worsening pressure wounds." "When I saw him last his right side was fairly clean and his left side had a stage I pressure wound." "Now both are stage IV easily." "They both have necrotic material in them and are worsening in nature." "His cares are not being	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 314	Continued From page 62	F 314		

met in an appropriate manner to my opinion." "He is under the care of a wound care nurse, but how a wound-care nurse can look at his wounds and feel like the cares are appropriate is not adequate to me." Lastly, "[Dr F.] will see him today."
- On 10/1/15, Wound Clinic Initial Note of Plastic Surgery Clinic, Dr F: Requested, but page 3 of the 4 page report was missing, which included the impression and plan of care.
- On 10/6/15, NH progress note: seen by the wound/burn specialist (transported to appointment) for concern for patient wound, wound dressing directions were given during that visit. "Sacral wound dressing continues with wound vac. Nurse reported bilateral ischial wounds were putting out excessive drainage and it has some odor, nurse had already completed dressing change today. Poor wound healing. Sacrococcygeal wound connected to wound vac, left and right ischial (the lowest of the three major bones that make up each half of the pelvis) wounds covered with dressings, unable to assess. [R439] had a normal mood and affect, and behavior was normal. Sacral ulcer stage IV, chronic and nonhealing. Patient also had bilateral ischial stage 2 ulcer [partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater] which is now draining excessive purulent malodorous drainage. Low grade temperature and nausea over the weekend. Obtain wound cultures [to look for infection] prior to next dressing change and blood culture next lab day."
- On 10/7/15, VOHRA Wound specialist signed off on R439.

The Progress Notes for the nursing home were reviewed from 10/13/15, going forward and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 63	F 314		

following was noted:
- On 10/13/15, NH progress note: "Bilateral unstageable ischial wound which was noted to be draining copious, malodorous greenish yellow drainage few days ago. Wound culture collected which came back with moderate growth of klebsiella pneumoniae [bacteria], moderate growth of enterobacter aerogenes [gram negative bacteria] and heavy growth of streptococcus B Beta hemolytic (S. Agalactiae) [gram positive bacteria]. Poor wound healing. Agrees to see in house psych [psychologist] and increase antidepressants and pain control. Wound culture with mixed growth, sensitive to tetracycline [antibiotic]. Continue to change wound dressing daily per wound specialist order."
- On 10/15/15, NH progress note indicated that the bilateral unstagable ischial wound were draining copious malodorous greenish yellow drainage.
- On 10/21/15, Nursing Weekly skin condition report (pressure and non pressure) noted the Sacrum measured 10.0 cm x 9.0 cm x 1.25 cm stage IV, the left IT (ischial tuberosity) measured 5.0 cm x 5.0 cm x 1.5 cm, and was a stage IV, the third ulcer on the right IT measured 4.0 cm x 4.0 cm x 1.25 cm and was a stage III ulcer.
- On 11/19/15, Nursing Weekly skin condition report (pressure and non pressure) noted the Sacrum measured 11.0 cm x 7.0 cm. The depth and the stage was not documented. The right IT measured 5.0 cm x 3.5 cm. The depth and the stage was not documented. The left IT measured 5.8 cm x 6 cm. The depth and the stage was not documented. The medical record was incomplete for the staging and measuring the depth for R439's wounds. In addition, review of the nursing notes for R439 between 9/15/15 and 10/14/15, lacked any documentation of refusals to turn or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 64	F 314		

reposition.

The quarterly Minimum Data Set (MDS) dated 12/15/15, indicated R439 was fully cognitively intact and had major depression, was on bedrest due to pressure ulcers, required assistance of two with turning and repositioning and did not resist cares.

On 2/9/16, the care plan was updated to state the pressure ulcers were all stage IV on admission, which directly conflicted with the Physician Progress Notes and admission assessments. The care plan identified R439 had been noncompliant with cares, however the medical record lacked evidence of supporting documentation for the statement. In addition, the care plan lacked direction for staff should R439 refuse cares, especially based on the significance of his wounds. In addition, there was no risk/benefit assessment completed and shared with R439.

The nursing assistant care card print date of 3/16/16, directed staff assist of two to reposition and turn in bed. grab bars on bed, turn and reposition every two hours when in bed and 30 minutes when up in wheelchair. R439 required assist of staff for mobility with stretcher transport to appointments.

On 3/16/16, at 8:36 a.m. R439 stated the night shift staff did not turn him, and he had reported that to registered nurse (RN)-N, and a handful of aides were no longer able to care for him.

On 3/17/16, continuous observations for two hours and fifteen minutes from 5:45 a.m. until 8:00 a.m. the resident was not repositioned. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 65	F 314		

6:24 RN-P knocked and entered room for blood glucose test. At 7:08 RN-P entered the room without knocking, called R439's name, and left the room within 15 seconds of entering. At 8:03 a.m. R439 was interviewed and stated he "had not been turned all night." At 8:05 a.m. RN-N was notified the resident had not been turned during the time of continuous observation, and the resident stated he had not been turned all night. RN-N stated "He should be turned every two hours." At 10:55 a.m., a pressure ulcer observation was not able to be obtained. At 11:00 a.m. the assistant director of nursing (ADON) stated the wounds have not changed in staging, it's maybe the difference between wound clinics. R439 had D-A and now had D-D and so maybe that accounted for the difference, but RN-N actually did the measurements. RN-N stated they have not changed stages since he started in September 2015. When interviewed at 11:16 a.m., RN-P stated she had entered R439's room to get his blood sugar and the second time to give insulin. At 11:20 a.m. nurse practitioner (NP)-B, stated she first saw R439 in 12/15, since then the wounds have decreased in size from grapefruit to less than a baseball, but bigger than a golf ball, and continue to have deep tunneling. An magnetic resonance imaging (MRI) was done on 3/14/16, to rule out osteomyelisitis (in the ischial tuberosities) and when the results arrived today we sent him to the hospital to receive intravenous antibiotics. NP-B stated the aides need to inform the nurses of what they see, because NP-B relied on the nursing staff to inform her of what's happening. The aides don't take direction from the nurses. At 11:30 a.m. D-C, stated with the change in ownership quality declined, but was coming back, "You have to have enough staff, and people who care what they are doing." D-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 66	F 314		

stated there was a system breakdown in pressure ulcer care in the facility. At 12:00 p.m. RN-N stated the wound had changed a lot since the last time she saw it, as it was oozing a lot more. RN-P "charge nurse", stated nursing does wound care daily, and the facility did wound rounds as the doctor measures and RN-P wrote it down. RN-P stated there had been three different wound providers for the facility, they had just started with a new wound doctor during the current week.

The MRI exam completed 3/14/16, identified bilateral deep ulcerative changes at the inferomeidal buttock soft tissue with extension anteriorly along the medial aspect of both ischial tuberosities, concerning for osteomyletitis (infection in the bone) and he was admitted to North Memorial Medical Center for IV antibiotics.

Review of North Memorial Medical Center (NMMC) emergency department records indicated the resident was sent back to the facility the evening of 3/17/16, on oral antibiotics, and indicated the osteomyelitis was chronic and not a new concern as stated by the MRI.

On 3/18/16, at 9:00 a.m. R439 stated the last time he was repositioned was at 8:30 p.m., a period of 12.5 hours. At 9:20 a.m. nursing assistant (NA)-Q stated they just transferred to this unit and didn't know R439, but just check the care card on the door. R439's care card said to reposition every two hours, and R439 was repositioned 15-20 minutes ago with NA-R. At 9:30 a.m. RN-N was informed the resident stated he had not been turned last night, and was asked if he had reported the allegation of neglect reported to him yesterday. RN-N stated he had reported it to the DON and consultant nurse (CN).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 67	F 314		

RN-N was asked if he had interviewed the resident after the allegation of neglect was reported. RN-N stated he had talked to R439, but had not asked about being repositioned on the night shift. At 10:24 a.m. the DON stated she spoke to the evening supervisor and R439 frequently refused to be turned at night, according to the night supervisor. At 11:04 a.m. RN-N, stated R439 "told me he was not being turned at night." At 2:04 p.m. RN-N stated he put an every two hour turn and reposition sheet up in R439"s room, because he took it very seriously when informed this morning, that R439 again stated he had not been turned again last night. RN-N called the nurse at home, who told him R439 had requested not to be disturbed at night. At 2:10 p.m. R439 stated he had never asked to not be disturbed at night. he may have occasionally refused to turn, because his shoulders may have been sore. R439 could not say what shift that occurred on, but clarified it was not very many times. R439 stated "I know I have to turn to get better."

On 3/21/16, at 5:10 a.m. no staff was observed in R439's unit, until RN-T made a facility wide announcement to welcome the health department to the facility. At 5:11 a.m. LPN-H, stated R439 refused the midnight turn, and accepted the 2:00 a.m. turn and got pain medicine, accepted the 4:00 a.m. turn but requested not to be awakened at 6:00 a.m. LPN-H stated R439 was offered pain meds whenever he's awakened. LPN-H, stated she would turn R439 again now, but stated aide who was working with her was helping in the 800 hallway (one of four hallways on the unit) right now. At 5:30 a.m. LPN-H called two other wings and asked if the aide was there with them, both answered no. At 5:35 a.m. the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 68	F 314		

(DON) came to R439's unit and spoke with LPN-H. At 5:42 a.m. LPN-H and LPN-I offered to turn R439, LPN-I stated "he just wanted the pillow removed, he didn't want to turn to the other side, and it's whatever makes him comfortable". At 6:53. a.m. LPN-I asked NA-S "Hey where were you, we were looking for you". NA-S stated, "I was taking my break." At 6:54 a.m. NA-Q was asked how many times R439 was turned last night, and she stated "hmm 3 or 4," however, acknowledged she had not been down the hallway to know whether R439 turned the forth opportunity or not. At 6:00 a.m. the DON stated there must be a language barrier, as RN-N was in R439's room right away at 8:00 a.m. At that time the DON was informed RN-N did not discuss the repositioning concern with R439.
R62's quarterly MDS dated 11/27/15, indicated he required extensive assistance from two staff for cares.

R62's Weekly Skin Report dated 12/31/15, indicated he had a pressure ulcer on his right buttock that was resolved.

R62's care plan dated 1/14/16, indicated he was at risk for pressure ulcers, admitted to the facility with a pressure ulcer on his coccyx and had a history of re-opening pressure ulcers. The care planned interventions at that time directed staff to complete weekly skin checks and encourage R62 to avoid positioning on coccyx. The care plan further indicated R62 was able to reposition himself in bed. However, that contraindicated what the MDS dated 11/27/15, noted.

There was no evidence of weekly skin assessments between 12/31/16 and 1/27/16, at which time, a facility Weekly Skin Condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 69	F 314		

Report indicated a new pressure ulcer to R62's right buttock. The pressure ulcer was described as unstageable, measuring 4 cm x 4.5 cm. The pressure ulcer was first observed on 1/20/16. On 2/4/16, A Weekly Skin Condition Report indicated a pressure ulcer to R62's coccyx measuring 5.0 cm x 4.7 cm x 0.8 cm depth. On 2/10/16, R62 was assessed by VOHRA (wound care company) wound physicians. A Wound Care Specialist Evaluation on that date indicated a stage IV pressure ulcer to the right ischium measuring 4.0 cm x 3.0 cm x 1.4 cm. The Evaluation also indicated a healed shear wound (an applied force or pressure exerted against the surface and layers of the skin) of the right superior buttock present for greater than 65 days. The shear wound was not noted in the previous skin assessments. R62's care plan was updated on 2/9/16, however, no new interventions were implemented even though R62 had developed a new pressure ulcer. The care plan continued to direct staff to encourage R62 to avoid pressure to his coccyx even though his MDS indicated he required extensive assist of two staff for bed mobility.

R62's quarterly MDS dated 2/26/16, indicated R62 was cognitively intact, required extensive assist of two staff for bed mobility and transfers, and had a stage IV pressure ulcer.

Observation on 3/16/16, at 3:06 p.m., R62 was lying in bed on his back watching television. During observations on 3/17/16, at 7:22 a.m., 7:50 am, and 8:44 a.m., R62 remained in his room lying in bed.

During an interview on 3/17/16, at 11:08 a.m., NA-K stated she was unaware of R62's skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 70	F 314		

condition. She stated, "I think there is an open area on his bottom ." She further stated, R62 had no scheduled cares and stated if he needs anything he will put his light on.

During an interview on 3/17/16, at 11:11 a.m., licensed practical nurse (LPN)-C stated, R62 had a couple of open areas to his bottom and has daily dressing changes. She stated during his dressing changes he was able to hold on to the grab bar. LPN-C further stated staff was supposed to go in and offer repositioning every two hours.

During an interview on 3/17/16, at 11:17 a.m., RN-M stated, R62 had a stage IV pressure ulcer when he moved to the unit. She stated the wound had healed on 12/31/15, and opened up again on 1/20/16.

During an interview on 3/17/16, at 3:07 p.m., the DON stated, R62 "is pretty good at repositioning himself." She stated he changed position in bed but was not sure if he was able to offload (relieve pressure).

While R62 was at increased risk for pressure ulcers and required staff assistance for repositioning, the facility did not implement interventions to ensure offloading of pressure from R62's bottom. Further, while previous pressure ulcers had healed and re-opened, no new individualized interventions were implemented to prevent worsening of existing pressure ulcers or prevention of new pressure ulcers.

A facility policy titled Pressure Ulcer Treatment Guidelines dated 5/13, was reviewed. The policy's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 71 purpose was to provide clinical guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy directed staff to focus on assessing the resident and the pressure ulcer, managing tissue loads, education and quality improvement.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate supervision while intoxicated for 1 of 1 resident (R104) who was known to consume alcohol (ETOH) in the facility. In addition, the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 7 of 15 residents (R77, R242, R248, R286, R429, R494, R511) who currently smoked in the facility. Findings include: Substance abuse: R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN [as needed] of resident room and room checks hourly and PRN for	F 323	F323 R104 is receiving adequate supervision related to ETOH consumption. R 77, R 286 and R494 have been discharged. R242, R248, R429, R104, and R511 are receiving supervision per smoking assessment recommendations. Current residents with a history of etoh abuse and/or smoking while residing in the community have the potential to be affected by this alleged deficiency. Residents requiring supervision related to ETOH or smoking are receiving appropriate supervision. Staff have been educated regarding supervision of residents who smoke or use ETOH. DON/designee will audit 2 residents per	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 72 prohibited substances," "MD [medical doctor] orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify if R104's was currently using alcohol, what interventions staff should attempt if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol. R104's significant change Minimum Data Set (MDS) dated 2/1/16, indicated R104 diagnoses included hepatic failure (liver failure) and cirrhosis, and R104 had severe cognitive impairment. A Wandering and Elopement Evaluation dated 2/4/16, indicated under the "Orientation" section R104 was not alert and oriented x 4 (person, place, time, situation). A box indicating if the resident was educated on the signing out policy and procedure was left blank. The assessment indicated the resident exhibited forgetfulness or shortened attention span and was independently mobile. The section to determine cognitive status using the Brief Inventory for Mental Status (BIMS) score section was not completed. Under the Wandering/Exit Seeking Patterns two boxes were checked "History of exit seeking at home or other setting, including current setting" and "Stays near exit doors." The summary and interventions section of the evaluation was not completed and did not indicate any initiation or review of R104's care plan. The evaluation was signed 2/6/16.	F 323	unit per week to ensure that supervision is provided. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 323	Continued From page 73	F 323		

Review of R104's Progress Notes from February through March 7, 2016, did not reveal documentation of R104's alcohol use.

R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5pm. Hx [history] of alcohol abuse. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note identified R104's hospice agency and MD were notified of the incident, an order was obtained to search R104's room for liquor, but none was found, and staff identified they would, "Monitor for s/sx [signs and symptoms] of alcohol intoxication every shift and hold narcotics as needed." Further, the note identified, "Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's Physician Orders dated 3/8/16, directed staff to, "Monitor for alcohol intoxications. Hold narcotics if suspecting drunkenness. Contact MD/NP [nurse practitioner] and hospice as needed for new orders every shift for hx of alcohol abuse."

R104's undated Kardex Report directed staff under the "Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" and that R104 was "aware of the risks." The Kardex further identified "MD orders to hold narcotic medications for lethargy and updated MD PRN for substance abuse. Psych [psychiatrist] orders received." Additionally, the Kardex included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 74	F 323		

"monitor for use of ETOH, NAR [nursing assistant registered] to report to nurse. Nurse if observed to have signs of impairment to ETOH, call MD for orders." The hourly checks were not documented anywhere in the medical record.

An interview on 3/17/16, at 7:45 a.m. with nursing assistant (NA)-E revealed that "a while ago" R104 "had a big problem with drinking" and he had "behaviors when drinking, he likes to swear. I think, he thinks he needs more help than he does and he gets an attitude. I'm not sure how he is getting alcohol, I haven't heard lately. He used to leave sometimes when he had a power chair to the liquor store down the road. "

- At 11:25 a.m. with registered nurse (RN)-I stated that RN-I was aware of R104's alcohol use and stated the last time R104 had used alcohol was "maybe two weeks ago."R104 had "gone out and come back drunk" and R104's physician was updated and an order was obtained to hold medications at those times and to monitor for intoxication. When asked about R104 leaving the facility, RN-I stated "He signs out up front at the desk sign out, he is able to do that and he goes and sits out front of the facility." RN-I also stated R104 used Metro Mobility for transportation, arranged his own rides and went to the bank and went shopping.
- At 9:34 a.m. with NA-F revealed R104 refused help a lot when he had been using alcohol and noted R104 "drank liquor last week" and he "curses a lot and is very aggressive when he's been drinking." NA-F was unable to provide a date and time to R104's alcohol consumption.
- At 2:22 p.m. licensed practical nurse (LPN)-B revealed R104 "drinks all the time" and "gets drunk." LPN-B revealed the physician ordered methadone (used as a pain reliever) cannot be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 75	F 323		

given if R104 has been drinking. LPN-B stated she had "been here seven months and this is an ongoing issue" (R104's alcohol use). LPN-B stated R104 had been using alcohol on her "shift for a couple months" and noted R104 to be using alcohol "multiple times per week." LPN-B further revealed that she "wouldn't be surprised" if R104 was "drunk" and he "just leans over and sleeps on the armrest" (of his w/c). When asked what she has been directed to do when R104 has been using alcohol or directed where to document the occurrence, LPN-B replied "I don't know, I would hope it would be my TAR [treatment record] and to monitor for intoxication." When asked what else she was directed to do when R104 has been using alcohol, LPN-B replied "nothing, just monitor-15 min checks, he will usually pass out in his wheelchair." LPN-B went on to say that if R104 was "belligerent, pushing, slapping, yelling or swearing" she would call the charge nurse or supervisor. LPN-B stated she had never had to call the hospital due to R104's alcohol use. When asked where R104 obtains alcohol LPN-B stated "There's a lot of suspicions that one liquor store delivers close by the front door and that one supervisor happened to be in the front area once and confiscated it before it was open. I've never seen a visitor outside of facility and never seen him leave the facility."

An interview on 3/18/16, at 8:37 a.m. with RN-J revealed she was aware of R104's drinking and "it's been awhile since I have seen him do it." When asked what she was directed to do when R104 has been using alcohol, RN-J replied "usually" a room search was completed, no pain medications are given and we notify the physician or hospice. When asked how often room searches are completed RN-J replied "I don't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 76	F 323		

know of a room search, usually if suspected drinking, that's just my guess."
- At 8:48 a.m. with NA-G revealed R104 used to drink "most of the time" and would come back from lunch "always drunk." NA-G would tell the nurse and the nurse would take R104 back to his room. NA-G stated she has not witnessed that recently, "its maybe been a month now" but she would tell the nurse and then management would be informed.
- At 8:54 a.m. with NA-H revealed R104 was often found by staff in the dining room "after he has been drinking and smells of alcohol." NA-H stated the last time that occurred was "a week and a few days ago." NA-H stated he told the nurse about R104 smelling of alcohol and the nurse brought him back to his room. NA-H stated he was not sure where R104 got the alcohol or where he drank it. NA-H stated he was unsure if R104 left the facility property as he never followed R104 down the elevator and was unsure of where he went when he was off of the nursing unit.
- At 10:13 a.m. with licensed social worker (LSW)-A indicated she "sometimes checks his [R104] room for alcohol if staff thinks he is intoxicated. We complete random checks if we suspect intoxication; I have never found alcohol." When asked how often checks are completed LSW stated it "just depends, nurses do it too" when asked what it "depends" on she stated she was "not sure what it depends on." LSW-A went on to say she thought R104 left the building and "goes out with Metro Mobility- not with any supervision, he tells the Health Unit Coordinator [HUC] and he usually signs out. He tells the HUC or charge nurse, as long as he is signed out he can leave." When asked if there was an assessment to determine if a resident could leave the facility unsupervised, the LSW responded that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 77	F 323		

it was based off a nursing assessment, and that she was not aware of any assessment or requirement for anyone to leave. The LSW also stated she had asked about the facility's alcohol policy and had "not received an answer on one."
- At 10:29 a.m. RN-K was interviewed and when asked about R104's alcohol use, RN-K replied that it was a "typical thing" for R104 and the facility did not have a policy for drinking, however it was something that was discouraged. RN-K indicated some residents have a Physician's Order to receive some alcohol but that was not of benefit to R104. RN-K went on to say staff was directed to complete random room searches for alcohol, hold narcotics and monitor the resident if he appeared intoxicated. When asked who was responsible for the room searches, RN-K replied that "typically social services" was responsible. However, she had periodically completed room searches with a second nurse and when she found alcohol she documented how much was found and emptied. RN-K indicated she had not found alcohol "lately." RN-K indicated staff was aware of R104's drinking and when R104 required an incontinent pad change staff were to look under his cushion as he stored mini-bottles of liquor and carried "suspicious coke bottles" that staff are supposed to dispose of. RN-K indicated the facility staff had found vodka bottles outside of the facility in planters and indicated these were R104's bottles. RN-K also stated she or facility staff were not able to identify where or how R104 obtained alcohol but he was "friends with everyone" at the facility and the connected assisted living facility. RN-K indicated R104 did leave the facility unsupervised and used to leave more often before his enrollment in Hospice on 1/23/16. RN-K went on to say she could not recall any nursing assessment to determine if he could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 78	F 323		

leave the facility unsupervised but that R104 had undergone "cognitive testing" and he was safe to call a cab however indicated that was "not a good idea" for R104. RN-K also indicated R104 used Metro Mobility for transportation that he set up himself, or with the social worker's assistance. When asked if there was any interventions in place to prohibit R104's alcohol use, RN-K stated R104 was encouraged to participate in more activities on the unit and that Alcoholics Anonymous (AA) had been discussed and declined by R104. RN-K also confirmed R104 had a fall on 11/5/15, while R104 was suspected to be intoxicated and did not use assistance with a transfer. RN-K indicated R104 did not have injury from the fall. RN-K was asked about the 3/8/16, Progress Note in R104's medical record and stated she was not aware of the incident and that she did not need to be informed of every time that R104 had been drinking.

Sharp Object safety:
R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c [wheelchair] cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and R104 was "offered alternative storage of items and declined." The care plan did not identify R104's possession of sharp objects or knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.

Review of R104's Progress Notes from February through March 7, 2016 did not reveal documentation of R104's threatened staff with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 323	Continued From page 79 knife(s) under the w/c cushion. R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 [one to one] for safety." The note identified R104's hospice agency and MD were notified of the incident. The Progress Note lacked evidence of any interventions being put into place to deter R104 from "swinging a knife at other people." R104's undated Kardex Report directed staff under the "Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" also included "frequent room checks hourly and PRN for prohibited substances" and that R104 was "aware of the risks." The "Behavior" section of the Kardex identified R104 "was at risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons." The hourly checks were not documented anywhere in the medical record. A vulnerability assessment was requested for R104. On 3/21/16, at 10:32 a.m. the director of nursing (DON) stated "Our social workers don't do a specific VA [vulnerable adults] assessment because all residents when they are admitted are VA" and stated that the "asterisks denote some vulnerability on the care plan." An interview on 3/17/16, at 9:34 a.m. with NA-F revealed R104 refused help a lot when he had been using alcohol and noted R104 "drank liquor last week" and he "curses a lot and is very	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 80	F 323		

aggressive when he's been drinking." NA-F was unable to provide a date and time to R104's alcohol consumption.

An interview on 3/18/16, at 10:29 a.m. RN-K was interviewed and indicated R104 did leave the facility unsupervised and used to leave more often before his enrollment in Hospice on 1/23/16. RN-K went on to say she could not recall any nursing assessment to determine if he could leave the facility unsupervised but that R104 had undergone "cognitive testing" and that he was safe to call a cab however indicated that was "not a good idea" for R104. RN-K also indicated that R104 used Metro Mobility for transportation that he set up himself, or with the social worker's assistance. RN-K was also aware R104 often had knives in his possession and then presented to the surveyor two knives (RN-K described as steak knives) that she had removed from R104's possession that she kept locked up in her office. RN-K stated that information was on R104's care plan (regarding R104 having knives) and R104 had been talked to multiple times about it and was at risk for skin breakdown because R104 punctures his wheelchair cushion with the sharp edges.

The DON was interviewed on 3/18/16, at 11:50 a.m. regarding R104's alcohol use and sharp objects use. The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. and the DON indicated she did not recall the incident and the assistant director of nursing (ADON) was on-call that evening. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated that she believed the incident involved a box cutter, not a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 81	F 323		

knife. The DON verified the box cutter did have a sharp blade end, however stated that she was not aware of R104 swinging it at others and that no one was threatened or harmed. The DON could not verify who the "other people" were and was unaware if any other staff or residents were involved with the situation. The DON confirmed there was no incident report made about the 3/8/16, occurrence and further indicated she did not expect an incident report to be completed every time R104 was intoxicated. The DON further stated that she would expect R104's nurse manager to be informed of any time that R104 is intoxicated and should be informed of what occurred on 3/8/16 at 17:49 with R104. The DON confirmed she was aware of R104's alcohol use. When asked where R104 obtained alcohol, the DON indicated the facility staff was unaware of where R104 obtained his alcohol and R104 left the building unsupervised and arranged his own transportation. The DON stated R104 purchased the alcohol himself and she was aware of a liquor store that delivered to the home. The DON also stated that having knifes or sharp objects was a "habit" of R104 and that was indicated on R104's care plan. The DON revealed there was no assessment completed to determine if R104 was able to leave the building unsupervised. However, the DON indicated his placement in the facility (on the second floor) indicated that he was able to leave the facility unsupervised and the nurses know who was able to leave the facility safely. The DON stated R104's alcohol use was identified on his care plan. When asked where that was on R104's care plan the DON displayed the care plan and pointed to the focus of "end stage liver disease, hx of ETOH, r/t cognitive impairment, hx of coffee ground emesis, hx of ETOH. Often refuses lactulose and is aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 82	F 323		

the risks and benefits. R104 "has a history of abnormal labs." Interventions included, "frequent safety checks hourly and PRN of resident and room checks hourly and PRN for prohibited substances. Resident is aware of the risks. MD orders to hold narcotic medications for lethargy. Update MD PRN for substance abuse. Psych orders received. Revisit and remind of activities that may interest, 1:1 visits and chaplain support PRN." The DON indicated with what was listed as interventions that "any reasonable and prudent nurse" would know that he was currently using alcohol and what to do if R104 was intoxicated at the facility. The DON further stated R104 had been offered support to discontinue drinking such as AA meetings, however that was not identified in R104's medical record. The DON further indicated room checks should be completed hourly (as identified on R104's care plan) by the nursing assistants (NA's) but that nurses could complete that as well. The DON confirmed she expected staff to be aware and follow R104's care plan. The DON confirmed the facility did not have an alcohol policy.

At 12:51 p.m. on 3/18/16, the surveyor was approached by the DON, along with the ADON, LSW-B and RN-H regarding the progress note written on 3/8/16, at 5:49 p.m.

The DON began to discuss RN-H charted inaccurate information in R104's medical record for the Progress Note and RN-H charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member.

The surveyor then asked RN-H if that was correct, and RN-H confirmed she had charted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 83	F 323		

what the ADON had told her when she was asked to come down to R104's floor to assist, as R104 was intoxicated. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was told to her by the ADON on the way down to R104's floor.

The ADON then denied that, and stated she did not know where RN-H "got this information."

The ADON and LSW-B then stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and also stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician.

The DON again stated what was charted on 3/8/16, at 17:49 p.m. by RN-H was not accurate, that "hearsay" was charted and that was why she was not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and expected staff to chart accurate information.

RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she had entered the 3/8/16, progress note in R104's chart. RN-H stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 84	F 323		

information that RN-H entered into R104's progress note. RN confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. and again confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information. RN-H stated in any situation like that she would have informed her supervisor, but since her supervisor (ADON) had told her the information she did not follow up. RN-H stated by the time she got down to R104's floor, R104 was not a threat to anyone and they did not send R104 to the emergency room.

An interview with the administrator on 3/21/16, at 7:50 a.m. revealed he was contacted on the evening of 3/8/16, regarding R104 being "under the influence" and the resident had a box cutter. The administrator stated the ADON informed him R104 was upset, had a box cutter in his hands but denied R104 was threatening anyone. When asked about the 3/8/16, progress note in R104's medical record, the administrator stated what was charted in the progress note was not what he was told that evening. He stated the note was charted inaccurately and the nurse did not observe that type of behavior from R104. The administrator stated that he expected staff to chart accurately and if that was what occurred that he should have been informed. The administrator stated RN-H was given direction from the ADON, and it would have been a good idea for the ADON to review what was written. When asked why the progress note was not followed up on and no information was provided further in the medical record, the administrator stated the facility "Can't go back and erase what was written" and was unsure about making a correction. The administrator also indicated the police would have been called if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 85 R104 had a weapon and was threatening people. When asked about R104's alcohol use, the administrator stated R104 was non-compliant and had not been a threat towards resident or staff in any manner. He went on to say staff are directed to monitor his behavior and lethargy when alcohol use was suspected. The administrator was unaware of how or where R104 was obtaining alcohol however stated R104 had visitors and goes on outings outside of the facility. The administrator confirmed he had heard suspicions of a liquor store that delivered to the resident. The administrator stated the liquor store was contacted about not delivering to private property of the facility. Additionally, the administrator stated the facility did not have an alcohol policy, and if residents had alcohol, they would be allowed a specific amount per Physician Orders and it would be kept in the medication room and only released per what was ordered by the physician. However, the Physician's Order dated 3/8/16, did not include if R104 was to receive a specific amount of alcohol. In addition, the medical lacked evidence of any staff member asking R104 if R104 wanted alcohol ordered by the physician and if R104 would keep the alcohol locked up in the medication room. On 3/21/16, at 7:41 a.m. R104's progress notes were reviewed and revealed R104's Progress Note from 3/8/16, at 5:49 p.m. was not revised, edited or followed up on in R104's medical record. R77's Admission Record dated 3/21/16, indicated R77 had diagnoses which included, restlessness, anxiety and difficult walking. R77 most current MDS dated 12/18/15, indicated R77 had	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 86	F 323		

moderate cognitive impairment. The MDS also indicated R77 needed staff supervision with personal hygiene, independent with transfers and mobility.

R77's record review identified a facility form titled "Smoking Evaluation" dated 12/18/15, indicated that R242 did not have any cognitive loss, visual deficit or a dexterity problem and could light own cigarette and required staff supervision while smoking.

R77's care plan dated 3/15/16, indicated R77 required staff supervision while smoking. However, the care plan was developed 88 days later after facility staff assessed R77 requiring staff supervision while smoking.

During resident room observation on 3/15/16, at 10:26 a.m. with RN-C, observed two opened packs of cigarettes in R77's night stand drawer. R242 was asked if she smoked the cigarettes that were located in her night stand R77 stated she goes out to smoke by herself and when her friend comes to visit.

When interviewed on 3/15/16, at 1:06 p.m., NA-C, stated he was usually assigned to R77's group. NA-C stated he was not aware R77 needed staff supervision while smoking.

On 3/17/16, at 2:16 p.m. RN-A acknowledged that R77 was a smoker. RN-A stated that she was not aware R77 needed staff supervision while smoking.

On 3/17/16, at 2:22 p.m. NA- D stated she usually works evening shift and assigned to take care of R77. NA-D continued to state sometimes R77

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 87	F 323		

goes outside to smoke independently and NA-D further stated she was not aware R77 needed staff supervision while smoking.

During interview on 3/18/16, at 10:33 a.m. RN-E acknowledged that the facility assessed R77 as unsafe to smoke independently and needed to be supervised while smoking on 12/18/15. RN-E verified that a care plan to address R77's unsafe smoking was not developed until 3/15/16 and the safe smoking interventions were not included in the NA Kardex. RN-E further stated residents needing staff supervision should not have smoking materials on their possession.

On 3/18/16, at 1:39 p.m., DON was interviewed and stated R77 was assessed to need staff supervision while smoking. DON stated the expectation is for plan of care to be developed once it has been determined that a resident was not safe to smoke independently.

R242's Admission Record dated 3/21/16, indicated R242 had diagnoses which included, muscle weakness, tobacco use and multiple sclerosis. R242's significant change MDS dated 3/4/16, indicated R242 had severe cognitive impairment. The MDS also indicated R242 needed staff assist with transfers, personal hygiene, dressing, toileting and that he used a wheelchair for mobility.

Review of R242's progress notes from 12/21/15, to 3/21/16, revealed a progress note dated 1/13/16, written by social worker (SW) the note indicated SW observed two cigarette butts on the floor in R242's room and SW had a discussion with R242 regarding facility's smoking policy. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 88	F 323		

progress note further indicated that R242 told SW that he will be taking himself out to smoke. A progress note dated 2/16/16, indicated that staff noticed burn holes in R242's clothing, R242's family was updated and family reported to facility staff that R242 had a habit of "flicking cigarettes outside and poking holes in his pants. " A SW progress note dated 2/17/16, indicated that nursing and SW discussed safe smoking with R242. The progress note further indicated that R242 needed staff supervision with smoking.

R242's record review identified a facility form titled "Smoking Evaluation" dated 11/29/15, indicated that R242 did not have any cognitive loss, visual deficit or a dexterity problem and can light own cigarette with no adaptive safety equipment required. The Smoking evaluation dated on 2/27/16, and on 3/7/16, both of these indicated that R242 did not have any cognitive loss, visual deficit or a dexterity problem, can light own cigarette, required a smoking apron and needed staff supervision with smoking.

R242's care plan dated 3/15/16, indicated R242 required a smoking apron and staff supervision with smoking. However the care plan was developed 61 days later after facility staff first became aware of R242 unsafe smoking practices.

During resident room observation on 3/15/16, at 9:55 a.m. with RN-C the following were observed on R242's clothing:
- 1st pair- Red jacket noted with six cigarette burn holes on the front chest area of jacket approximately 1/4" to 1/2" in size.
- 2nd pair- Gray pants had nine cigarette burn holes on the front and 2 cigarette burn holes on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 89	F 323		

the back of right pant leg and three cigarette burn holes on the front of left leg.
- 3rd pair- Checkered jacket five cigarette burn holes on the front chest area of the jacket.
- 4th pair- Light teal/green jacket had nine cigarette burn holes on the front chest area of the jacket.
- When interviewed R242 stated at times he went out to smoke without a smoking apron or staff supervision.

When interviewed on 3/15/16, at 10:18 a.m. RN-C stated R242 did not have a smoking schedule. RN-C stated she was aware R242 needed an apron and staff supervision with smoking but did not know where the smoking apron was kept. RN-C further stated smoking apron was kept down stairs.

When interviewed on 3/15/16, at 1:06 p.m., NA-B, stated he noticed cigarette burn holes on R242's clothing when he started working at the facility about a month ago. NA-B stated he was not aware R242 needed an apron and staff supervision with smoking.

On 3/15/16, at 1:15 p.m., RN-D stated she completed a smoking assessment on 3/7/16, and assessed R242 to be unsafe to smoke independently. RN-D stated R242 needed a smoking apron and staff supervision with smoking. RN-D further stated looked at the clothing the resident had on at the time, she remembers checking R242's red jacket and the red jacket did not have any burn holes in it.

On 3/15/16, at 2:22 p.m., a family member (F)-A was interviewed via phone and stated she was aware of the number of cigarette burn holes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 90	F 323		

R242's clothing. F-A stated R242 used to live at an assisted living facility, they found cigarette burn holes on his clothing too and she informed facility staff. F-A further stated R242 was to have a smoking apron and needs to be supervised while smoking, but it was "hit and miss" depending which staff was working and if they are aware where the smoking apron was kept.

During interview on 3/18/16, at 10:52 a.m. RN-E acknowledged the facility became aware of unsafe smoking practices by R242 on 1/13/16. RN-E verified that a care plan to address R242's unsafe smoking was not developed until 3/15/16 and the safe smoking interventions were not included in the NA Kardex (nursing assistant assignment sheet).

On 3/18/16, at 1:48 p.m., the DON was interviewed and stated R242 was assessed to need a smoking apron and staff supervision while smoking. DON stated the expectation was for plan of care to be developed once it had been determined that a resident was not safe to smoke independently. The DON further stated it was her expectation that a resident assessed to need a smoking apron should be readily available to resident.

R248's Admission Record dated 3/21/16, indicated R248 had diagnoses which included, chronic obstructive pulmonary disease, generalized weakness, restless leg syndrome and difficult walking. R248 most current MDS dated 1/12/16, indicated R248 was cognitively intact. The MDS also indicated R248 needed staff supervision with personal hygiene, dressing, transfers and mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 91 R248's record review identified a facility form titled "Smoking Evaluation" dated 1/22/16, indicated that R248 did not have any cognitive loss, could light own cigarette but had a visual deficit and a dexterity problem. The smoking evaluation form indicated R248 did not require any safety interventions. R248's care plan dated 3/14/16, indicated R248 was a smoker. However, the care plan did not address R248's visual deficit and dexterity problem that were identified in the smoking assessment and the care plan was developed 52 days later after facility staff assessed R248's smoking. On 3/16/16, at 8:40 a.m. R248 was observed smoking a cigarette by the entry way to the facility. The DON was observed to walk to R248 and was heard to tell R248 that smoking was not allowed near the building and asked R248 to put out her cigarette. R248 was observed to put out her cigarette on the wall. The DON did not correct R248 when R248 put out her cigarette on the wall. During interview on 3/16/16, at 10:57 a.m. R248 stated she smokes outside of the building by the main entrance. When asked how she disposes off cigarette butts, R248 stated she throws them on the ground or in the garbage and continued to state "there is no ash tray down there." On 3/18/16, at 10:07 a.m. R248 stated the facility has cigarettes but disposal receptacles by the main entrance that was placed by the entrance after surveyor had interviewed her about cigarette disposals.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 92	F 323		

When interviewed on 3/15/16, at 1:06 p.m., nursing assistant (NA)-C, stated he was usually assigned to R77's group and continued to state he was not aware R77 needed staff supervision while smoking.
During interview on 3/18/16, at 10:20 a.m. RN-E acknowledged R248 was assessed to have a visual deficit and a dexterity problem. RN-E further acknowledged R248's care plan did not address R248's visual deficit and dexterity problem.

On 3/18/16, at 1:17 p.m. DON stated it was not safe to dispose cigarettes on the ground or in the garbage. DON stated her expectation was for the care plan to be developed once the assessments are completed to address all concerns identified with an assessment.

R286 was admitted on 1/27/16, with admission diagnoses of pneumonia, chronic obstructive pulmonary disease, cognitive communication deficit, and anxiety disorder.

A smoking assessment was completed on 1/29/16, The assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette, and did not state if the resident was safe to smoke or had limitations. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community smoking rules description.

On 2/16/16 a care plan was initiated that stated resident goes outside to smoke, with a goal that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 93	F 323		

the resident will follow smoking contract (which stated the facility was nonsmoking). The intervention was to remind resident to not smoke on facility grounds. On 3/14/16 a new intervention was added to state the resident will be offered nicotine patch if requests to discontinue smoking. The nursing assistant care card was requested but not provided.

On 3/15/16, at 10:07 a.m. R286 stated, smokes down the street, and has been cleaning up the TCU entrance, for days, I even was picking it up last night, it's should be cleaned up it looks terrible. TCU entrance, had more than 75 cigarette butts on the ground on 3/15/16. There was a garbage with a plastic liner covered but with open sides, and a large green bin of sidewalk salt.

R429 was admitted 2/17/16, with admission diagnoses of repeated falls, medication mismanagement, traumatic brain injury (TBI) with seizures. R429 signed smoking contract 2/17/15.

A smoking assessment was completed on 2/19/16, The assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette, and did not state if the resident was safe to smoke or had limitations. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community smoking rules description.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 94	F 323		

On 3/14/16 a smoking care plan was initiated that (after a list of smoking residents was requested by survey) and indicated resident chooses to smoke despite facility no smoking policy. Goal will be encouraged to comply with no smoking policy, Resident will be encouraged to decrease smoking. Interventions: offer nicotine patch if R429 chooses and smoking assessments quarterly.

At 9:59 on 3/15/16, stated she had cigarettes and lighter in jacket pocket (jacket draped over w/c, no evidence of burns), smokes down the road away.

On 3/18/16, at 10:30 a.m. the DON stated the facility had started a smoking focus group and talked to smokers, and they noted that we did not have ashtrays out. The facility was revamping policy about no smoking, people know it's a no smoking facility, and sign contract agreeing not to smoke and then go out to smoke anyway. Assessments were done on people who identify themselves as smokers on admission assessment, nurses do assessment on safe smoking. A new task force on smoking was developed. We are still in the process of planning and care planning.

The facility had resident smoking at the main entrance and at the TCU entrance, but lacked any safe smoking receptacles to put out cigarettes and put cigarette butts safely into.

R494 was observed on 3/15/16, at 10:49 a.m. a clean folded smoking apron was on the table in R494 room

On 3/16/16, at 8:40 a.m. R494 was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 95	F 323		

outside with two staff members asking staff and residents if they have a cigarette to lend. R494 did not have a smoking apron on.

During random observation 3/21/16, at 7:20 a.m. R494 was observed by a surveyor smoking at the end of the sidewalk outside of facility with another resident. A staff member was supervising smoking. R494 did not have a smoking apron on.

R494 was admitted on 10/27/15, with admission diagnoses indicated on admission record dated 3/21/16, of fracture of right hip, right femur, and multiple fractures of ribs, facial bones and skull with resulting cognitive communication deficit, muscle weakness and dysphagia (swallowing difficulty).

R494's quarterly MDS dated 2/1/16, indicated R494 had moderately impaired cognition and decision making and sometimes understood others if simple and direct communication. R494's MDS indicated need for assistance with all activities of daily living including eating.

A Progress Note dated 3/7/16, indicated RN-M went out side with R494 to assess ability to safely smoke. The Progress Note indicated R494 was able to light cigarette and smoke it safely. It also indicated R494 struggled with figuring out how to put out the cigarette. The information was not documented on smoking assessment or care plan.

A smoking assessment was completed on 3/14/16, The assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 96	F 323		

lacked any assessment of the ability to handle ashes, put out the cigarette. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community rules description. The assessment indicated R 494 did not have cognitive loss or visual deficits but did have a dexterity problem. Frequency of R494 liking to smoke was indicated as morning evening and night. The smoking assessment also indicated R494 could safely light a cigarette and required a smoking apron and staff supervision.

On 3/14/16, a smoking care plan was initiated that indicated R494 was choosing to smoke despite facility no smoking policy. The care plan goal was R494 would be encouraged to comply with no smoking policy. Interventions identified in the care plan were R494 was to be offered nicotine patches if R494 choose to discontinue smoking, R494 would receive smoking assessments by nursing staff and that the smoking assessment deemed that R494 required supervision to smoke. Intervention initiated on 3/14/16, on R494's activities of daily living care plan instructed staff that R494 chose to smoke and should have staff supervision. When staff see R494 propel down the hall they need to assist outside to ensure smoking safety. Care plan also informed staff that R494 would get very verbally aggressive with yelling and swearing at staff when R494 wanted to go outside to smoke. Care plan did not instruct staff to have R494 wear a smoking apron in accordance with smoking assessment.

During observation on 3/15/16, at 10:49 a.m. the Visual/Bedside Kardex Report dated 1/14/16, was posted inside R494 closet. The Visual/Bedside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 97	F 323		

Kardex Report dated 1/14/16, provided staff with no instructions regarding R494's smoking. A copy of the Visual/Bedside Kardex Report dated 1/14/16, was requested but facility provided Visual/Bedside Kardex Report dated 3/21/16, which instructed staff that resident smoking assessment deemed that R494 required supervision to smoke.

During interview on 3/21/16, at 5:14 a.m. LPN-D said, "Now we need to supervise R494. Last week they started smoking aprons and supervision."

During interview on 3/21/16, at 12:55 p.m. R494 stated "I go outside to smoke. They gave me this apron to wear last week. You guys want someone to watch us so I put up with it as long as there is someone to go out with me. I go out in the evening up till about 11p.m. and then 6:20 a.m. or 6:30 a.m. I smoke sometimes without anyone there. I have been smoking for several weeks. It is all I want to do." R494's mother verified R494 had been smoking for a while and that apron and supervision was new.

R511's significant change MDS dated 1/15/16, indicated he was cognitively intact and required staff assistance for all activities of daily living. R511's care plan dated 2/5/16, did not address smoking. A North Ridge Skilled, LLC progress Note dated 1/5/16, indicated R511 told activity aide (AA)-O, "I just want to go outside and smoke."

During an observation on 3/14/16, at 8:10 p.m., R511 was outside smoking a cigarette. He was using oxygen via nasal cannula, running at four liters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 98	F 323		

During an interview on 3/14/16, at 8:13 a.m., the administrator stated all residents sign an agreement on admission that they acknowledge the facility is smoke free. He stated if residents go outside to smoke they have been identified as able to smoke independently.

During an interview on 3/14/16 at 8:26 p.m., the DON stated R511 did not have a smoking assessment completed. She stated he had not been identified a resident who smoked. She further stated, all residents sign a smoking agreement as part of their admission.

A Smoking assessment was completed on 3/14/16, after the administrator and DON were notified of R511 smoking with his oxygen in use. The assessment indicated R511 needed reminders not to smoke with his oxygen running. Smoking safety was not added to R511's care plan.

During an interview on 3/15/16, at 10:37 a.m., R511 stated he had not been outside to smoke prior to the previous night. He further stated he did not know where he got the cigarette. He stated he was told on admission if he wanted to smoke he would have to go outside.

During an interview on 3/15/16, at 2:03 p.m., NA-T stated she was unsure if R511 smoked. She stated she knew he went outside but did not pay attention to whether or not he was smoking.

During an interview on 3/15/16, at 2:06 p.m., LPN-C stated R511 was asked about smoking on admission and stated he did not smoke. She stated she had never seen him smoke but stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 99 he does spend his time out in the common area by the front door. During an interview on 3/15/16, at 2:16 p.m., AA-O stated R511 told her he wanted to go outside and smoke. She stated she "did not remember" if she had told anyone. During a subsequent interview on 3/15/16, at 3:23 p.m., the administrator stated the facility had identified smoking as a concern. He stated the student administrator had been completing audits and determining when residents are going outside to smoke. He stated residents will outside to enjoy the weather and then decide to smoke. He stated, "This is a major concern for us." The facility's Smoking Policy revised 3/19/2012, directed that the facility shall establish and maintain safe resident smoking practices. The policy directed the facility will have designated smoking areas, smoking will only occur in smoking areas, facility approved ashtrays will be used and emptied into designated receptacles. The policy further indicated that residents who smoke will be evaluated for "safe smoking", any smoking restrictions/concerns shall be included in a resident's care plan and all residents requiring supervision with smoking shall have direct supervision at all times while smoking.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 100 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction was attempted for 1 of 5 residents (R422) reviewed for unnecessary medications. Findings include: A Pharmacy Consultation Report dated 10/1/15, indicated a recommendation to decrease R422's Remeron (an atidepressant) dose to 7.5 milligram (mg) at bedtime. The Pharmacy Report was not addressed by the facility. R422's quarterly Minimum Data Set dated 1/8/16, indicated he had no cognitive impairments, required assistance with activities of daily living	F 329	F329 R422 has been discharged. Facility has reviewed all outstanding gradual dose reduction requests and resolved as appropriate. All current residents using psychoactive medications have the potential to be affected by this alleged deficiency. Licensed staff have been educated regarding gradual dose reduction process. The DON/designee will audit 2 residents per unit, per month to ensure that gradual dose reduction recommendations have been addressed by the provider and processed appropriately. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 101 and displayed no behaviors. R422's care plan dated 1/14/16, indicated use of psychotropic medications for depression and anxiety, but did not address insomnia. A review of R422's Physician's Orders dated 3/18/16, indicated he was receiving Remeron 15 mg by mouth at bed time for insomnia. During an interview on 3/14/16, at 6:33 p.m. R422 stated he prefers to stay up until 2:00 a.m. to 3:00 a.m. He stated the night staff coming at 6:00 a.m. make a lot of noise and wake him up. During an observation on 3/17/16, at 2:36 p.m. R422 was lying in bed on his left side with his eyes closed. He appeared to be sleeping. During an interview on 3/18/16, at 8:32 a.m. registered nurse (RN)-M stated, the pharmacy recommendations go to the director of nursing and then get distributed to the units. She stated she was not aware of the recommendations by the pharmacist. During a subsequent interview on 3/18/16, at 1:13 p.m. RN-M stated, "the pharmacy recommendation was not followed up on." She stated she took care of it today. A facility policy titled, Tapering Medication and Gradual Drug Dose Reduction, dated September 2012 was reviewed. The policy indicated tapering of medications and gradual dose reductions will be completed in consultation with the physician and consultant pharmacist.	F 329		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 102 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 resident's (R4, R481, R57) were free from significant medication errors related to improper transcription. This resulted in actual harm for R4 and R481. R4 who was hospitalized related to seizure activity and R481 who suffered "almost constant pain" rated 10/10. Findings include: R4's quarterly Minimum Data Set (MDS) dated 1/8/16, indicated she had some cognitive impairment, required extensive to total assistance with all activities of daily living, and had an active diagnosis which included seizure disorder. During an observation on 3/16/16, at 2:40 p.m., R4 was sitting up in her wheel chair. She was alert and able to converse briefly with surveyor. During an interview on 3/16/16, at 2:40 p.m., family member (F)-B stated R4 was more "down and depressed." F-B stated she brought R4 to an appointment with the physician who admitted R4 to the hospital. She stated during the hospital stay it was discovered that R4 was getting "too little Lamotrigine." F-B stated R4 should have been receiving 200 milligrams (mg) four times daily and an additional 50 mg as needed. A review of facility Medication Administration	F 333	F333 R4 has been discharged. R481 and R57 medications have been transcribed appropriately. Current residents have the potential to be affected by this alleged deficiency. Residents are receiving medications transcribed appropriately as ordered by the health care provider. Licensed staff and health unit coordinators have been educated regarding appropriate transcription of medication orders. DON/designee will review all medication errors. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 103	F 333		

Record (MAR) dated January 2016 indicated R4 was receiving Lamotrigine (Lamotrigine is an anti-convulsant drug used in the treatment of seizure disorders) 200 mg four times daily until 1/6/16. At that time the dose was decreased to 50 mg four times daily.

A review of a facility Transfer/discharge Report dated 1/5/16, indicated a new order for "Lamotrigine 25 mg tab - take two tablets by gastric (G)-tube as directed." The order did not include the time/times it should be administered. The order was transcribed by the health unit coordinator (HUC) and verified by registered nurse (RN)-L. The order was transcribed as follows: Lamotrigine 50 mg via G-tube four times a day for cluster seizures. That was a decrease from 800 mg daily to 200 mg daily. The transfer/discharge report also indicated orders for Hyaluronic acid, Prevnar, and lab draws. A review of a North Ridge Skilled, LLC Progress Note dated 1/8/16 indicated, spoke with R4's physicians office to "clarify orders for labs and Hyaluronic acid." There was no indication a clarification was requested for the dosage of Lamotrigine.

A review R4's hospital history and physical (H & P) dated 2/7/16, indicated R4 had been hospitalized 2/1/16, due to atypical "withdrawn behavior, decreased interaction, and new left leg stiffness." The overall etiology of the patient's altered mental status was thought to be "multifactoral secondary to probable urinary tract infection, mild hyponatremia and/or subclinical seizures." The H&P indicated R4 had undergone an electroencephalogram (EEG). (an EEG is a test that measures and records the electrical activity of the brain and is often used to detect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 104	F 333		

seizure activity) and was placed on continuous EEG monitoring as she was found to have intermittent seizures. Her Lamotrigine dose was increased and two additional anti-epileptic medications were added.

During an interview on 3/18/16 at 8:06 a.m. RN-K stated she was aware of a discrepancy with R4's Lamotrigine error, but stated she was "not sure of the details."

During an interview on 3/21/16 at 12:38 p.m., the director of nursing (DON) stated, "I was aware of the seizures during [R4's] hospitalization." The DON further stated RN-K should have done a full chart review when R4 returned from the hospital.

During a subsequent interview on 3/18/16, at 12:51 p.m., RN-K stated she would have expected RN-L to question the decrease in R4's Lamotrigine dose and call the physician to get a clarification.

R481's admission MDS dated 2/9/16, indicated R481 was cognitively intact, suffered from moderate/severe depression, and required assistance with all activities of daily living except eating. In addition, R481 was identified as having almost constant pain that limited her day to day activities, with the most severe pain being rated at 10/10 (on a scale where 10 is the most painful). The Physician's Admission Orders/note dated 2/2/16, indicated R481 was admitted to the facility on hospice for gastric (stomach) cancer. R481 was placed at harm as R481 did not receive the physician ordered pain medication and R481 remained in pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 105	F 333		

A Care Area Assessment (CAA) for pain dated 2/11/16, was completed in relation to the 2/9/16 MDS. The CAA for pain had been triggered due to R481's responses to interview questions indicating she had pain which limited her activity, was almost constant, and rated 10/10. The CAA indicated R481 had advanced metastatic (mets) adenocarcimoma with mets to lymph and bone, arthritis/ DJD (degenerative joint disease), back pain with chronic pain syndrome hx (history) and opioid dependence. The CAA further indicated Allina Hospice was closely involved and along with their consulting pharmacist are working closely to manage pain with a goal of pain < (less than) 5.

The care plan initiated 2/11/16, indicated R481 had pain related to cancer of the stomach and lymph system that had spread to the bones, and interventions instructed staff to "administer analgesia [sic] [pain killer medication] as per orders."

The post hospital Discharge Orders dated 2/2/16, indicated staff were to give R481 gabapentin (medication to treat nerve pain) 800 mg three times daily for nerve pain, methadone (narcotic pain medication) 5 mg three times daily for severe pain, Morphine (narcotic pain medication) concentrate 20 mg/milliliter (ml) give 0.75 ml every four hours as needed for pain (PRN) or shortness of breath, and acetaminophen (a mild analgesic) 1000 mg three times daily for pain.

The Hospice Certification and Plan of Treatment dated 2/2/16, also indicated R481 was to receive gabapentin 800 mg three times a day and care planed for treatment neuropathic pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 106	F 333		

A review of R481's MAR indicated the gabapentin had not been identified on R481's February 2016 MAR.

The Allina Hospice and Palliative Care Facility Visit Record dated 2/3/16, patient complained of pain at 10/10. The Allina Hospice and Palliative Care Facility Visit Record dated 2/4/16, R481 indicated pain improved to 7/10. R481 received seven doses of Morphine 15 mg. in last 18 hours. New orders written to increase methadone to 10 mg three times a day and increase morphine to 20 mg every hour PRN.

Allina Hospice and Palliative Care Facility Visit Record dated 2/6/16, R481 rated pain at 6/10. Goal set to get pain down to 5/10.

Allina Hospice and Palliative Care Facility Visit Record dated 2/11/16, patient rated pain at 7/10.

The Physician Orders dated 2/11/16, indicated to discontinue Gabapentin 800 mg three times a day for nerve pain because R481 had not been receiving it, and increased Methadone to 15 mg three times a day scheduled. A copy of R481's Physician Orders were requested but not provided.

A Medication Error Report dated 2/11/16, and revised 3/3/16, indicated: "Hospice nurse informed writer that resident has not received Gabapentin 800 mg TID [three times a day] since arrival. Two nurses checked and it was not transcribed into PCC [Point Click Care-electronic health record]." The report further indicated there had been no injury to the resident, but failed to address the resident's pain level. The root cause analysis section of the Error Report indicated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 107	F 333		

"resident is a new admit on 2/2/16. Resident on hospice. Resident has not received Gabapentin 800 mg TID since arrival. Medication was not given d/t [due to] the fact it was not transcribed into PCC. Educate staff update MD [medical doctor] and family." R481 was placed at harm as R481 did not receive the physician pain medication upon admission.

RN-K said R481's medication error was discovered by an evening supervisor. The admission orders had been checked by two nurses but the gabapentin was missed. RN-K said, "I think it is the consistency of having someone on the desk. My assistant can cover the desk but only to 3:30 p.m."

R57's admission MDS dated 2/9/16, indicated R57 was cognitively intact, required assistance with all activities of daily living except eating, and had diagnoses of hypertension and end stage kidney disease with dependence on dialysis.

A Geriatric Services of Minnesota (GSM) long term care (LTC) Initial Intake form dated 2/4/16, indicated R57 had undergone a CABG x 4 (coronary artery bypass graft involving four arteries) in December of 2011.

The nursing home Admission Record, indicated R57 had been admitted to the facility 2/2/16. After Discharge Orders dated 2/2/16, indicated staff were to administer Coreg 3.125 mg by mouth three times weekly on Monday, Wednesday, Friday; and Coreg 6.25 mg by mouth with breakfast four times weekly Sunday, Tuesday, Thursday, and Saturday. The After Discharge Orders also instructed staff to give R57 Coreg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 108	F 333		

6.25 mg daily with the evening meal and indicated R57 attended dialysis Mondays, Wednesdays and Fridays at 12 :00 p.m.

The facility's Order Summary Report dated 3/21/16, indicated only Coreg 6.25 mg every day with evening meal had been entered into the electronic health record from 2/2 through 2/12/15, when Coreg 3.125 mg by month three times weekly Monday, Wednesday, Friday with breakfast; and Coreg 6.25 mg by mouth with breakfast four times weekly Sunday, Tuesday, Thursday, and Saturday were added. Review of R57's MAR indicated the resident had missed five doses of Coreg 3.25 mg, and five doses of Coreg 6.25 mg, between 2/2 and 2/12/16.

Review of R57's Weights and Vitals Summary dated 3/23/16, indicated R57's blood pressures had been checked daily, and had fluctuated, systolic 154-195, over diastolic 60-96 between 2/2 and 2/11/16. After the Coreg order had been clarified, R57's blood pressure range was identified as systolic 125-162, over diastolic 64-85 as documented 2/12 to 2/29/16. There were only two days between 2/12 through 2/29/16, where R57's systolic blood pressure was greater than 166 compared to nine days between 2/2 through 2/11/16.

A Medication Error Report dated 2/12/16, and revised 3/11/16, indicated, "Huc [health unit coordinator] indicated that Coreg was not on PCC and need clarification. Res. missed Coreg medicalization [sic] since admit ion [sic]. Coreg order was not clarified." The report further indicated new orders received and no injury. Predisposing factors identified medications with similar names. Root cause analysis indicated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 109	F 333		

"Resident received less than prescribed dose of Coreg. NP [nurse practitioner] notified. Error occurred with follow up clarification. Resident without injury from med error. Orders clarified with provider same day. IDT [interdisciplinary team] to provide education to individual recognized as responsible for error."

During interview on 3/21/16, at 10:19 a.m. registered nurse (RN)-E said, "the process when we receive a new order is the health unit coordinator (HUC) inputs the order in to the computer and then the nurse will check it. If the HUC does not input the order, one nurse will input it into the computer and the second nurse will check it."

During interview on 3/21/16, at 10:45 a.m. RN-K nurse manager said, the process for orders when a new admit arrives were The HUC would enter the orders into PCC then the charge nurse would clarify any orders needing clarification and then perform a second check on them. We try to do the clarification and second check on the same day as admission.

RN-K said R57's medication error occurred because, "the HUC wrote the order needed clarification and then we were without a charge nurse for several days. The nurse practitioner found the error and clarified the order." It was communicated to staff that it was not appropriate to write needs clarification. If an order has not been inputted into PCC the nurse checking the orders would enter the order and then have another nurse second check it. RN-K said, "We have not had a charge nurse consistently. The floor nurses having to pick that up."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 333	Continued From page 110	F 333		

During interview on 3/21/16, at 11:09 a.m. the DON said, "We changed our process for medication errors in October. Any nurse who finds a medication error should enter it in the computer, notify the doctor and responsible party. The nurse should get new orders and any monitoring needed and any assessments needed. They would notify the supervisor and possible call the DON or Assistant DON. Then the nurse manager can view the medication error, do education, and follow up, looking at precipitating factors, root cause analysis and sometimes discipline." Once the medication errors are signed by nurse manager then the DON reviews the errors. The administrator reviews the errors then the medication errors are taken to quality assessment and assurance meeting and the minimum effective dose committee. The DON said, "Our medication error trends are transcription errors. The DON said if there was harm from a medication error, if the resident required medical attention, if the resident required increased in monitoring, or if there was a negative effect from the medication error we would report the error to the state."

Administering Medications Policy revised April 2010, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed."
3. Medications must be administered in accordance with orders, including a required time frame.
4. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication

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F 333	Continued From page 111 shall contact the resident's Attending Physician or the facilities Medical Director to discuss the concerns."	F 333		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334		5/3/16

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F 334	Continued From page 112 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R310) was offered and/or received influenza and pneumococcal vaccinations as recommended by Centers for Disease Control (CDC).	F 334	F334 R310 has been discharged All admissions will be offered the appropriate immunizations. Current residents will be audited related to their immunization status at their next quarterly MDS and appropriate immunizations	

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F 334	Continued From page 113 Findings include: The Admission Record dated 3/21/16, indicated R310 was admitted to the facility on 11/10/15. Review of R310's facility immunization record lacked documentation if an influenza and pneumococcal vaccination had been received, contraindicated or refused. Review of R310's Minnesota Immunization Information Connection record provided by the facility indicated R310 received an influenza vaccination on 10/14/14 and lacked any documentation if he received a pneumococcal vaccination. On 3/21/16, at 2:40 p.m. the director of nursing (DON) stated documentation should be on the Informed Consent for Influenza and Pneumococcal Vaccine sheet, "but the forms change all the time and I don't know what all the forms are." On 3/21/16, at 3:00 p.m. the corporate consultant (CC), stated "sometimes they have the vaccines before they are admitted or at the hospital." On 3/21/16, at 3:40 p.m. DON stated the previous infection control nurse had a log for all the residents and "we can't find it." On 3/21/16, at 4:12 p.m. CC stated they could not find an informed consent record for influenza and pneumococcal for R310, "he may have had them at the AL [assisted living], we'll find it." The facility Influenza Vaccine (Residents) - Revised September 2012 indicated residents will	F 334	offered. Licensed nurses will be educated regarding immunizations the pneumococcal and influenza immunization. DON or designee will audit the immunization status of 2 residents per unit, per week to regarding immunization status. Results of audit will be reviewed by QAPI.	

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F 334	Continued From page 114 be offered the influenza vaccine annually, will be provided pertinent information about the significant risks and benefits of vaccines and that "between October 1st and March 31st each year, the influenza vaccine shall be offered to residents unless the vaccination is medically contraindicated or the resident has already been immunized." The facility Pneumococcal Vaccine - Revised September 2012 indicated residents will be offered the pneumococcal vaccine to aid in preventing pneumococcal infections, that prior to or upon admission, residents will be assessed for eligibility to receive it and when indicated will be offered the vaccination within thirty days of admission to the facility.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure resident dinnerware was clean of food debris and stagnant water to minimize the possibility of food borne illness. This had the potential to affect 288 of 293	F 371	F371 Food Procedure/store/prepare/serve Identified serviceware items were washed at the time of identification. Current residents who receive meals from	5/3/16

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F 371	Continued From page 115 residents in the facility who were served food out of the kitchen. Findings include: During the evening Bridgeway South (BWS) dining observation on 3/14/16, at 5:15 p.m. dietary aide (DA)-B was observed serving food to three staff members who were giving the food orders at the front of the steam table. Next to the plate warmer was a deep sided yellow plastic dish rack sitting on a three shelf push cart. DA-B continually took bowls as needed out of the dish rack and filled approximately 20 food orders for the back BWS service. At 6:03 p.m. the front BWS evening service started. When DA-B pulled three bowls out of the same yellow plastic dish rack, approximately 30cc of water was observed to run out of each of the bowls. DA-B continued to use the bowls, filling them with pureed meat and/or mashed potatoes and gravy serving them to residents seated in the dining room. During interview on 3/14/16, at 6:07 p.m. DA-A verified the multiple blue serving bowls in the yellow plastic rack were not dry and should have been allowed to dry properly before use. At 6:08 p.m. DA-A removed the yellow plastic dish rack of bowls and brought a new rack of dry bowls. During interview on 3/14/16, at 6:35 p.m. DA-B stated he "tries to look out for the ones with water in them." A puddle of water approximately 8 inches in diameter was observed underneath the area where the yellow dish rack had been sitting. There were also puddles of water on the second and third shelf of the three shelf push cart. DA-A verified the water on the cart had dripped out of the yellow plastic rack of dishes.	F 371	the kitchen have the potential to be affected by this alleged deficiency. Dietary Staff were educated on proper practices for mechanical washing of bowls and coffee cups. Audits to be completed up to 5 times per week by Dietary Manager or designee. Audits will be brought to QAPI meeting for review.	

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F 371	Continued From page 116 During the follow-up kitchen tour on 3/17/16, at 2:00 p.m. with the director of nutrition (DN), deep plastic dish racks were observed to contain numerous amounts of either all blue cereal bowls or a mix of blue cereal bowls and/or smaller fruit bowls or coffee mugs. The dishes were thrown into the racks, with some stored in an upright position. In the ten dish racks there were numerous bowls stored with water in them and at least eight cereal and fruit bowls contained dried food debris, some with water in them. The DN verified the dishes should have been stored clean of food debris and not stored wet with water in them. DN stated "we will be changing that procedure." Review of the facility Dishwashing Machine Use - Revised March 2012 included direction to "presoak dishes or pots that contain dried or burnt food, do not overcrowd racks and after running items through entire cycle, allow to air-dry." On 3/18/16, at 7:58 a.m. the DN stated she would expect the dishes to be clean and dry. DN stated "we need to do it right, I'm changing it right now."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		5/3/16

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F 425	Continued From page 117 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain antibiotic as ordered for 1 of 1 resident (R305) who was diagnosed with bronchitis. Findings include: During observation on 3/16/16, at 10:57 a.m. R305 was observed to be very short of breath with audible wheezing and usage of accessory muscles. R305 was unable to complete initial interview due to shortness of breath. R305 was sitting upright in a wheelchair with oxygen on via nasal cannula. There was a nebulizer machine sitting on the table next to R305. R305's annual Minimum Data Set (MDS) dated 2/9/16, indicated R305 was cognitively intact, required assistance with all activities of daily living except for eating which required supervision. R305 did not have shortness of breath or used oxygen during the assessment reference period of the MDS. R305's annual MDS did indicate	F 425	F425 R305 has received the prescribed antibiotic. Current residents have the potential to be affected by this alleged deficiency. Emergency drugs and biological are available to residents. Licensed nurses have been educated regarding the emergency drugs and biological. DON/Designee will audit administration of stat medications weekly Results of audit will be reviewed by QAPI.	

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F 425	Continued From page 118	F 425		

R305 had diagnoses of dementia, anxiety and asthma.

The care plan initiated on 3/15/16, indicated R305 had shortness of breath when lying flat due to a diagnoses of chronic obstructive pulmonary disease, and R305 used supplemental oxygen for comfort and has a history of bronchitis.

The Physician Telephone Order dated 3/15/16, indicated staff were do give Roxanol 20/milligrams(mg.)/milliliter(ml.) every hour as needed (PRN) for comfort and start oxygen at two liters by nasal cannula continuous for comfort.

The resident was seen by nurse practitioner on the evening of 3/16/16, and wrote orders for Keflex (antibiotic) 250 mg three times a day by mouth for seven days for bronchitis. "Start stat [immediately, without delay]!", albuterol neb (breathing treatment) 2.5 mg twice a day for five days stat every two hours and PRN and Prednisone (steroid that reduces inflammation) 10 mg STAT then every a.m. for four days.

The Geriatric Services of Minnesota Progress Notes dated 3/16/16, indicated (R305) alert, up and dressed cough bothering her, does want antibiotic. Lungs with diminished breath sounds and audible wheezes. Assessment was "bronchitis, not actively dying." The plan was appropriate to treat with antibiotics, prednisone, and nebulizer treatments.

A review of March 2016 Medication Administration Record did not indicate Keflex was given as ordered on 3/16/16. Prednisone 10 mg. stat was given at 6:06 p.m.

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F 425	Continued From page 119	F 425		

Northridge 1 SW Omnicell (automated medication dispensing system) Inventory faxed to facility on 3/18/16, at 10:23 a.m. was provided as a list of medications available in the facility for emergencies. Cephalexin (Keflex) 250 mg was on the list.

During interview on 3/16/16, at 11:00 a.m. registered nurse (RN)-F stated R305 was very short of breath yesterday so we obtained orders yesterday for morphine. R305 did not have a fever, and the oxygen saturations are 92 percent. R305 does not normally use oxygen.

On 3/17/16, at 8:30 a.m. trained medication aide (TMA)-A asked RN-G about R305's order for Keflex three times a day. TMA-A said "none has been given and it is not due until noon"

During interview on 3/17/16, at 2:12 p.m. RN-G said, "The order was inputted incorrectly. It was set up to start at noon, so I corrected it to 9:00 a.m." RN-G verified the Keflex had not been given on 3/16/16.

During interview on 3/18/2016, at 10:03 a.m. nurse practitioner (NP) said, "I was called on the fifteenth and was told she looked like she was dying so I ordered morphine [a narcotic]. When I saw her on the sixteenth she was up in her chair having difficulty breathing but not dying, so I ordered nebs, prednisone and an antibiotic. 'STAT' does not mean start the next day. It means as soon as possible. No one notified me that there was an issue getting the antibiotic. Delays in giving STAT medications are not acceptable."

During interview on 3/18/16, at 10:55 a.m. RN-H said, "STAT means as soon as possible. There

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F 425	Continued From page 120 was an issue with scheduling the medication. If we start it in the evening she might not get all of her doses. There was no supply of the antibiotic until the morning. If we order a medication from the pharmacy STAT they can get it for us in four hours." RN-H was not sure if Keflex was in the emergency kit. On 3/18/16, at 12:06 p.m. RN-E nurse manager said stat means now. "Sometimes we cannot get the medications from the pharmacy. I expect staff to notify the medical doctor if they cannot give a STAT medication." Administering Medications Policy revised April 2010, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed." "3. Medications must be administered in accordance with orders, including a required time frame."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 428	F428 R422 has been discharged	5/3/16

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F 428	Continued From page 121 review, the consulting pharmacist failed to follow up on recommendations for a gradual dose reduction for 1 of 5 residents (R422) reviewed for unnecessary medications. Findings include: A Pharmacy Consultation Report dated 10/1/15, indicated a recommendation to decrease R422's Remeron (an anti-depressant) dose to 7.5 milligrams (mg) at bedtime. The Pharmacy Report was not addressed by the facility. R422's quarterly Minimum Data Set dated 1/8/16, indicated he had no cognitive impairments, required assistance with activities of daily living and displayed no behaviors. R422's care plan dated 1/14/16, indicated use of psychotropic medications for depression and anxiety, but did not address insomnia. A review of R422's Physician's Orders dated 3/18/16, indicated he was receiving Remeron 15 mg by mouth at bed time for insomnia. During an interview on 3/14/16, at 6:33 p.m., R422 stated he prefers to stay up until 2:00 a.m. to 3:00 a.m. He stated the night staff coming at 6:00 a.m. make a lot of noise and wake him up. During an observation on 3/17/16, at 2:36 a.m., R422 was lying in bed on his left side with his eyes closed. He appeared to be sleeping. During an interview on 3/18/16, at 8:32 a.m., registered nurse (RN)-M stated, the pharmacy recommendations go to the director of nursing and then get distributed to the units. She stated she was not aware of the recommendations by	F 428	Current residents have the potential to be affected by this alleged deficient practice. Consultant pharmacist reports recommendations have been addressed. Unit managers have been educated regarding consultant pharmacist report recommendations DON/Designee will audit consultant pharmacist report recommendations monthly Results of audit will be reviewed by QAPI.	

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F 428	Continued From page 122 the pharmacist. During a subsequent interview on 3/18/16, at 1:13 p.m., RN-M stated, "the pharmacy recommendation was not followed up on." She stated she took care of it today. A facility policy titled, Tapering Medication and Gradual Drug Dose Reduction, dated September 2012 was reviewed. The policy indicated tapering of medications and gradual dose reductions will be completed in consultation with the physician and consultant pharmacist.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 123 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to keep medications secured on 1 of 2 units. Findings include: During random observation on 3/14/16, at 12:50 p.m. medication cart across from room 607 was observed to be unlocked. 12:54 p.m. nursing assistant passed medication cart. 12:55 p.m. staff member passed the medication cart delivering supplies. 12:57 p.m. R388 and a visitor passed the medication cart 1:01 p.m. registered nurse (RN)-R locked medication cart. 1:04 p.m. RN-R verified medication medication cart had been unlocked and the cart contained Coumadin (blood thinner), prescription medications, over the counter medications and narcotics in the cart. During interview on 3/21/16, at 11:09 a.m. the director of nursing (DON) stated the facility had	F 431	F431 Medications are secure on the unit. Current residents have the potential to be affected by this alleged deficiency. Medication is secure on all units. Nurses have been educated on securing medications. DON/designee will audit the security of medications on the unit daily. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 124 locked carts on the unit, unless the resident has a self-administration order and then they should secure them in their room. Staff should lock the medication cart if they are not able to adequately supervise it. The DON said medications that were dished up on top of the medication cart are not adequately secured if they are out of reach of the trained medication aide or nurse.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 441	Continued From page 125 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene, glove usage and linen handling were implemented while providing care for 2 of 3 residents (R35, R282) observed for wound or personal cares. Findings include: R35 was observed on 3/7/16, at 9:08 a.m. registered nurse (RN)-G applied a glove to the right hand without washing hands or using sanitizer. RN-G reached across R35's legs and removed left heel dressing. There was yellow and brown drainage on dressing. RN-G moved ankle to visualize the heel. R35's left heel was black. RN-G palpated the left wound edges. RN-G then removed the right heel dressing without changing gloves. RN-G pushed the right heel skin flap back and put R35's feet down so R35's bare heels were touching the bed sheets. RN-G removed gloves, washed hands. At 9:23 a.m. RN-G re-entered room. RN-G put gloves on and applied right heel dressing then taped square foam cover dressing to right heel. Without changing gloves RN-G applied left heel dressing then taped square foam cover dressing to left heel.	F 441	F441 R35 has been discharged. R282 is receiving care consistent with proper hand hygiene, glove usage, and linen handling. Current residents have the potential to be affected by this alleged deficiency. Residents are receiving care consistent with proper hand hygiene, glove usage and linen handling. Nursing staff has been educated regarding hand hygiene, glove usage, and linen handling. DON/designee will audit 2 resident care encounters per unit per week to ensure proper hand hygiene, glove usage and linen handling. Results of audit will be reviewed by QAPI.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 441	Continued From page 126 During R35's wound care observation on 3/17/16, at 11:44 a.m. RN-G said to R35 we need to change the dressing on your bottom. RN-G applied gloves, knelt on ground and removed the heels up device from under R35's legs. RN-G put the clean dressings still in their package on a chair. Nursing assistant (NA)-J helped roll R35 toward the wall and held R35 in place during the dressing change. NA-J opened the incontinence brief. There was brown stool on the brief. RN-G removed dressing from coccyx. RN-G applied wound cleanser to gauze and cleansed the coccyx wound. Coccyx wound was irregularly shaped with two ovals connected by a narrow strip of slough filled skin. The two ovals were filled with cream colored slough and the right oval was larger than the left oval. RN-G applied a pink dressing to R35's coccyx. NA-J cleaned stool from R35's bottom. NA-J then wiped stool off gloves with an incontinence wipe. A clean incontinence brief was placed under R35. RN-G removed dressing from left ischial tuberosity and cleansed wound with wound cleanser. The wound was circular approximately two centimeters in diameter. RN-G applied a pink dressing to wound. NA-J did not wipe the front of peri-area before applying incontinence product. NA-J removed gloves, washed hands and applied new gloves. RN-G said to NA-J, "usually when I do a dressing change, I wear two to three gloves so I just remove one layer at a time because after you remove your gloves you cannot put the others on." During interview on 3/17/16, at 11:55 a.m. RN-G verified saying "usually when I do a dressing change, I wear two to three gloves so I just remove one layer at a time because after you	F 441		

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F 441	Continued From page 127	F 441		

remove your gloves you cannot put the others on." RN-G said, "When I do a dressing change I do not wash my hands between gloves or use sanitizer. I just wash my hands when I am done."

During interview on 3/18/16, at 1:29 pm RN-E said I expect them to change gloves and wash hands after doing peri care. I expect them to change gloves and wash their hands between different wounds. We should not double glove ever.

During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) stated would expect staff to wash hands before they start treatment, explain what they are going to do, assesses for pain, use the bed side table. I expect after they remove the dressing to change their gloves and wash hands if they came in contact with anything before to put new gloves on. ADON verified expected staff to change gloves between wounds because would not want any cross contamination. ADON said there is no need to wear multiple pairs of gloves at the same time while doing cares. The ADON stated, "Staff are to wash their hands or use sanitizer after they remove gloves. Staff should remove gloves and wash hands after doing pericare or cleaning up stool. It is not acceptable to take a wipe and wipe off stool from glove."

R282's Minimum Data Set (MDS) dated 10/12/15, identified R282 required extensive assistance with toileting, dressing, bathing and personal hygiene.

During an observation on 3/17/16, at 8:10 a.m. nursing assistant (NA)-E provided incontinent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 441	Continued From page 128	F 441		

care along with morning cares. R282 was incontinent of bowel. NA-E donned gloves to provided incontinent care. NA-E assisted R282 to turn to the right side and began to clean R282's bowel movement with wipes and then provided personal care with a washcloth and towel. After the care was provided NA-E removed the gloves, applied a clean incontinent product underneath R282 and assisted R282 to lay flat on the bed. NA-E then donned new gloves and provided peri care to R282. NA-E cleaned R282's bowel movement and then provided perineal care. NA-E did not wash hands between cares.

After providing perineal cares, NA-E removed gloves and donned a new pair of gloves. NA-E proceeded to assist R282 with dressing. After completion of R282's personal care and dressing, NA-E stated to R282 that there were no bags in the room (to put the dirty linen in for laundry) and R282 stated "there's nothing unusual about that." NA-E then threw R282's gown, washcloth and towel on the floor.

NA-E called for additional help to transfer R282 out of bed and into the wheelchair. After the transfer was completed, NA-E brushed R282's hair and handed R282 her toothbrush. NA-E then removed her gloves and indicated that R282's morning cares were complete.

An interview with registered nurse (RN)-I on 3/17/16, at 11:25 a.m. confirmed staff hands should be washed in between incontinent care, perineal care and providing other personal cares. RN-I also confirmed that each room had bags for dirty linen to be put in for laundry and soiled linen should not be thrown on the floor.

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 441	Continued From page 129 A facility policy entitled Handwashing/Hand Hygiene dated April 2010, indicated that employee hands should be washed before and after assisting residents with toileting and indicated handwashing should be completed using soap and water.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure a safe, functional and sanitary environment, and resident equipment was kept in good repair for 9 of 10 residents (R10, R19, R77, R104, R118, R179, R282, R329, R368) whose rooms were reviewed for environmental concerns. In addition, the facility did not ensure a sanitary environment in 2 of 5 kitchenettes. This had the potential to affect 130 of 293 residents who were served food out of the Bridgeway South (BWS) and 2 West kitchenettes. Findings include: On 3/18/16, at 8:00 a.m. to 9:10 a.m. an environment tour was conducted with the maintenance director, director of housekeeping (DOH), maintenance staff (MS)-A, at 8:30 a.m. the facility's administrator joined the tour, during the tour the following environmental concerns	F 465	F465 Safe/functional sanitary environment Environmental concerns were addressed for R10, R19, R77, R104, R118, R179, R282, R329, and R368. Current residents who reside in the rooms defined by the deficiency have the potential to be affected by the alleged deficiency. Manufacturer guidelines were reviewed form grab bar in room 224. R104□s wheelchair was cleaned. Bridgeway South kitchenette backsplash was repaired. 2 West kitchenette was cleaned. Bridgeway entrance carpet was replaced. All residents have the potential to be affected, rooms and bathrooms will be cleaned daily. Staff will be re-educated on providing a safe, functional, sanitary, and comfortable environment.	5/3/16

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 465	Continued From page 130 were reviewed and verified. 1 South West - Room 126 closet door off track and missing handle. When asked how long it has been off track and missing the handle, the maintenance director stated he was not aware of the closet being off the track and missing handle. Maintenance director stated staff are to put in a teles work order for any items needing maintenance electronically. -Room 125 second bed a large gauge (approximately 8 inches by 4 inches) was noted on the wall in the room by the head of the bed. 2 West - Room 230 had a strong foul/malodorous smell in room - Room 224 had 2 large stains on the carpet on hallway by the entry into room, a large spider web in the corner above the foot of the bed, fan was noted with dirt and dust build up, and bilateral grab bars on the bed were loose. - R104's wheel chair (w/c) was noted to have a clear tape on bilateral arm rests and seat cushion was noted to be filthy with food debris. DOH stated tape on w/c was not a cleanable surface and w/c needed to be cleaned. 3 West - Room 322 had a strong urine odor in the room, the bathroom had a malodorous odor and the garbage can in the bathroom was noted to be filled with used incontinent products. - Room 338 the carpet was noted to be dirty/filthy with 3 black/brown stains on the carpet - Room 346 had a strong urine odor - 2 large black/brown stains on the carpet by the doorway to room 361 and 365 on the 3 west near	F 465	Environmental audits and TELS audits will be completed weekly. Audits will be reviewed by QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 465	Continued From page 131	F 465		

north hallway. DOH stated she was aware of the stains in the hallway and the hallway was shampooed on Monday 3/14/16 but she did not check back after the carpet was shampooed.
- R368's w/c brakes and left arm rest on w/c was noted to be loose, and w/c was noted to be filthy with food debris on both arm rests and on the cushion. Maintenance director verified that w/c brakes and arm rest were loose and stated they needed to be fixed.

BWS
- 6 dark stains on the carpet by the entry way to the BWS unit.
- Room 312 had 2 black stains on the carpet and no soap dispenser in the bathroom.
- Room 314- brown colored stain on the wall by the head of the bed, a large stain on the seat of wooden chair, the bathroom floor was sticky and had black/brown colored dirt buildup around the edges of the bathroom floor.

Kitchenettes

During the follow-up kitchen tour on 3/17/16, at 2:10 p.m., the following was observed and confirmed by the director of nutrition (DN).

- The Bridgeway South kitchenette had an eight foot kitchen counter which contained an ice machine on the left and sink to the right. There was a four inch backsplash behind the entire length of the counter which had white caulking above the backsplash and where the backsplash met the counter. Approximately three feet of this caulking behind the sink was brown/yellow colored with dirt and food buildup. The wall behind the clothing protector receptacle and two waste containers was splattered with food debris.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 132 - The 2 West kitchenette had a back wall to the left and behind the toaster cart which was directly behind the serving area of the steam table. Approximately four feet by four feet of the wall to the left of the toaster cart and approximately two feet by four feet of the back wall to the right of the toaster cart was splattered with heavy dried food debris. There was a heavy buildup of black/brown grime and food debris along the perimeter of the flooring. During an interview on 3/17/16, at 2:25 p.m., the DN verified both areas were a concern, needed cleaning and stated she would contact housekeeping who is responsible for cleaning the areas. On 3/18/16, at 9:10 a.m. DOH stated nursing staff were responsible for w/c cleaning and when asked how often w/c were cleaned, DOH stated she was not aware how often the w/c were cleaned. DOH further stated residents' rooms and bathrooms are cleaned daily. On 3/18/16, at 9:20 a.m. maintenance director stated he checked the electronic teles work order requests and could not find any teles work orders for the maintenance concerns that were identified during the environmental tour. Maintenance director further stated it ' s the expectation for staff to fill out an electronic teles work order anytime maintenance issues are identified. During interview on 3/18/16, at 1:11 p.m. the unit nurse manager RN-E stated that w/c are cleaned weekly and as needed by nursing staff on the night shift. RN-E further stated that housekeeping keeps the w/c cleaning schedules.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 465	Continued From page 133 On 3/18/16, at 2:08 p.m., the director of nursing (DON) stated that her expectation is for resident w/c to be kept clean. The facility's Cleaning/repairing Carpeting and Cloth Furnishings Policy revised 12/2009, indicated that the facility's carpeting and cloth furnishings shall be cleaned regularly according to the facility's cleaning schedules. - A routine maintenance policy was requested but none provided - A general, resident equipment, resident room and resident bathroom cleaning policy was requested but none provided.	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 134 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Quality Assessment (QA) committee recognized and developed action plans to address potential for injury for one resident who was consuming alcohol, becoming intoxicated, and posed a risk for injury to himself and other residents. In addition, the QA committee failed to develop an action plan to address an identified lack of sufficient staff necessary to provide care and services in accordance with their assessed needs for 14 of 23 residents (R439, R35, R62, R104, R77, R242, R248, R286, R429, R494, R511, R4, R481, R57). These deficient practices had potential to affect all 294 residents residing in the facility. Findings include: Refer to F314: the facility failed to provide care and services to prevent worsening of pressure ulcers for 1 of 4 residents (R439). This failure to provide care resulted in actual harm, worsening of pressure ulcers for R439. In addition the facility failed to prevent development of pressure ulcers for 1 of 4 residents (R62). Refer to F323: the facility failed to ensure adequate supervision while intoxicated for 1 of 1 resident (R104) who was known to consume alcohol (ETOH) in the facility. In addition, the	F 520	The facility has developed action plans for residents consuming alcohol, pressure ulcers, medication errors, and for providing adequate staffing. Current residents have the potential to be affected by the alleged deficiency. Facility staff and QAPI committee will be re-educated on the QAPI action plans to correct deficiencies. The NHA is responsible for compliance. NHA will review QAPI reports monthly to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 135	F 520		

facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 7 of 15 residents (R77, R242, R248, R286, R429, R494, and R511) who currently smoked in the facility.

Refer to F333: the facility failed to ensure 3 of 3 resident's (R4, R481, and R57) were free from significant medication errors related to improper transcription. This resulted in actual harm for R4 and R481. R4 was hospitalized related to seizure activity and R481 suffered "almost constant pain" rated 10/10.

During an interview on 3/18/16, at 8:37 a.m., the director of nursing (DON) stated she identified an ineffective process for medication error reporting. She stated during the months of August and September of 2015 she did not receive any medication error reports indicating an area for process improvement. She stated at that time she changed the process from a paper system to a computerized system. The DON stated, any of the nurses can initiate a medication error and the errors get recorded immediately. She stated she was able to track the medication errors daily. She further stated she tracked the errors on a report and brings them to QA.

While the process enabled the facility to track medication errors, it did not identify prevention of transcription errors and as a result, actual harm occurred for R4, and R481.

During an interview on 3/21/16, at 2:33 p.m., the administrator stated the facility QA committee met monthly to review a "multitude of projects" including infection control, pressure ulcers, medication storage, call light response times and

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 136	F 520		

repositioning. The administrator stated the QA committee identified staffing concerns and implemented a new performance based incentive program. He further stated the committee was currently working on a pressure ulcer project. He stated pressure ulcers are being tracked based on what comes in from outside the building, if there was improvement, how many are in the building and if they are acquired in the facility. However, he stated he did not know what particular process changes had been implemented.

While the facility identified a need for process improvement regarding pressure ulcers, there was no evidence of any recently revised systems. As a result actual harm occurred for R439.

The DON was interviewed on 3/18/16, at 11:50 a.m. regarding R104's alcohol use and aggressive tendancies, including the use of sharp objects when intoxicated. The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated that she believed the incident involved a box cutter, not a knife. The DON confirmed there was no incident report made about the 3/8/16, occurrence and further indicated she did not expect an incident report to be completed every time R104 was intoxicated. The DON indicated with identified care plan interventions, "any reasonable and prudent nurse" would know he was currently using alcohol and what to do if he was intoxicated. The DON confirmed the facility did not have a policy related to resident use of alcohol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 137 A facility QA policy was requested, but none received.	F 520		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WK73

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00238

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

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

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

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

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

6. DATE OF SURVEY **7/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

12.Total Facility Beds **320** (L18)

13.Total Certified Beds **320** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Lou Anne Page, HFE NE II 8/1/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 8/3/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245183

August 3, 2016

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

Dear Ms. Guindon:

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

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

Effective June 20, 2016 the above facility is certified for:

320 Skilled Nursing Facility/Nursing Facility Bedss

Your facility's Medicare approved area consists of all 320 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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 1, 2016

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

RE: Project Number S5183025, H5183121, and H5183122

Dear Ms. Guindon:

On April 7, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 12, 2016. (42 CFR 488.422)

On May 10, 2016, 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 survey completed on March 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on March 21, 2016. However, compliance with the health deficiencies issued pursuant to the March 21, 2016 survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to survey, completed on March 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to the survey, completed on March 21, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On July 21, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of $450.00, effective March 21, 2016. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective June 21, 2016. (42 CFR 488.417 (b))

On July 22, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 20, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 22, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 20, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

- Per day civil money penalty be discontinued as of June 20, 2016. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 21, 2016 be rescinded effective June 20, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245183	A. Building B. Wing	7/22/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 06/20/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** GD/kfd	**DATE** 8/1/2016	**SIGNATURE OF SURVEYOR** 18622	**DATE** 7/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/21/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WK73

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00238

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

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

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

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

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

6. DATE OF SURVEY **06/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

12.Total Facility Beds **320** (L18)

13.Total Certified Beds **320** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Rebecca Wong, HFE NE II 07/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 07/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 29, 2016

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

RE: Project # S5183025 and Complaint Numbers , H5183121, H5183122, H5183110, and H5183112

Dear Ms. Guindon:

On April 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on March 21, 2016 that included an investigation of complaint numbers , H5183121, H5183122, H5183110, and H5183112. This survey 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 14, 2016, the Minnesota Department of Health and on May 10, 2016, 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 an extended survey, completed on March 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 21, 2016. At the time of this revisit, we identified the following new deficiency:

F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality

The most serious deficiency in your facility was found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) , as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 4, 2016. (42 CFR 488.422)

However, as we notified you, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide

Training and/or Competency Evaluation Programs (NATCEP) for two years from June 21, 2016.

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 21, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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,

- Include electronic acknowledgement signature of provider and date.

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 remedy be imposed:

• 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 September 21, 2016 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health
PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2016

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

RE: Project Number S5183025

Dear Ms. Guindon:

On April 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 21, 2016 that included an investigation of complaint number H5183121,H5183122, **5183110 and H5183112**. This survey 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 May 10, 2016, 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 a standard survey, completed on March 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on March 21, 2016.

However, compliance with the health deficiencies issued pursuant to the March 21, 2016 standard extended survey has not yet been verified. The most serious health deficiencies in your facility at the time of the 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 June 21, 2016. (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 June 21, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 21, 2016. 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 June 21, 2016. 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 https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@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 312-353-1502 or by e-mail at tamika.brown@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 September 21, 2016 (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:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R 06/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on June 13 - 14, 2016 to determine compliance with Federal deficiencies issued during a recertification survey exited on 3/21/16. During this visit, certification tags were corrected that can be found on the CMS2567B. A new certification tag was issued that can be located on the CMS2567. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 4 of 4 residents (R150, R517, R425, R409) who were tablemate's and were dependent on staff assistance for eating.	F 241	Preparation, submission and implementation of this plan of correction does not constitute an admission of our agreement with the facts and conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or	6/20/16

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

Electronically Signed | 7/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R 06/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 Findings include: R150 was observed slapping her left leg continuously with her left hand while sitting in her wheelchair at the dining room table on 6/13/16, from at least 8:29 until 8:46 a.m. Three other residents (R517, R409, R425) and a family member were seated at the table with R150. R150 was sitting upright in the wheelchair with her legs elevated in front of her. R150 continuously slapped her left leg with both hands and then began slapping both legs with both hands. R150 then placed her foot on the table as she pounded her leg on the table. R517 was being assisted to eat by a family member at the time. R150 continued to slap at her legs and pound her foot on the table, placed her leg over the chair armrest. She then rubbed and hit her legs with both hands and then continued to hit at her right leg with her hand while pounding her foot on the table. Family member (F-A) who was seated across the table from R150 shook her head. At 8:50 a.m. a nurse was administering medications to R425, who was seated at the same table as R150, however, the nurse did not communicate with R150 or intervene in any way. On 6/13/16, at 8:43 a.m. F-A stated she came everyday for the morning meal and reported R150 "hits and pounds her foot on the table everyday, hits her legs everyday, and nobody does anything about it. She also takes other peoples food." On 6/13/16, at 8:45 a.m. an anonymous family member (F-B) stopped the surveyor and stated he visited a resident on the unit daily for the majority of meals. F-B reported R150, "She hits like that everyday. They never do nothing about	F 241	executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance. R150's foot was removed from the table. Skin assessment was completed 6/14 for source of behavior. Communication was provided to the provider, pain assessment was completed and the plan of care was reviewed. Resident 150 also had her wheelchair tilted in a more upright position when sitting by the table to ensure a more comfortable eating position and more appropriate positioning of her LE. She was also seated by the Aviary until just prior to serving the meal. Resident 150 has since then expired. R425, R517, and R409 are receiving a dignified dining experience. Residents in the front of Bridgeway South dining room have the potential to be impacted. Ongoing audits to identify any additional similar non-dignified dining behaviors have not revealed additional concerns with foot placement. Should other dining dignity concerns arise staff have been educated to appropriately intervene and manage potential behaviors to preserve a dignified dining experience. Residents experiencing behaviors impacting the dignity of other will be reviewed in our weekly PAR meeting to ensure that appropriate interventions are in place. The dining process has been altered to include a change in dining times and a change in the way we provide meal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R 06/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 that." R150's Minimum Data Set (MDS) assessment dated 11/12/15, identified R150's cognition was severely impaired. R150'S MDS care area assessment dated 11/12/15 identified R150 had a history of being occasionally restless in her wheelchair. R150's careplan dated 9/16/14 identified weight loss with potential further weight loss due to cognition, and the possibility of increased needs. Interventions included "staff assist with meals as needed; while resident is sitting at the meal table, staff to offer food and drink to keep resident occupied while waiting." R517's facesheet identified diagnoses including Alzheimer's disease. R517's the MDS dated 3/7/16, and careplan indicated that R517 required physical assistance with eating. R425's facesheet identified diagnoses of Alzheimer's disease. R425's careplan dated 6/1/15, indicated the resident required staff assistance to eat. R409's facesheet identified diagnoses including Alzheimer's disease. R409's MDS care area assessment dated 1/22/16, and careplan dated 2/16/15, identified R409 required staff assistance with eating. On 6/15/16, at 11:48 a.m. the assistant director of nursing (ADON) verified the breakfast had not been a dignified dining experience. The ADON would have expected staff to reposition R150 if she was making constant movement and remove the resident's foot from the table. On 6/15/16, at 1:00 p.m. the consultant regional registered nurse (CRN) stated she was unfamiliar with R150 and her observed behavior. When	F 241	service set up. Staff have been re-educated on the Quality of Life-Dignity policy which includes possible sources of behaviors in Dementia and appropriate interventions to manage those behaviors in a dignified way. Audits were completed on the unit and no other similar behaviors have been observed. DON/Designee will audit 2 meals per week in the front of Bridgeway South dining room to ensure a dignified dining experience. Results of the audits will be reviewed by QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R 06/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 asked how staff was directed to intervene by policy or procedure the CRN responded, it was "not my role--I don't direct them to do anything." The facility's 10/09, Quality of Life--Dignity policy directed "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality..." The policy did not address promoting dignity at mealtime.	F 241		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245183 Y1	A. Building B. Wing Y2	6/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016
ID Prefix F0250	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.15(g)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016
ID Prefix F0282	Correction	ID Prefix F0311	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016
ID Prefix F0314	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016
ID Prefix F0333	Correction	ID Prefix F0334	Correction	ID Prefix F0353	Correction
Reg. # 483.25(m)(2)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.30(a)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/22/2016	30951	6/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245183 Y1	A. Building B. Wing Y2	6/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0371	Correction	ID Prefix F0425	Correction	ID Prefix F0428	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.60(c)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	05/03/2016	LSC	05/03/2016	LSC	05/03/2016
ID Prefix F0520	Correction				
Reg. # 483.75(o)(1)	Completed				
LSC	05/03/2016				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/21/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245183	A. Building 01 - MAIN BUILDING 01 B. Wing	5/10/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0021	Correction Completed 05/03/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 05/03/2016	ID Prefix Reg. # NFPA 101 LSC K0146	Correction Completed 05/03/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 6/29/2016	SIGNATURE OF SURVEYOR 37009	DATE 5/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/16/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WK73

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00238

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

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

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

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

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

6. DATE OF SURVEY **03/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **320** (L18)

13.Total Certified Beds **320** (L17)

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 05/03/2016 (L19)
Kathy Sass, HPR-Dietary Specialist

18. STATE SURVEY AGENCY APPROVAL Date: 05/06/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

REVISED LETTER, 4/13/2016

Electronically delivered

April 7, 2016

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

RE: Project Number S5183025 and Complaint Numbers , H5183121, H5183122, H5183110, and H5183112

I have corrected the Complaint Numbers for the unsubstantiated complaints. They should be H5183110 and H5183112.

Dear Mr. Chies:

On March 21, 2016, 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. In addition, at the time of the March 21, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5183121 and H5183122. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the March 21, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers **H5183110 and H5183112,** that were unsubstantiated.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on June 5, 2015. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 12, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at F314 and F333. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

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

Failure to submit an acceptable PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC

and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 21, 2016 (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 September 21, 2016 (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:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Tom Linhoff, Fire Safety Supervisor

Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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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. 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. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint, H5183122 was completed. The complaint was substantiated. Deficiency(ies) issued at F353, F282, F312 and F333. An investigation of complaint, H5183121 was completed. The complaint was substanitated. Deficiency(ies) issued at F353, and F312. An investigation of complaint, H5183110 was completed. The complaint was not substantiated. An investigation of complaint, H5183112 was completed. The complaint was not substantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157		5/3/16

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

Electronically Signed | 04/15/2016

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F 157	Continued From page 1 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to notify family of the development of pressure ulcer on resident heels for 1 of 1 resident (R35). In addition, the facility failed to notify the medical doctor (MD) of the missed antibiotic for 1 of 1 resident (R305).	F 157	Preparation, submission and implementation of thie plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies	

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F 157	Continued From page 2 Findings include: R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed: - 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed was elevated 45 degrees. R35 had oxygen in place via nasal cannula. - 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about turning or repositioning before leaving room to get breakfast tray. R35 remained in same position as observed at 7:05 a.m. - 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's left heel and left without repositioning R35 off bottom. - 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35. During interview on 3/17/16, at 10:58 a.m. family member (F)-A said that in the last three weeks she [R35] had gotten so bad. "Three weeks ago she knew everything. They told me she had a bed sore on her bottom." F-A said, "No one told me about blisters on her heels." The facility provided a letter dated 3/22/16, from F-A which indicated "I was also aware of the pressure areas on her heels as the staff updated me regarding these concerns."	F 157	and licensing violations stated herein. This plan of correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance. F 157 R35 family has been notified. R305 MD has been notified. Each resident who has a accident resulting in injury with potential for requiring physician intervention, a significant change in status, a need to alter treatment significantly, or a decision to transfer or discharge, will have family and MD notification and is potential at risk related to this alleged deficiency. Licensed staff have been reeducated regarding notification of changes. Don/designee will audit 2 residents per unit per week to ensure that notification has occurred. Results of audit will be reviewed by QAPI	

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F 157	Continued From page 3	F 157		

During interview on 3/24/16, at 9:05 a.m. F-A stated, "They called me the next day after you spoke with me and told me about all of her ulcers."

R305 was observed on 3/16/16, at 10:57 a.m. to be very short of breath with audible wheezing and usage of accessory muscles. R305 was unable to complete initial interview due to shortness of breath. R305 was sitting upright in a wheelchair with oxygen on via nasal cannula. There was a nebulizer machine sitting on the table next to R305.

R305 was seen by the nurse practitioner on the evening of 3/16/16, and wrote orders for Keflex (antibiotic) 250 milligrams (mg) three times a day by mouth for seven days for bronchitis. The order read, "Start stat [immediately, without delay]!" albuterol nebulizer (neb-breathing treatment) 2.5 mg twice a day for five days stat every two hours and as needed (PRN) and "Prednisone (steroid that reduces inflammation) 10 mg stat" then every a.m. for four days.

The Geriatric Services of Minnesota Progress Notes dated 3/16/16, indicated (R305) "alert, up and dressed cough bothering her, does want antibiotic. Lungs with diminished breath sounds and audible wheezes. Assessment was 'bronchitis, not actively dying'." The plan was to treat with antibiotics, prednisone, and nebulizer treatments.

Review of the March 2016 Medication Administration Record (MAR) did not indicate the Keflex was given as ordered on 3/16/16.

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F 157	Continued From page 4	F 157		

Prednisone 10 mg stat was given at 6:06 p.m.

On 3/17/16, at 8:30 a.m. the trained medication aide (TMA)-A asked RN-G about R305's order for Keflex three times a day. TMA-A said "None has been given and it is not due until noon."

During interview on 3/17/16, at 2:12 p.m. RN-G said, "The order was inputted incorrectly. It was set up to start at noon, so I corrected it to 9:00 a.m." RN-G verified that Keflex had not been given on 3/16/16.

During interview on 3/18/16, at 10:03 a.m. nurse practitioner (NP) said, "I was called on the fifteenth and was told she looked like she was dying so I ordered Morphine (a narcotic). When I saw her on the sixteenth she was up in her chair having difficulty breathing but not dying, so I ordered nebs, prednisone and an antibiotic. 'STAT does not mean start the next day. It means as soon as possible.' No one notified me that there was an issue getting the antibiotic. Delays in giving stat medications are not acceptable."

Northridge 1 SW Omnicell (Southwest automated medication dispensing system) Inventory faxed to facility on 3/18/16, at 10:23 a.m. was provided as a list of medications available in the facility for emergencies. Cephalexin (Keflex) 250 mg was on the list.

During interview on 3/18/16, at 10:55 a.m. RN-H said, STAT meant as soon as possible. "There was an issue with scheduling the medication. If we start it in the evening she might not get all of her doses. There was no supply of the antibiotic until the morning. If we order a medication from the pharmacy STAT they can get it for us in four

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F 157	Continued From page 5 hours." RN-H was not sure if Keflex was in the emergency kit. On 3/18/16, at 12:06 p.m. RN-E nurse manager said STAT meant now. "Sometimes we cannot get the medications from the pharmacy. I expect staff to notify the medical doctor if they cannot give a STAT medication." Administering Medications Policy revised 2010, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed."	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		5/3/16

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F 225	Continued From page 6 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report and thoroughly investigate an incident involving 1 of 1 (R104) intoxicated resident documented to be threatening others with a knife. Findings include: R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5 pm. Hx [history] of alcohol abuse...Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note indicated R104's hospice agency and primary physician were notified of the incident and, "Received order to search resident's room and remove any alcohol found and continue to	F 225	F225 R104 Behavioral episode was reported and thoroughly investigated. Current resident have the potential to be affected by this alleged deficiency. Alleged violations are thoroughly investigated and measures put in place to prevent potential abuse during the investigation. Results of investigations are reported to the administrator or his designee and the State agency within 5 working days of the incident. Staff have been reeducated regarding reporting and investigating. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by QAPI	

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F 225	Continued From page 7	F 225		

monitor residents' VS [vital signs] and place on 15 min [minute] check for safety. Writer and NAR (nursing assistant) searched resident's room and found no liquor...Ok to monitor VS q [every] 1 hour for the next 2 hours then check VS q shift x 24 hours. Monitor for s/sx [signs and symptoms] of alcohol intoxications every shift and hold narcotics as needed. Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN (as needed) of resident room and room checks hourly and PRN for prohibited substances," "MD (medical doctor) orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify interventions to assist when R104's was actively drinking alcohol, what to do if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe related to R104's alcohol consumption.

R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. The care plan also included: R104 "prefers to hoard objects under w/c (wheelchair) cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and was "offered alternative storage of items and

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F 225	Continued From page 8	F 225		

declined." The care plan did not identify what staff should do if sharp objects were observed in R104's possession, or how to ensure the safety of other residents.

R104's significant change MDS dated 2/1/16, indicated R104 diagnoses included hepatic (liver) failure, cirrhosis, and severe cognitive impairment.

On 3/18/16 at 10:29 a.m. RN-K was asked about the 3/8/16 Progress Note regarding the resident's alcohol use and swinging of a knife, and RN-K stated she was not aware of the incident, and would not be informed every time R104 had been drinking. RN-K also stated that if a resident was identified as a danger to self or others, an immediate report would be made to the supervisor, assistant director of nursing (ADON), and DON, and staff would ensure the safety of the resident. RN-K stated that the progress note from 3/8/16 was a "unique situation" but if it was reported, a full investigation should be completed.

On 3/18/16 at 10:45 a.m., the DON was asked about the Progress Note dated 3/8/16, regarding R104's alcohol consumption and knife. The DON stated she did not recall the incident, but stated the ADON had been on-call that evening. The DON further stated she'd never been informed at any time of R104 swinging a knife at other people and would have expected to be informed if that had happened. The DON confirmed there was no incident report completed for the incident of 3/8/16, and no report was made to the SA. The DON also verified that having knifes or sharp objects was a "habit" of R104 that had been identified on R104's care plan.
At 12:51 p.m. on 3/18/16, the DON, ADON,

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F 225	Continued From page 9	F 225		

licensed social worker (LSW)-B and RN-H requested to discuss the Progress Note documentation from 3/8/16, at 5:49 p.m. with the surveyor. The DON stated RN-H had charted inaccurate information in R104's medical record because what RN-H had been charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member. RN-H then stated she'd charted what the ADON had told her when she was asked to come to R104's floor to assist due to R104's intoxication. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was what she was told by the ADON on the way down to R104's floor. The ADON then denied that, and stated she did not know where RN-H "got this information." The ADON and LSW-B stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician. The DON again stated the charting on 3/8/16, at 17:49 p.m. by RN-H was not accurate. "Hearsay" was charted and that was why she was not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and her expectation was staff was to chart accurate information. The DON additionally confirmed that had this incident occurred she would have expected the information to be reported to the administrator, law enforcement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 225	Continued From page 10 and the state agency (SA). RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN-H confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. based on what the ADON was now reporting. However, RN-H confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information at the time the chart entry was made. RN-H stated in any situation like that she would have informed her supervisor, but since her the ADON was her supervisor and had been the one to report the information RN-H did not follow up. RN-H stated by the time she got to R104's unit, R104 was not a threat to anyone and they did not send R104 to the emergency room. An interview with the administrator on 3/21/16, at 7:50 a.m. revealed he was contacted on the evening of 3/8/16, regarding R104 being "under the influence" and the resident had a box cutter. The administrator stated the ADON informed him R104 was upset, had a box cutter in his hands but denied R104 was threatening anyone. When asked about the 3/8/16, progress note in R104's medical record, the administrator stated what was charted in the progress note was not what he was told that evening. He stated the note was charted inaccurately and the nurse did not observe that type of behavior from R104. The administrator stated he expected staff to chart accurately and if that was what occurred that he should have been	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 11 informed. The administrator stated RN-H was given direction from the ADON, and it would have been a good idea for the ADON to review what was written. When asked why the progress note was not followed up and no information was provided further in the medical record, the administrator stated the facility "Can't go back and erase what was written" and was unsure about making a correction. The administrator also indicated that police would have been called if R104 had a weapon and was threatening people and reports would have been filed to the appropriate agency. A facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals, dated 3/16 indicated: All suspected incidents of abuse will be immediately reported to the stated agency. Additionally, the policy indicated under the definition of "verbal abuse" as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 intoxicated resident (R104) reported to be	F 226	F226 R104 Behavioral episode was reported to the state agency and administrator.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 226	Continued From page 12 threatening others with a knife was immediately reported to the administrator and the State agency (SA). Findings include: A facility policy titled Abuse Prevention Program, dated 3/16, and indicated, residents have the right to be free from abuse and neglect. A facility policy titled Reporting Abuse to Facility management- Revised 9/12, directed staff to report any suspected abuse to the administrator. The policy indicated the following definition: "neglect" the failure to provide the goods and services necessary to avoid physical harm. Additionally, the policy indicated under the definition of "verbal abuse" as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families. A facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals, dated 3/16, indicated: All suspected incidents of abuse will be immediately reported to the SA. R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5 pm. Hx [history] of alcohol abuse...Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note indicated R104's hospice agency and primary physician were notified of the incident and, "Received order to search resident's room and	F 226	Current residents have the potential to be affected by this alleged deficiency. Allegations of mistreatment, neglect, abuse of residents and misappropriation of resident□s property will be immediately reported to the administrator and State agency. Staff have been reeducated regarding implementation of the abuse and neglect policy and procedure. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 13	F 226		

remove any alcohol found and continue to monitor residents' VS [vital signs] and place on 15 min [minute] check for safety. Writer and NAR (nursing assistant) searched resident's room and found no liquor...Ok to monitor VS q [every] 1 hour for the next 2 hours then check VS q shift x 24 hours. Monitor for s/sx [signs and symptoms] of alcohol intoxications every shift and hold narcotics as needed. Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN [as needed] of resident room and room checks hourly and PRN for prohibited substances," "MD orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify interventions to assist when R104's was actively drinking alcohol, what to do if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol.

R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c [wheelchair] cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and R104 was "offered alternative storage of items and declined."The care plan did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 226	Continued From page 14	F 226		

not identify R104's possession of sharp objects or knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.

R104's significant change MDS dated 2/1/16, indicated R104 diagnoses included hepatic (liver) failure, cirrhosis, and severe cognitive impairment.

On 3/18/16, at 10:29 a.m. registered nurse (RN)-K was asked about the 3/8/16, Progress Note in R104's medical record and stated she was not aware of the incident and that she did not need to be informed of every time that R104 had been drinking. RN-K also stated that if somebody was a danger to self or others an immediate report would be made to the supervisor, ADON and DON and staff would ensure the safety of the resident. RN-K stated that the progress note from 3/8/16 referred to a "unique situation" but if it was reported a full investigation should be completed.

The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. and the DON indicated she did not recall the incident but the ADON was on-call that evening. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated that she believed the incident involved a box cutter, not a knife. The DON verified the box cutter did have a sharp blade end, however stated that she was not aware of R104 swinging it at others and that no one was threatened or harmed. The DON could not verify who the "other people" were and was unaware if any other staff or residents were involved with the situation. The DON confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 226	Continued From page 15	F 226		

there was no incident report completed for the incident of 3/8/16 and no report was made to the state agency (SA). The DON also stated that having knifes or sharp objects was a "habit" of R104 and that was identified on R104's care plan. At 12:51 p.m. on 3/18/16, the DON, ADON, licensed social worker (LSW)-B and RN-H requested to discuss the progress note written on 3/8/16, at 5:49 p.m.

The DON began to discuss RN-H charted inaccurate information in R104's medical record for the Progress Note as RN-H charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member. RN-H stated she charted what the ADON had told her when she was asked to come to R104's floor to assist, as R104 was intoxicated. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was what she was told by the ADON on the way down to R104's floor. The ADON then denied that, and stated she did not know where RN-H "got this information." The ADON and LSW-B stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician. The DON again stated the charting on 3/8/16, at 17:49 p.m. by RN-H was not accurate. "Hearsay" was charted and that was why she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 16	F 226		

not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and her expectation was staff was to chart accurate information. The DON additionally confirmed that had this incident occurred she would have expected the information to be reported to the administrator, law enforcement and the state agency (SA).

RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN-H confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. based on what the ADON was now reporting. However, RN-H confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information at the time the chart entry was made. RN-H stated in any situation like that she would have informed her supervisor, but since her the ADON was her supervisor and had been the one to report the information RN-H did not follow up. RN-H stated by the time she got to R104's unit, R104 was not a threat to anyone and they did not send R104 to the emergency room.

An interview with the administrator on 3/21/16, at 7:50 a.m. revealed he was contacted on the evening of 3/8/16, regarding R104 being "under the influence" and the resident had a box cutter. The administrator stated the ADON informed him R104 was upset, had a box cutter in his hands but denied R104 was threatening anyone. When asked about the 3/8/16, progress note in R104's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17 medical record, the administrator stated what was charted in the progress note was not what he was told that evening. He stated the note was charted inaccurately and the nurse did not observe that type of behavior from R104. The administrator stated he expected staff to chart accurately and if that was what occurred that he should have been informed. The administrator stated RN-H was given direction from the ADON, and it would have been a good idea for the ADON to review what was written. When asked why the progress note was not followed up and no information was provided further in the medical record, the administrator stated the facility "Can't go back and erase what was written" and was unsure about making a correction. The administrator also indicated that police would have been called if R104 had a weapon and was threatening people and reports would have been filed to the appropriate agency. A facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals, dated 3/16 indicated: All suspected incidents of abuse will be immediately reported to the stated agency. Additionally, the policy indicated under the definition of "verbal abuse" as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify and implement appropriate interventions including the potential utilization of internal and external resources for 1 of 1 resident (R104) with an identified concern related to alcohol intoxication and aggression. Findings include: R104's significant change Minimum Data Set dated 2/1/16, indicated R104 diagnoses included hepatic (liver) failure, cirrhosis, and R104 had severe cognitive impairment. R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5 pm. Hx [history] of alcohol abuse...Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note indicated R104's hospice agency and primary physician were notified of the incident and, "Received order to search resident's room and remove any alcohol found and continue to monitor residents' VS [vital signs] and place on 15 min [minute] check for safety. Writer and NAR (nursing assistant) searched resident's room and found no liquor...Ok to monitor VS q [every] 1 hour for the next 2 hours then check VS q shift x 24 hours. Monitor for s/sx [signs and symptoms]	F 250	F250 R104 is receiving medically related social services including utilization of internal and external resources as appropriate. Current resident with a history of ETOH abuse have the potential to be affected by this alleged deficiency. Residents with ETOH use/abuse are receiving medically related social services including utilization of internal and external resources as appropriate. LSW□s have been reeducated regarding provision of medically related social services including utilization of internal and external resources. Lead Social worker/designee will audit up to 2 residents per unit, per week. Results of audits will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 19	F 250		

of alcohol intoxications every shift and hold narcotics as needed. Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN [as needed] of resident room and room checks hourly and PRN for prohibited substances," "MD [medical doctor] orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify interventions to assist when R104's was actively drinking alcohol, what to do if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol.

R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c [wheelchair] cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and R104 was "offered alternative storage of items and declined."The care plan did not identify R104's possession of sharp objects or knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 20	F 250		

R104's undated Kardex Report directed staff under the "Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" and that R104 was "aware of the risks." The Kardex further identified "MD orders to hold narcotic medications for lethargy and updated MD PRN for substance abuse. Psych [psychiatrist] orders received." Additionally, the Kardex included "monitor for use of ETOH, NAR [nursing assistant registered] to report to nurse. Nurse if observed to have signs of impairment to ETOH, call MD for orders." The "Behavior" section of the Kardex identified R104 "was at risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons." The hourly checks were not documented anywhere in the medical record.

A vulnerability assessment was requested for R104. On 3/21/16, at 10:32 a.m. the director of nursing (DON) stated "Our social workers don't do a specific VA [vulnerable adults] assessment because all residents when they are admitted are VA." The DON further stated the "asterisks denote some vulnerability on the care plan."

An interview on 3/17/16, at 7:45 a.m. with nursing assistant (NA)-E revealed that "a while ago" R104 "had a big problem with drinking" and had "behaviors when drinking, he likes to swear. I think, he thinks he needs more help than he does and he gets an attitude. I'm not sure how he is getting alcohol, I haven't heard lately. He used to leave sometimes when he had a power chair to the liquor store down the road. " At 11:25 a.m. registered nurse (RN)-I stated that she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 21	F 250		

aware of R104's alcohol use and stated the last time R104 had used alcohol was "maybe two weeks ago." R104 had "gone out and come back drunk." R104's physician was updated and an order was obtained to hold medications at those times and to monitor for intoxication. When asked about R104 leaving the facility, RN-I stated "He signs out up front at the desk sign out, he is able to do that and he goes and sits out front of the facility." RN-I also stated R104 used Metro Mobility for transportation, arranged his own rides and went to the bank and went shopping. At 9:34 a.m. NA-F revealed R104 refused help a lot when he had been using alcohol and noted R104 "drank liquor last week" and he "curses a lot and is very aggressive when he's been drinking." NA-F was unable to provide a date and time to R104's alcohol consumption. At 2:22 p.m. licensed practical nurse (LPN)-B revealed R104 "drinks all the time" and "gets drunk." LPN-B revealed the physician ordered methadone (used as a pain reliever) cannot be given if R104 has been drinking. LPN-B stated she had "been here seven months and this is an ongoing issue." LPN-B stated R104 had been using alcohol on her shift "for a couple months" and noted R104 to be using alcohol "multiple times per week." LPN-B further revealed that she "wouldn't be surprised" if R104 was "drunk" and he "just leans over and sleeps on the armrest" of his w/c. When asked about the specific interventions for R104 when intoxicated and how/where to document issues, LPN-B replied "I don't know, I would hope it would be my TAR [treatment record] and to monitor for intoxication." When asked what else she was directed to do when R104 has been using alcohol, LPN-B replied "nothing, just monitor-15 min checks, he will usually pass out in his wheelchair." LPN-B went on to say that if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 22	F 250		

R104 was "belligerent, pushing, slapping, yelling or swearing" she would call the charge nurse or supervisor. LPN-B stated she had never had to call the hospital due to R104's alcohol use. When asked where R104 obtained alcohol LPN-B stated "There's a lot of suspicions that one liquor store delivers close by the front door and that one supervisor happened to be in the front area once and confiscated it before it was open. I've never seen a visitor outside of facility and never seen him leave the facility."

On 3/18/16, at 8:37 a.m. RN-J revealed she was aware of R104's drinking and "it's been awhile since I have seen him do it." When asked what was done when R104 was using alcohol, RN-J replied "usually" a room search was completed, no pain medications were given and the physician or hospice was notified. When asked how often room searches were completed RN-J replied "I don't know of a room search, usually if suspected drinking, that's just my guess." At 8:48 a.m. NA-G revealed R104 used to drink "most of the time" and would come back from lunch "always drunk." NA-G would tell the nurse and the nurse would take R104 back to his room. NA-G stated she has not witnessed that recently, "its maybe been a month now" but she would tell the nurse and then management would be informed. At 8:54 a.m. NA-H revealed R104 was often found by staff in the dining room "after he has been drinking and smells of alcohol." NA-H stated the last time that occurred was "a week and a few days ago." NA-H stated he told the nurse about R104 smelling of alcohol and the nurse brought him back to his room. NA-H stated he was not sure where R104 got the alcohol or where he drank it. NA-H stated he was unsure if R104 left the facility property as he never followed R104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 23	F 250		

down the elevator and was unsure of where he went when he was off of the nursing unit. At 10:13 a.m. licensed social worker (LSW)-A indicated she "sometimes checks his room for alcohol if staff thinks he is intoxicated. We complete random checks if we suspect intoxication; I have never found alcohol. " When asked how often checks are completed LSW stated it "just depends, nurses do it too" when asked what it "depends" on she stated she was "not sure what it depends on." LSW-A went on to say she thought R104 left the building and "goes out with Metro Mobility- not with any supervision, he tells the Health Unit Coordinator [HUC] and he usually signs out. He tells the HUC or charge nurse, as long as he is signed out he can leave." When asked if there was an assessment to determine if a resident could leave the facility unsupervised, LSW-A responded that it was based off a nursing assessment, and that she was not aware of any assessment or requirement for anyone to leave. LSW-A stated she had asked about the facility's alcohol policy and had "not received an answer on one." At 10:29 a.m. RN-K was interviewed and when asked about R104's alcohol use, RN-K replied that it was a "typical thing" for R104. RN-K went on to say staff was directed to complete random room searches for alcohol, hold narcotics and monitor the resident if he appeared intoxicated. When asked who was responsible for the room searches, RN-K replied that "typically social services" was responsible. RN-K indicated the facility staff found vodka bottles outside of the facility in planters and indicated these were R104's bottles. RN-K also stated staff was unable to identify where or how R104 obtained alcohol but he was "friends with everyone" at the facility and the connected assisted living facility. When asked if there was any interventions in place to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 24 prohibit R104's alcohol use, RN-K stated R104 was encouraged to participate in more activities on the unit and that Alcoholics Anonymous (AA) had been discussed but declined by R104. RN-K was aware R104 often had knives in his possession and presented two knives described as steak knives, that she had removed from R104's possession that she kept locked up in her office. RN-K stated the knives were identified on R104's care plan and R104 had been talked to multiple times about it. In addition, R104 was at risk for skin breakdown because R104 punctured his wheelchair cushion with the sharp objects. On 3/18/16 at 11:50 a.m. the DON confirmed she was aware of R104's alcohol use. When asked where R104 obtained alcohol, the DON indicated the facility staff was unaware of where R104 obtained his alcohol and R104 left the building unsupervised and arranged his own transportation. The DON stated R104 purchased the alcohol himself and she was aware of a liquor store that delivered to the home. The DON further stated R104 had been offered support to discontinue drinking such as AA meetings, however that was not identified in R104's medical record. The DON also stated that having knifes or sharp objects was a "habit" of R104 and that was indicated on R104's care plan. The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. and the DON indicated she did not recall the incident. The assistant director of nursing (ADON) was on-call that evening. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated she believed the incident involved a box cutter, not a knife.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 250	Continued From page 25	F 250		

At 12:51 p.m. on 3/18/16, the DON, ADON, licensed social worker (LSW)-B and RN-H requested to discuss the progress note written on 3/8/16, at 5:49 p.m.

The DON began to discuss RN-H charted inaccurate information in R104's medical record for the Progress Note as RN-H charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member. RN-H stated she charted what the ADON had told her when she was asked to come to R104's floor to assist, as R104 was intoxicated. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was what she was told by the ADON on the way down to R104's floor. The ADON then denied that, and stated she did not know where RN-H "got this information." The ADON and LSW-B stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician. The DON again stated the charting on 3/8/16, at 17:49 p.m. by RN-H was not accurate. "Hearsay" was charted and that was why she was not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and her expectation was staff was to chart accurate information. The DON additionally confirmed that had this incident occurred she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 26	F 250		

would have expected the information to be reported to the administrator, law enforcement and the state agency (SA).

RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN-H confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. based on what the ADON was now reporting. However, RN-H confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information at the time the chart entry was made. RN-H stated in any situation like that she would have informed her supervisor, but since her the ADON was her supervisor and had been the one to report the information RN-H did not follow up. RN-H stated by the time she got to R104's unit, R104 was not a threat to anyone and they did not send R104 to the emergency room.

There was no documentation to support LSW-B's interaction with R104 on 3/8/16, or documentation the removal of the box cutter from R104's possession. No new interventions were added to R104's care plan following the incident. Although R104 had a significant issue with alcohol consumption, aggressive tendencies when intoxicated, and created a potential threat to residents, visitors and staff when intoxicated, there were no individualized interventions in place to ensure the safety of R104 and other residents. In addition, staff was unaware of the interventions currently in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care (POC) for 2 of 7 residents (R511, R429) who were identified as smokers. Findings include: R511 was observed on 3/14/16, at 8:10 p.m., was outside smoking a cigarette. He was using oxygen via nasal cannula, running at four liters. A Progress Note dated 1/5/16, indicated R511	F 279	F279 R511 and R429 have comprehensive care plans that include smoking. Current resident who smoke while residing at the community have the potential to be affected by this alleged deficiency. Residents who choose to smoke have comprehensive care plans that include smoking. Licensed staff have been educated regarding comprehensive care plans that include smoking. Lead Social worker/designee will audit up	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 279	Continued From page 28 told activity aide (AA)-O, "I just want to go outside and smoke." R511's significant change Minimum Data Set (MDS) dated 1/15/16, indicated he was cognitively intact and required staff assistance for all activities of daily living. R511's care plan dated 2/5/16, did not address smoking. During an interview on 3/14/16, at 8:13 a.m., the administrator stated all residents sign an agreement on admission that they acknowledge the facility is smoke free. He stated if residents go outside to smoke they have been identified as able to smoke independently. During an interview on 3/14/16, at 8:26 p.m., the director of nursing (DON) stated R511 did not have a smoking assessment completed. She stated he had not been identified as a resident who smoked. She further stated, all residents sign a smoking agreement as part of their admission. A Smoking assessment was completed on 3/14/16, after the administrator and DON were notified of R511 smoking with his oxygen in use. The assessment indicated R511 needed reminders not to smoke with his oxygen running, however, smoking safety was not added to R511's care plan. During an interview on 3/15/16, at 10:37 a.m., R511 stated he had not been outside to smoke prior to the previous night. He further stated he did not know where he got the cigarette. R511 stated he was told on admission if he wanted to smoke he would have to go outside.	F 279	to 2 smoking residents per unit per week for comprehensive smoking care plans. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 29	F 279		

During an interview on 3/15/16, at 2:03 p.m., nursing assistant (NA)-T stated she was unsure if R511 smoked. She stated she knew he went outside but did not pay attention to whether or not he was smoking.

During an interview on 3/15/16, at 2:06 p.m., licensed practical nurse (LPN)-C stated R511 was asked about smoking on admission and stated he did not smoke. She stated she had never seen him smoke but stated he does spend his time out in the common area by the front door.

During an interview on 3/15/16, at 2:16 p.m., AA-O stated R511 told her he wanted to go outside and smoke. She stated she "did not remember" if she had told anyone.

During a subsequent interview on 3/15/16, at 3:23 p.m., the administrator stated the facility had identified smoking as a concern. He stated the student administrator had been completing audits and determining when residents are going outside to smoke. He stated residents will outside to enjoy the weather and then decide to smoke. He stated, "This is a major concern for us."

While R511 was observed smoking a cigarette with his oxygen running, and had expressed a desire to smoke, the facility assessed a need for reminders regarding smoking with oxygen but there was no evidence R511's care plan was updated to include smoking safety.
R429 was admitted 2/17/16, with admission diagnoses of repeated falls, medication mismanagement, traumatic brain injury (TBI) with seizures. R429 signed smoking contract 2/17/15.

A smoking assessment was completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 30	F 279		

2/19/16, the assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette, and did not state if the resident was safe to smoke or had limitations. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community smoking rules description.

On 3/14/16, a smoking care plan was initiated (after surveyor intervention) and indicated resident chooses to smoke despite facility no smoking policy. The goal will be encouraged to comply with no smoking policy. The resident would be encouraged to decrease smoking. Interventions were to offer nicotine patch if R429 chooses and the smoking assessments quarterly. R429 did not have an identified care plan for smoking in the medical record.

At 9:59 on 3/15/16, stated she had cigarettes and lighter in jacket pocket (jacket draped over w/c, no evidence of burns), smokes down the road away.

On 3/15/16, at 10:07 a.m. observation of the TCU entrance, had more than 75 cigarette butts on the ground on 3/15/16. There was a garbage with a plastic liner covered but with open sides, and a large green bin of sidewalk salt.

On 3/18/16, at 10:30 a.m. the DON stated the facility started smoking focus group and talked to smokers. They noted that, "we didn't have ashtrays out. The facility was revamping policy about no smoking, people know it's a no smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 31 facility, and sign contract agreeing not to smoke and then go out to smoke anyway. The assessments were done on people who identify themselves as smokers on admission assessment, nurses do assessment on safe smoking. A new task force on smoking was developed. We are still in the process of planning and care planning." The facility had residents smoking at the main entrance and at the TCU entrance, but lacked any safe smoking receptacles to put out cigarettes and put cigarette butts safely into.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 32 by: Based on observation, interview and document review, facility failed to revise the care plans for 2 of 2 residents (R35, R62) to reflect changes in care required with development of pressure ulcers and decline in condition. In addition, the facility failed to revise the plan of care (POC) for 1 of 5 residents (R104) who were identified to be currently using alcohol and carried a knife under the wheelchair (w/c) cushion. Findings include: R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed: - 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed was elevated 45 degrees. R35 had oxygen in place via nasal cannula. - 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about turning or repositioning before leaving room to get breakfast tray. R35 remained in same position as observed at 7:05 a.m. - 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's left heel and left without repositioning R35 off bottom. - 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35. The heels were left flat on the mattress after the treatment had been completed. The heels were not placed in a position to relive	F 280	F280 R35 is discharged. R62 and R104 have had their care plans revised to reflect current status. Current resident with skin breakdown or who have a history of etoh abuse have the potential to be affected by this alleged deficiency. Residents who have skin ulcerations or consume alcohol have been reviewed and care plans revised as appropriate. Licensed staff have been educated regarding care plan revisions for residents with skin alterations and residents who consume alcohol. DON/designee will audit up to 2 residents per unit per week to ensure appropriate revisions of care plan. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 33	F 280		

pressure.
-9:32 a.m. R35 was being fed breakfast and still not one offered to reposition her.

The annual Minimum Data Set (MDS) dated 2/5/16, indicated R35 was modified Independence with decision making. R35 required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35 had a history of falls in the last 90 days and was identified as at risk for the development of pressure ulcers. R35's MDS indicated R35 had diagnosis of heart failure, anemia, peripheral vascular disease, arthritis, dementia, and dysphagia (difficulty swallowing).

R35's Pressure Ulcer Care Area Assessment (CAA) dated 2/12/16, indicated R35 had risk for pressure ulcers related to being incontinent of bladder, below normal weight, and needing assist with bed mobility. CAA also indicated skin was intact and free of breakdown. CAA indicated R35 had a ROHO cushion (air filled cushion to reduce pressure on bottom while sitting) in chair and would care plan interventions to minimize risk factors for skin breakdown,

R35's Urinary CAA dated 2/12/16, indicated R35 was frequently incontinent of bladder and needed assist with toileting, managing clothing, peri care and incontinent pad. R35's CAA indicated facility would care plan interventions to manage incontinence when it occurs and reduce potential for complications related to incontinence.

Pressure ulcer care plan dated 3/3/16, identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 34	F 280		

that "R35 has the potential for skin breakdown/bruising r/t [related to] fragility/aging, incontinence, Prednisone [a steroid medication] use- has chronic senile purpura of both limbs and muscle wasting. The resident also had a diagnosis of peripheral vascular disease with the right great toe being ischemic, lower extremity edema, and history of ulceration. "Resident with skin breakdown on buttock r/t refusal to turn and reposition, end of life." The care plan instructed staff: "Creams/ointments/tx [treatments] as ordered, encourage side to side positioning - resident reluctant but encourage, encourage to sit with legs elevated as she allows, R35 has a ROHO cushion in WC pressure reduction mattress on bed. Check cushion inflation q [every] shift, observe skin daily with cares report concerns to licensed nurse, and skin check weekly on bath day by licensed nurse, treatments per MD/NP orders." While the care plan identified R35 as having skin breakdown on the buttocks, it did not address heel ulcers or Kennedy Ulcer. The care plan did not address the location or stages of ulcers. The care plan was not revised to include interventions to reduce pressure on the on heels.

On 2/29/16, the treatment sheet noted to keep heels dry and offload heels while blisters were intact. The care plan lacked direction for the staff on how to relieve pressure on the heels while in bed.

The Visual Bedside Kardex Report sheet dated 3/17/16, (after surveyor intervention) instructed staff to encourage R35 to allow side to side positioning, R35 "can turn and reposition using bilateral grab bars. Staff assist of two every 2 hours and PRN, per preference. Family is aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 35	F 280		

of resident refuse to turn and reposition. The risks and benefits was provided to resident and family." In addition, staff were to check and change R35 every two hours and as needed, Keep heels dry and off load pressure while blisters are intact. However the sheet lacked direction for the staff on how to relieve pressure on the heels while in bed.

A Progress Note dated 3/5/16, at 1:00 p.m. "Oh please don't move me. I'm hurting so much. My legs are hurting bad. Don't make me turn please." The note indicated staff were to continue to encourage turning/ repositioning every two hours as resident allowed to reduce pressure on buttocks. The medical record lacked any information of relieving pressure on the heels.

During interview on 3/17/16, at 12:46 p.m. with RN-E and RN-J, RN-E said "When I spoke to you Monday and today to the best of my knowledge [R35] had three pressure ulcers; one on her coccyx and two on her heels. [RN-G] told me [R35] had a new stage three wound on left lateral posterior upper thighs." RN-E said that when a new wound is found it is our facility protocol is to use risk assessment to document the wound. RN-E verified the care plan did not indicate R35 had current pressure ulcers nor was hospice on the care plan until after survey had started. RN-J stated R35's significant change in condition happened in March.

During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said the nurses look at the skin weekly. The ADON said the process is the nurse manager enters documentation regarding wounds on the pressure /non pressure ulcer report. ADON stated, "I would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 36	F 280		

expect to a nurse to document finding a new wound and alert nurse manager and nursing supervisor, notify hospice physician and family and put it on the 24 hour report. The nurse should pass it on in report including new open areas."

R62's Weekly Skin Report dated 12/31/15, indicated he had a pressure ulcer on his right buttock that was resolved. The care planned interventions at that time directed staff to complete weekly skin checks and encourage R62 to avoid positioning on coccyx. The care plan further indicated R62 was able to reposition himself in bed, however, his quarterly assessment dated 11/27/15, indicated he required extensive assistance from two staff. There was no evidence of weekly skin assessments between 12/31/16 and 1/27/16, at which time, a facility Weekly Skin Condition Report indicated a new pressure ulcer to R62's right buttock.

R62's care plan dated 1/14/16, indicated he was at risk for pressure ulcers, admitted to the facility with a pressure ulcer on his coccyx and had a history of re-opening pressure ulcers.

R62's care plan was updated on 2/9/16, however, no new interventions were implemented even though R62 had developed a new pressure ulcer. The care plan continued to direct staff to encourage R62 to avoid pressure to his coccyx even though his MDS indicated he required extensive assist of two staff for bed mobility.

R62's quarterly MDS dated 2/26/16, indicated he had no cognitive impairment, required extensive assist of two staff for bed mobility and transfers, and had a stage IV pressure ulcer (Full thickness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 37	F 280		

skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers).

During an observation on 3/16/16, at 3:06 p.m., R62 was lying in bed on his back watching television. During observations on 3/17/16, at 7:22 a.m., 7:50 am, and 8:44 a.m., R62 remained in his room lying in bed.

During an interview on 3/17/16, at 11:08 a.m., nursing assistant (NA)-K stated she was unaware of R62's skin condition. She stated, "I think there is an open area on his bottom." She further stated, R62 had no scheduled cares and stated if he needed anything he would put his light on.

During an interview on 3/17/16, at 11:11 a.m., licensed practical nurse (LPN)-C stated, R62 has a couple of open areas to his bottom and has daily dressing changes. She stated during his dressing changes he is able to hold on to the grab bar, she further stated staff are supposed to go in and offer repositioning every two hours. However, there was no care planned interventions directing staff to do that. LPN-C stated RN-M was responsible for the care plan.

During an interview on 3/17/16, at 11:17 a.m., registered nurse (RN)-M stated, R62 had a stage IV pressure ulcer when he moved to the unit. She stated the wound had healed on 12/31/16, and opened up again on 1/20/16.

During an interview on 3/17/16, at 3:07 p.m., the director of nursing (DON) stated, R62 "is pretty good at repositioning himself." She stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 38	F 280		

changed position in bed but was not sure if he was able to offload. While R62 was at increased risk for pressure ulcers and required staff assistance for repositioning, the facility did not implement interventions to ensure offloading of pressure from R62's bottom. Further, while previous pressure ulcers had healed and re-opened, the care plan was not revised with new interventions to prevent worsening of existing pressure ulcers or prevention of new pressure ulcers.

R104's significant change MDS assessment dated 2/1/16, indicated R104 had diagnoses that included hepatic failure and cirrhosis. The MDS also revealed R104's cognition was severely impaired.
R104's progress note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5pm. Hx [history] of alcohol abuse ... Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 [one to one] for safety. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note identified R104's hospice agency and medical doctor (MD) were notified of the incident, an order was obtained to search R104's room for liquor, but none was found, and staff identified they would, "Monitor for s/sx [signs and symptoms] of alcohol intoxication every shift and hold narcotics as needed." Further, the note identified, "Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 39	F 280		

R104's care plan identified R104 had "end stage liver disease, hx [history] of ETOH [alcohol], r/t cognitive impairment, hx of coffee ground emesis, hx of ETOH. Often refuses lactulose and is aware of the risks and benefits. R104 "has a history of abnormal labs. " Interventions include " frequent safety checks hourly and PRN [as needed] of resident and room checks hourly and PRN for prohibited substances. Resident is aware of the risks. MD [medical doctor] orders to hold narcotic medications for lethargy. Update MD PRN for substance abuse. Psych orders received. Revisit and remind of activities that may interest, 1:1 visits and chaplain support PRN. "
The care plan failed to identify R104's current alcohol use, what interventions staff should attempt if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol.
R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his wheelchair. R104 "prefers to hoard objects under w/c cushion including sharp objects like scissors" R104 "is aware of the risks and benefits" and R104 was "offered alternative storage of items and declined. "
The care plan did not identify R104's possession of knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.
R104's Kardex Report directed staff under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 40	F 280		

"Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" also included "frequent room checks hourly and PRN for prohibited substances" and that R104 was "aware of the risks". The Kardex further identified " MD orders to hold narcotic medications for lethargy and updated MD PRN for substance abuse. Psych orders received. " Additionally, the Kardex included "monitor for use of ETOH, NAR to report to nurse. Nurse if observed to have signs of impairment to ETOH, call MD for orders. " The "Behavior" section of the Kardex identified that R104 "was at risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons".

Information identified on the Kardex Report under the "Safety" section was not identified on R104's care plan.

A vulnerability assessment was requested for R104. On 03/21/2016 at 10:32 a.m. the DON stated that " Our social workers don't do a specific VA assessment because all residents when they are admitted are vulnerable adults" and stated that "asterisks denote some vulnerability on the care plan. "

An interview with RN-K on 3/18/16 at 10:29 a.m. revealed that RN-K was asked about the 3/8/16 progress note in R104's medical record stated that she was not aware of the incident and that she did not need to be informed of every time that R104 had been drinking. RN-K was also aware that R104 often has knives in his possession and then presented to the surveyor two knives (RN-K described as steak knives) that she had removed from R104's possession that she keeps locked up in her office. RN-K stated that this information is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 41	F 280		

on R104's care plan (regarding R104 having knives) and R104 has been talked to multiple times about it and is at risk for skin breakdown because R104 punctures his wheelchair cushion with the sharp edges.
The DON confirmed that she was aware of R104's alcohol use. When asked where R104 obtains alcohol, the DON indicated that the facility staff is unaware of where R104 obtains his alcohol and that R104 leaves the building unsupervised and arranges his own transportation. The DON stated that R104 purchases alcohol himself and that she is aware of a liquor store that delivers. The DON also stated that having knifes or sharp objects was a "habit" of R104 and that this was indicated on R104's care plan.
An interview with the Director of Nursing (DON) on 3/18/16 at 11:30 a.m. revealed that there was no assessment completed to determine if R104 was able to leave the building unsupervised however indicated that his placement in the facility (on the second floor) indicated that he was able to leave the facility unsupervised and that the nurses know who is able to leave the facility safely. The DON stated R104's alcohol use was identified on his care plan. When asked where this was on R104's care plan the DON displayed the care plan and pointed to the focus of "end stage liver disease, hx of ETOH, r/t cognitive impairment, hx of coffee ground emesis, hx of ETOH. Often refuses lactulose and is aware of the risks and benefits. R104 "has a history of abnormal labs". Interventions include "frequent safety checks hourly and PRN of resident and room checks hourly and PRN for prohibited substances. Resident is aware of the risks. MD orders to hold narcotic medications for lethargy. Update MD PRN for substance abuse. Psych

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 42	F 280		

orders received. Revisit and remind of activities that may interest, 1:1 visits and chaplain support PRN". The DON indicated that with what was listed as interventions that "any reasonable and prudent nurse" would know that he is currently using alcohol and what to do if R104 was intoxicated at the facility. The DON further stated that R104 has been offered support to discontinue drinking such as AA meetings, however this was not identified in R104's medical record. The DON further indicated that room checks should be completed hourly (as identified on R104's care plan) by the nursing assistants (NA's) but that nurses could complete this as well. The DON confirmed that she expects staff to be aware and follow R104's care plan. The DON confirmed that the facility did not have an alcohol policy.

POLICY

A policy entitled Care Plans-Comprehensive dated November 2012 indicated that "the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians orders. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change." The policy further indicates that

"each resident's comprehensive care plan is designed to:

a. Incorporate identified problem areas;

b. Incorporate risk factors associated with identified problems;

c. Build on the resident's strengths;

d. Reflect the resident's expressed wishes regarding care and treatment goals if applicable;

e. Reflect treatment goals, timetables and objectives in measurable outcomes;

f. Aid in preventing or reducing declines in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 43 resident's functional status and/or functional levels; g. Enhance the optimal functioning of the resident". A facility policy labeled Care Plans-Comprehensive, dated November 2012, indicated The Care Panning/Interdisciplinary team is responsible for the priodic review and updating of care plnas: when there has bee a significant change in the residents condition, and when the desired outcome is not met.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R439, R35) was repositioned as directed by the care plan; the facility failed to provide personal hygiene care for 1 of 1 resident in the sample (R35) who was dependent upon staff for personal cares according to the plan of care; and the facility failed to provide ambulation assistance to improve or maintain each resident's ability for 1 of 1 resident (R179) according to the plan of care. Findings include: Repositioning: R439 was admitted to the facility on 9/15/15, after	F 282	F282 R439 and R179 are receiving services by qualified persons per care plan. R35 has been discharged. Current resident have the potential to be affected by this alleged deficiency. Residents are receiving services by qualified persons per care plan including personal hygiene, turning and repositioning and ambulation assistance. Nursing staff have been educated regarding the provision of personal hygiene, turning and repositioning and ambulation assistance. DON/designee will audit will audit 2 residents per unit per week to ensure	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 44 extensive hospitalizations in acute care hospitals and long term acute care hospitals. 439's admission diagnosis from the Face Sheet included paraplegia [functional], pressure ulcer of sacral region Stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers), type II diabetes and morbid obesity, and major depression. The initial care plan dated 9/28/15, indicated R439 had pressure ulcers and potential for pressure ulcers development related to disease process, prolonged immobility. There was no discussion on the care plan of where the pressure ulcers were or any stages listed. The initial goal dated 9/28/15, indicated R439's pressure ulcer will show signs of healing and remain free from infection. The initial interventions dated 9/28/15, indicated, " Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Inform the resident and family/caregivers of any new area of skin breakdown. Pressure relieving/reducing device in bed/chair. Treat pain as per orders prior to treatments/turning etc. to ensure comfort. Educate R439/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. " On 3/17/16, continuous observations from 5:45 a.m. until 8:00 a.m. the resident was not repositioned, or approached to be repositioned.	F 282	appropriate provision of care by qualified persons. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 45	F 282		

At 6:24 a.m. registered nurse (RN)-P, knocked and entered room for blood glucose test. At 7:08 a.m. RN-B entered room without knocking, then called R439 by name, she left the room within 15 seconds of entering and placed something in the treatment cart garbage. At 11:16 a.m. RN-B stated she had entered his room the first time to get his blood sugar and the second time to give insulin. At 8:03 a.m. resident R439 was interviewed and stated he had not been turned on the night shift. At 8:05 a.m. RN-N was notified that the resident had not been turned during the time of continuous observation, and that the resident had stated he had not been turned all night. RN-N stated "He should be turned every two hours. "

On 3/18/16, at 9:08 a.m. R439 was interviewed and stated he had returned to facility last night from North Memorial Medical Center where he had been assessed in the emergency department. When asked when he had last turned, R439 responded last night at 8:30 p.m. At 9:52 a.m. notified RN-N, that resident stated not turned since 830 p.m. RN-N stated the charge nurse had shown him in point of care (POC - nursing assistant care tracking system), that R439 refused to turn. RN-N opened the POC charting and stated last turned at 11:09 p.m. There was no documentation for the night shift. RN-N stated the aide should inform the nurse when R439 refused (because aides cannot document more than yes or no). RN-N did verify the resident should be given the risks and benefits of refusal of repositioning and the risks and benefits and refusal should be documented each time he refused. A review of the nursing notes lacked documentation that R439 refused to turn. RN-N stated, " After you talked to me, I put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 46	F 282		

the orders for NA to continue repositioning on the care plan, I told nurses to document if he refused. " At 11:04 a.m. RN-N, stated he had interviewed R439 who told him "They [staff] do not reposition him at night."

The facility was able to print out the last 30 days of NA charting for bed mobility, turning and repositioning which revealed that out of four opportunities per shift (12 opportunities per day), a total of 360 opportunities there were 84 actual documentation as follows:
- On 2/20/16, 2/2816, 3/5/16, 3/8/16, 3/11/16, and 3/17/16, the night shift NA did not document anything on R439 for turning and repositioning.
- On 2/21/16, 2/26/16, 3/4/16, 3/9/16, 3/10/16, and 3/18/16, the NA documented " NO " once, for turning and repositioning.
- On 2/27/16, 2/29/16, 3/9/16, 3/14/16, and 3/15/16, the NA charting indicated the resident refused to turn once per shift, however there was no evidence that the NA informed the nurse who was then expected to re-approach R439 or document the risks and benefits of refusal to turn in the nursing Progress Notes.

On 3/18/16, at 10:24 p.m. the director of nursing (DON) stated she spoke to the evening supervisor and R439 frequently refused to be turned at night.
-At 10:41 a.m. the DON verified expectation that aides would follow the care plan.

Toileting:
R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed:
- 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 282	Continued From page 47	F 282		

was elevated 45 degrees. R35 had oxygen in place via nasal cannula.
- 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about toileting needs. R35 remained in same position as observed at 7:05 a.m.
- 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's and did not offer to check and change R35.
- 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35.
-9:32 a.m. R35 was being fed breakfast and still not one offered to reposition her nor did the staff check and change her.

The annual Minimum Data Set (MDS) dated 2/5/16, indicated R35 was modified independence with decision making. R35 required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35 had a history of falls in the last 90 days and was identified as at risk for the development of pressure ulcers. R35's MDS indicated R35 had diagnosis of heart failure, anemia, peripheral vascular disease, arthritis, dementia, and dysphagia (difficulty swallowing).

R35's Urinary CAA dated 2/12/16, indicated R35 was frequently incontinent of bladder and needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 48	F 282		

assist with toileting, managing clothing, peri care and incontinent pad. R35's CAA indicated facility would care plan interventions to manage incontinence when it occurs and reduce potential for complications related to incontinence.

Care plan revised 2/15/16, indicated R35 had a Self Care Performance Deficit related to pain, weakness/anemia, congestive heart failure, chronic obstructive pulmonary disease. Care plan was revised on 3/15/16, after the survey started to include "resident is currently enrolled on North Memorial Hospice. Decline expected." The care plan interventions written 3/15/16, instructed staff: R35 is checked and changed by staff every two hours and PRN.

Care sheet dated 3/17/16, instructed staff to check and change R35 every two hours and as needed, Keep heels dry and off load pressure while blisters are intact.

During interview on 3/17/16, at 9:50 a.m. NA-J stated, "I am to turn [R35] after every two hours. I check her for incontinence in the morning at the beginning of the shift and then at the end of the shift. I turned her around 6:00 a.m. when I got here." NA verified had not offer to reposition or do incontinence care R35 since 6:00 a.m.

During interview on 3/17/16, at 9:52 a.m. RN-G stated "She is supposed to be turned every two hours. I think that it is the same for checking her for incontinence every two hours."

During interview on 3/17/16, at 11:55 a.m. RN-G said, "After you left the floor [NA-J] and I spoke and he went in and changed her. She was wet but did not have any stool until we did the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 49 dressing change. I verified it had been over three hours since he last changed her." During interview on 3/18/16, at 1:29 p.m. RN-E said, "I expect them to at least offer to reposition a resident in accordance to her care plan. I expect them to do check and change or toilet and in accordance to the care plan." During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said "I would expect them to follow the check change or toileting care plan." Ambulation: R179's physical therapy (PT) discharge therapy note dated 7/31/15, indicated R179 had met his therapy goals and PT services were discontinued with instructions for nursing rehabilitation on the unit to ambulate R179 to meals. R179's care plan, last revised on 8/8/15, indicated R179 was to ambulate to all meals with a front wheeled walker and assist of one staff. R179's Kardex (nursing assistant assignment sheet) dated 3/10/16, indicated R179 was to walk to meals with a front wheeled walker (an assistive walking device) and wheelchair to follow. During observations on 3/16/16, at 11:04 a.m. R179 was observed to wheel self in the hallway. At 11:07 a.m. staff were observed to wheel R179 into the dining room. There were no offers by staff to ambulate R179 to the dining room. On 3/17/16, at 7:53 a.m. nursing assistant (NA)-A was observed to assist R179 with morning cares. NA-A applied a transfer belt around R179's waist and assisted R179 as he utilized a front wheeled	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 50	F 282		

walker to transfer self from the bed and onto a shower chair. At 9:00 a.m. R179 wheeled self to the dining room for breakfast. There were no offers by staff to ambulate R179 to the dining room.

When interviewed on 3/17/16, at 11:21 a.m. NA-A verified R179 was not walked to meals. NA-A further stated it had been several weeks since R179 had walked to the dining room.

On 3/17/16, at 11:35 a.m. registered nurse (RN)-A stated she was not aware if R179 was on a walking program and needed to check the Kardex. After checking R179's Kardex, RN-A verified R179 was to be walked to meals. RN-A stated she had worked on the unit for six months and had never seen R179 walked to meals. RN-A further stated that NA assigned to R179 was responsible for ambulating R179.

During interview on 3/18/16, at 11:13 a.m. unit nurse manager RN-E stated NA assigned to R179 was responsible for ambulating R179. RN-E further stated the expectation was for staff to follow resident's care plan, document any refusals and report to the nurse.

During interview on 3/18/16, at 11:30 a.m. the facility's director of nursing (DON) stated she expected staff to follow resident's care plan, if resident refuses cares NA are to report to the nurse and nurse to document in the resident's medical record.

The facility's Rehabilitative Nursing Care Policy revised 4/2007, indicated that the facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 51 optimal level of self-care and independence. The policy directed rehabilitative nursing care to be performed daily for residents who require such services.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation assistance to improve or maintain each resident's ability for 1 of 1 resident (R179) reviewed for ambulation with activities of daily living (ADL's). Findings include: R179's physical therapy (PT) discharge therapy note dated 7/31/15, indicated R179 had met his therapy goals and PT services were discontinued with instructions for nursing rehabilitation on the unit to ambulate R179 to meals. R179's care plan, last revised on 8/8/15, indicated R179 was to ambulate to all meals with a front wheeled walker and assist of one staff. R179's current Minimum Data Set (MDS) dated 1/29/16, indicated R179 was diagnosed with dementia, had mild cognitive impairment and required one staff assistance for bed mobility, transfers, dressing, toileting and ambulation. R179's Physical Functioning Assessment: dated	F 311	F311 R179 is has been reevaluated by physical therapy and is receiving ambulation services per recommendation. Current resident receiving restorative ambulation programs have the potential to be affected by this alleged deficiency. Appropriate residents are ambulated. Nursing staff have been educated regarding ambulating residents. DON/designee will audit 2 residents per unit per week to ensure appropriate residents ambulate. Results of audit will be reviewed by QAPI.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 52	F 311		

1/28/16, indicated R179 required assistance of one staff with ambulation.

R179's Kardex (nursing assistant assignment sheet) dated 3/10/16, indicated R179 was to walk to meals with a front wheeled walker (an assistive walking device) and wheelchair to follow.

During observations on 3/16/16, at 11:04 a.m. R179 was observed to wheel self in the hallway. At 11:07 a.m. staff were observed to wheel R179 into the dining room. There were no offers by staff to ambulate R179 to the dining room.

On 3/17/16, at 7:53 a.m. nursing assistant (NA)-A was observed to assist R179 with morning cares. NA-A applied a transfer belt around R179's waist and assisted R179 as he utilized a front wheeled walker to transfer self from the bed and onto a shower chair. At 9:00 a.m. R179 wheeled self to the dining room for breakfast. There were no offers by staff to ambulate R179 to the dining room.

When interviewed on 3/17/16, at 11:21 a.m. NA-A verified R179 was not walked to meals. NA-A further stated it had been several weeks since R179 had walked to the dining room.

On 3/17/16, at 11:35 a.m. registered nurse (RN)-A stated she was not aware if R179 was on a walking program and needed to check the Kardex. After checking R179's Kardex, RN-A verified R179 was to be walked to meals. RN-A stated she had worked on the unit for six months and had never seen R179 walked to meals. RN-A further stated the NA assigned to R179 was responsible for ambulating R179.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 53 During interview on 3/18/16, at 11:13 a.m. the unit nurse manager RN-E stated the NA assigned to R179 was responsible for ambulating R179. RN-E further stated the expectation was for staff to follow resident's care plan, document any refusals and report to the nurse. During interview on 3/18/16, at 11:30 a.m. the facility's director of nursing (DON) stated she expected staff to follow resident's care plan, if resident refuses cares NA are to report to the nurse and nurse to document in the resident's medical record. The facility's Rehabilitative Nursing Care Policy revised 4/2007, indicated that the facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The policy directed rehabilitative nursing care to be performed daily for residents who require such services.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to provide personal hygiene care for 1 of 1 resident in the sample (R35) who was dependent upon staff for personal	F 312	F312 R35 has been discharged. Current residents who are incontinent of bowel and bladder have the potential to be affected by this alleged deficiency.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 54 cares. Findings include: R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed: - 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. The head of the bed was elevated 45 degrees. R35 had oxygen in place via nasal cannula. - 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula only in one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about toileting needs. R35 remained in same position as observed at 7:05 a.m. - 9:08 a.m. registered nurse (RN)-G started nebulizer machine and applied mask with nebulization chamber attached to resident's face. RN-G completed the wound care to R35's and did not offer to check and change R35. - 9:23 a.m. RN-G came to finish wound care on the other heel and left the room without repositioning R35. -9:32 a.m. R35 was being fed breakfast and still not one offered to reposition her nor did the staff check and change her. The annual Minimum Data Set (MDS) dated 2/5/16, indicated R35 was modified independence with decision making. R35 required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35	F 312	Dependent residents who are incontinent are receiving care. Nursing staff have been educated regarding the provision of incontinent care for dependent residents. DON or designee will audit 2 dependent residents per unit per week for the provision of incontinent care Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 55	F 312		

had a history of falls in the last 90 days and was identified as at risk for the development of pressure ulcers. R35's MDS indicated R35 had diagnosis of heart failure, anemia, peripheral vascular disease, arthritis, dementia, and dysphagia (difficulty swallowing).

R35's Urinary CAA dated 2/12/16, indicated R35 was frequently incontinent of bladder and needed assist with toileting, managing clothing, peri care and incontinent pad. R35's CAA indicated facility would care plan interventions to manage incontinence when it occurs and reduce potential for complications related to incontinence.

Care plan revised 2/15/16, indicated R35 had a Self Care Performance Deficit related to pain, weakness/anemia, congestive heart failure, chronic obstructive pulmonary disease. Care plan was revised on 3/15/16, after the survey started to include "resident is currently enrolled on North Memorial Hospice. Decline expected." The care plan interventions written 3/15/16, instructed staff: R35 is checked and changed by staff every two hours and PRN.

Care sheet dated 3/17/16, instructed staff to check and change R35 every two hours and as needed, Keep heels dry and off load pressure while blisters are intact.

During interview on 3/17/16, at 9:50 a.m. NA-J stated, "I am to turn [R35] after every two hours. I check her for incontinence in the morning at the beginning of the shift and then at the end of the shift. I turned her around 6:00 a.m. when I got here." NA verified had not offer to reposition or do incontinence care R35 since 6:00 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 56 During interview on 3/17/16, at 9:52 a.m. RN-G stated "She is supposed to be turned every two hours. I think that it is the same for checking her for incontinence every two hours." During interview on 3/17/16, at 11:55 a.m. RN-G said, "After you left the floor [NA-J] and I spoke and he went in and changed her. She was wet but did not have any stool until we did the dressing change. I verified it had been over three hours since he last changed her." During interview on 3/18/16, at 1:29 p.m. RN-E said, "I expect them to at least offer to reposition a resident in accordance to her care plan. I expect them to do check and change or toilet and in accordance to the care plan." During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said "I would expect them to follow the check change or toileting care plan."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 57 Based on observation, interview and document review, the facility failed to provide care including monitoring and assessment, to prevent deterioration of pressure ulcers for 1 of 4 residents (R439) reviewed who had presssure ulcers. The failure to provide adequate care resulted in actual harm for R439 whose pressure ulcers deteriorated. In addition the facility failed to prevent development of pressure ulcers for 2 of 4 residents (R35, R62). Findings include: R439 was interviewed on 3/16/16, at 8:35 a.m. and stated "The night shift does not turn me." R439 stated he had reported that to the head nurse, and several aides were no longer allowed to care for him. R439 was admitted to the facility on 9/15/15, after extensive hospitalizations in acute care hospitals and long term acute care hospitals. R439's admission diagnosis from the Face Sheet included paraplegia [functional], pressure ulcer of sacral region, Stage IV (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers), type II diabetes and morbid obesity, and major depression. The admission Care Area Assessment (CAA) dated 9/27/15, indicated R439 was admitted with stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) to the sacrum/coccyx and two stage III pressure areas (Full thickness	F 314	F314 R35 has been discharged. R62 and R439 are receiving treatment and services to prevent/heal pressure sores. Current residents with pressure ulcers or risk risk of pressure ulcers have the potential to be affected by this alleged deficiency. Residents are receiving treatment of pressure ulcers and prevention of pressure ulcers. Nursing staff have been educated regarding the prevention and treatment of pressure ulcers. DON/designee will audit 2 residents per unit per week to ensure that care is provided to treat pressure ulcers or prevent pressure ulcers. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 58	F 314		

tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) to left and right buttocks. The areas had developed during prolonged hospitalization with multiple medical complications. A colostomy (intestinal diversion) and Foley catheter (urine collection system in the bladder) was initiated during the hospitalization as well as wound vac (mechanical wound management) to manage/treat pressure areas. A plastics [plastic surgery] doctor (MD) was following R439 and was considering a flap closure of the pressure ulcer (surgical covering of pressure ulcer to promote healing),and the follow-up scheduled for 10/1/15. A wound MD was following R439 while here and CAA indicated to see the Physician Progress Notes for measurements and debridement since admit. A Nutrition CAA had triggered as R439 had lost 150 pounds over the past six months, which was nutritionally significant, increased metabolic needs secondary to pressure areas.

The initial care plan dated 9/28/15, indicated R439 had pressure ulcers and potential for pressure ulcer development related to disease process and prolonged immobility. There was no discussion on the care plan of where the pressure ulcers were or any stages listed. The initial goal dated 9/28/15, indicated R439's pressure ulcer would show signs of healing and remain free from infection. The initial interventions dated 9/28/15, indicated staff were to assess/record/monitor wound healing. They were to measure length, width and depth where possible. assess and document status of wound perimeter, wound bed and healing progress. Staff were directed report improvements and declines to the MD. "Inform

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 59	F 314		

the resident and family/caregivers of any new area of skin breakdown. Pressure relieving/reducing device in bed/chair. Treat pain as per orders prior to treatments/turning etc. to ensure comfort." R439 required supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Staff were to educate R439/family/caregivers as to causes of skin breakdown which included transfer/positioning requirements; importance of taking care during ambulating /mobility, good nutrition and frequent repositioning.

The Physician Progress Notes from 9/16/15, going forward were reviewed and were as followed:
- On 9/16/15, initial progress note since admission to facility. R439 was admitted for management of Sacrococcygeal Stage IV pressure ulcer with possible osteomyelitis (infection in the bone) and respiratory failure requiring tracheostomy and lower paraplegia. Chronic pain due to sacral pressure ulcer, now on Fentanyl patch (extended release pain control) with Dilaudid (oral pain control) for break through pain. A colostomy and Foley catheter were started to promote wound healing ."Nursing reports patient has been cooperative with cares since admission. Patient with chronic sacral ulcer stage IV which was developed during extended and complicated hospitalization, being managed by a wound vac and followed by plastic surgery. Air mattress to assist with wound healing. Plan to continue physical therapy [PT] and occupational therapy [OT]."
- On 9/17/15, VOHRA (a wound company that specializes in wounds) Wound specialist progress note: "Consult requested for pressure ulcers. Stage IV wound of sacrum with moderate serous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 60	F 314		

exudate. Stage IV pressure ulcer of the sacrum 7 cm [centimeters] x 11.5 cm x 0.5 cm moderate serous exudate, 100% granulation tissue, dressing negative pressure three times per week (wound vac). Stage III pressure ulcer of the right ischium 4 cm x 4 cm x 1.5 cm with moderate serous exudate, thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. Wound debrided via surgical excision and subcutaneous tissue removed along with necrotic tissue. Post debridement depth 1.6 cm. Dressing Foam once daily, Santyl (helps clean wound) once daily. Stage III pressure ulcer of the left ischium 4 cm x 5.5 cm x 2 cm with moderate serous exudate. Thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. Wounds debrided via surgical excision and subcutaneous tissue removed along with necrotic issue. Post debridement depth 2.1 cm. Dressing, foam once daily, Santyl once daily, Calcium Alginate (provide antimicrobial action to prevent infection, absorb exudates and maintain a moist environment to promote rapid healing) once daily.
- On 9/21/15, nursing home (NH) progress note: seen by plastics team on 9/17/15, (transported to appointment) suggested a different wound vac. "Patient requested to be up 1-2 hours a day for meals and mental health, stated 'feels like he is in jail.' Requested shower on wound vac change days, charge nurse promised they will work around when more staff would be available to help. Sacrococcygeal wound connected to wound vac, left and right ischial (the lowest of the three major bones that make up each half of the pelvis) wounds covered with dressings, unable to assess. [R439] had a normal mood and affect, and behavior was normal. Bedrest except up 1-2 hours per day for a meal or leisure ."
- On 9/24/15, Wound specialist progress note:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 61	F 314		

"Stage IV pressure ulcer of the sacrum 10 x 11.5 x 1.5 cm moderate serous exudate, 100% granulation tissue, dressing negative pressure three times per week (wound vac) deteriorated to generalized decline of patient. Optimize nutrition. Stage III pressure ulcer of the right ischium 5 cm x 5 cm x 0.5 cm with moderate serous exudate, thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. No change. Stage III pressure ulcer of the left ischium 4 x 6 x 0.6 cm with moderate serous exudate. Thick adherent devitalized necrotic tissue 90%, granulation tissue 10%. Improved, decreased depth ."

- On 9/30/15, VOHRA Wound specialist progress note read, "Stage IV pressure ulcer of the sacrum 8.2 x 14.8 x 1.6 cm moderate serous exudate, 100% granulation tissue, dressing negative pressure three times per week (wound vac). No change. Stage III pressure ulcer of the right ischium 5.0 cm x 4.2 cm x 0.2 cm, improved, decreased depth. Stage III pressure ulcer of the left ischium 4 x 6 x 1.4 cm, improved, increased granulation."

- On 10/1/15, Plastic Surgery Clinic, doctor (D)-B: "[R439], last seen 1 month ago. Referral to D-A was never made, under the care of wound providers at facility. Sacral wound looked substantially improved with a nice granulating bed with no debris and no fibrinous material," and "Unfortunately in the last month, he had a significant progression and worsening of his ischial tuberosity pressure wounds. With a comment of the lack of pressure ulcer care which contributed to worsening pressure wounds." "When I saw him last his right side was fairly clean and his left side had a stage I pressure wound." "Now both are stage IV easily." "They both have necrotic material in them and are worsening in nature." "His cares are not being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 62	F 314		

met in an appropriate manner to my opinion." "He is under the care of a wound care nurse, but how a wound-care nurse can look at his wounds and feel like the cares are appropriate is not adequate to me." Lastly, "[Dr F.] will see him today."
- On 10/1/15, Wound Clinic Initial Note of Plastic Surgery Clinic, Dr F: Requested, but page 3 of the 4 page report was missing, which included the impression and plan of care.
- On 10/6/15, NH progress note: seen by the wound/burn specialist (transported to appointment) for concern for patient wound, wound dressing directions were given during that visit. "Sacral wound dressing continues with wound vac. Nurse reported bilateral ischial wounds were putting out excessive drainage and it has some odor, nurse had already completed dressing change today. Poor wound healing. Sacrococcygeal wound connected to wound vac, left and right ischial (the lowest of the three major bones that make up each half of the pelvis) wounds covered with dressings, unable to assess. [R439] had a normal mood and affect, and behavior was normal. Sacral ulcer stage IV, chronic and nonhealing. Patient also had bilateral ischial stage 2 ulcer [partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater] which is now draining excessive purulent malodorous drainage. Low grade temperature and nausea over the weekend. Obtain wound cultures [to look for infection] prior to next dressing change and blood culture next lab day."
- On 10/7/15, VOHRA Wound specialist signed off on R439.

The Progress Notes for the nursing home were reviewed from 10/13/15, going forward and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 63	F 314		

following was noted:
- On 10/13/15, NH progress note: "Bilateral unstageable ischial wound which was noted to be draining copious, malodorous greenish yellow drainage few days ago. Wound culture collected which came back with moderate growth of klebsiella pneumoniae [bacteria], moderate growth of enterobacter aerogenes [gram negative bacteria] and heavy growth of streptococcus B Beta hemolytic (S. Agalactiae) [gram positive bacteria]. Poor wound healing. Agrees to see in house psych [psychologist] and increase antidepressants and pain control. Wound culture with mixed growth, sensitive to tetracycline [antibiotic]. Continue to change wound dressing daily per wound specialist order."
- On 10/15/15, NH progress note indicated that the bilateral unstagable ischial wound were draining copious malodorous greenish yellow drainage.
- On 10/21/15, Nursing Weekly skin condition report (pressure and non pressure) noted the Sacrum measured 10.0 cm x 9.0 cm x 1.25 cm stage IV, the left IT (ischial tuberosity) measured 5.0 cm x 5.0 cm x 1.5 cm, and was a stage IV, the third ulcer on the right IT measured 4.0 cm x 4.0 cm x 1.25 cm and was a stage III ulcer.
- On 11/19/15, Nursing Weekly skin condition report (pressure and non pressure) noted the Sacrum measured 11.0 cm x 7.0 cm. The depth and the stage was not documented. The right IT measured 5.0 cm x 3.5 cm. The depth and the stage was not documented. The left IT measured 5.8 cm x 6 cm. The depth and the stage was not documented. The medical record was incomplete for the staging and measuring the depth for R439's wounds. In addition, review of the nursing notes for R439 between 9/15/15 and 10/14/15, lacked any documentation of refusals to turn or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 64	F 314		

reposition.

The quarterly Minimum Data Set (MDS) dated 12/15/15, indicated R439 was fully cognitively intact and had major depression, was on bedrest due to pressure ulcers, required assistance of two with turning and repositioning and did not resist cares.

On 2/9/16, the care plan was updated to state the pressure ulcers were all stage IV on admission, which directly conflicted with the Physician Progress Notes and admission assessments. The care plan identified R439 had been noncompliant with cares, however the medical record lacked evidence of supporting documentation for the statement. In addition, the care plan lacked direction for staff should R439 refuse cares, especially based on the significance of his wounds. In addition, there was no risk/benefit assessment completed and shared with R439.

The nursing assistant care card print date of 3/16/16, directed staff assist of two to reposition and turn in bed. grab bars on bed, turn and reposition every two hours when in bed and 30 minutes when up in wheelchair. R439 required assist of staff for mobility with stretcher transport to appointments.

On 3/16/16, at 8:36 a.m. R439 stated the night shift staff did not turn him, and he had reported that to registered nurse (RN)-N, and a handful of aides were no longer able to care for him.

On 3/17/16, continuous observations for two hours and fifteen minutes from 5:45 a.m. until 8:00 a.m. the resident was not repositioned. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 65	F 314		

6:24 RN-P knocked and entered room for blood glucose test. At 7:08 RN-P entered the room without knocking, called R439's name, and left the room within 15 seconds of entering. At 8:03 a.m. R439 was interviewed and stated he "had not been turned all night." At 8:05 a.m. RN-N was notified the resident had not been turned during the time of continuous observation, and the resident stated he had not been turned all night. RN-N stated "He should be turned every two hours." At 10:55 a.m., a pressure ulcer observation was not able to be obtained. At 11:00 a.m. the assistant director of nursing (ADON) stated the wounds have not changed in staging, it's maybe the difference between wound clinics. R439 had D-A and now had D-D and so maybe that accounted for the difference, but RN-N actually did the measurements. RN-N stated they have not changed stages since he started in September 2015. When interviewed at 11:16 a.m., RN-P stated she had entered R439's room to get his blood sugar and the second time to give insulin. At 11:20 a.m. nurse practitioner (NP)-B, stated she first saw R439 in 12/15, since then the wounds have decreased in size from grapefruit to less than a baseball, but bigger than a golf ball, and continue to have deep tunneling. An magnetic resonance imaging (MRI) was done on 3/14/16, to rule out osteomyelisitis (in the ischial tuberosities) and when the results arrived today we sent him to the hospital to receive intravenous antibiotics. NP-B stated the aides need to inform the nurses of what they see, because NP-B relied on the nursing staff to inform her of what's happening. The aides don't take direction from the nurses. At 11:30 a.m. D-C, stated with the change in ownership quality declined, but was coming back, "You have to have enough staff, and people who care what they are doing." D-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 66	F 314		

stated there was a system breakdown in pressure ulcer care in the facility. At 12:00 p.m. RN-N stated the wound had changed a lot since the last time she saw it, as it was oozing a lot more. RN-P "charge nurse", stated nursing does wound care daily, and the facility did wound rounds as the doctor measures and RN-P wrote it down. RN-P stated there had been three different wound providers for the facility, they had just started with a new wound doctor during the current week.

The MRI exam completed 3/14/16, identified bilateral deep ulcerative changes at the inferomeidal buttock soft tissue with extension anteriorly along the medial aspect of both ischial tuberosities, concerning for osteomyletitis (infection in the bone) and he was admitted to North Memorial Medical Center for IV antibiotics.

Review of North Memorial Medical Center (NMMC) emergency department records indicated the resident was sent back to the facility the evening of 3/17/16, on oral antibiotics, and indicated the osteomyelitis was chronic and not a new concern as stated by the MRI.

On 3/18/16, at 9:00 a.m. R439 stated the last time he was repositioned was at 8:30 p.m., a period of 12.5 hours. At 9:20 a.m. nursing assistant (NA)-Q stated they just transferred to this unit and didn't know R439, but just check the care card on the door. R439's care card said to reposition every two hours, and R439 was repositioned 15-20 minutes ago with NA-R. At 9:30 a.m. RN-N was informed the resident stated he had not been turned last night, and was asked if he had reported the allegation of neglect reported to him yesterday. RN-N stated he had reported it to the DON and consultant nurse (CN).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 67	F 314		

RN-N was asked if he had interviewed the resident after the allegation of neglect was reported. RN-N stated he had talked to R439, but had not asked about being repositioned on the night shift. At 10:24 a.m. the DON stated she spoke to the evening supervisor and R439 frequently refused to be turned at night, according to the night supervisor. At 11:04 a.m. RN-N, stated R439 "told me he was not being turned at night." At 2:04 p.m. RN-N stated he put an every two hour turn and reposition sheet up in R439"s room, because he took it very seriously when informed this morning, that R439 again stated he had not been turned again last night. RN-N called the nurse at home, who told him R439 had requested not to be disturbed at night. At 2:10 p.m. R439 stated he had never asked to not be disturbed at night. he may have occasionally refused to turn, because his shoulders may have been sore. R439 could not say what shift that occurred on, but clarified it was not very many times. R439 stated "I know I have to turn to get better."

On 3/21/16, at 5:10 a.m. no staff was observed in R439's unit, until RN-T made a facility wide announcement to welcome the health department to the facility. At 5:11 a.m. LPN-H, stated R439 refused the midnight turn, and accepted the 2:00 a.m. turn and got pain medicine, accepted the 4:00 a.m. turn but requested not to be awakened at 6:00 a.m. LPN-H stated R439 was offered pain meds whenever he's awakened. LPN-H, stated she would turn R439 again now, but stated aide who was working with her was helping in the 800 hallway (one of four hallways on the unit) right now. At 5:30 a.m. LPN-H called two other wings and asked if the aide was there with them, both answered no. At 5:35 a.m. the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 68	F 314		

(DON) came to R439's unit and spoke with LPN-H. At 5:42 a.m. LPN-H and LPN-I offered to turn R439, LPN-I stated "he just wanted the pillow removed, he didn't want to turn to the other side, and it's whatever makes him comfortable". At 6:53. a.m. LPN-I asked NA-S "Hey where were you, we were looking for you". NA-S stated, "I was taking my break." At 6:54 a.m. NA-Q was asked how many times R439 was turned last night, and she stated "hmm 3 or 4," however, acknowledged she had not been down the hallway to know whether R439 turned the forth opportunity or not. At 6:00 a.m. the DON stated there must be a language barrier, as RN-N was in R439's room right away at 8:00 a.m. At that time the DON was informed RN-N did not discuss the repositioning concern with R439.

R35's annual minimum data set (MDS) dated 2/5/16, indicated R35 had multiple diagnoses including heart failure, anemia, peripheral vascular disease, and dementia. The MDS identified R35 had modified Independence with decision making, required occasional assistance of one person in maneuvering in bed and while transferring from bed to chair or walking with walker. R35 required assistance with dressing, toileting and hygiene. R35 was incontinent of bowel and bladder. R35 was identified as at risk for the development of pressure ulcers.

R35's Pressure Ulcer Care Area Assessment (CAA) dated 2/12/16, indicated R35 had risk for pressure ulcers related to being incontinent of bladder, below normal weight, and needing assist with bed mobility. The CAA also indicated skin was intact and free of breakdown. CAA indicated R35 had a ROHO cushion (air filled cushion to reduce pressure on bottom while sitting) in the chair and would care plan interventions to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 69	F 314		

minimize risk factors for skin breakdown.

The care plan revised 2/15/16, indicated R35 had a Self Care Performance Deficit r/t pain and weakness. The care plan was revised on 3/15/16, one day after survey entrance. It included "resident is currently enrolled on North Memorial Hospice. Decline expected." The care plan instructed staff to check and change R35 every two hours and as needed (PRN). R35 could turn and reposition using bilateral grab bars. Two staff were to assist every two hours and PRN, per preference. Family was aware of resident refused to turn and reposition. The risks and benefits was provided to the resident and family.

R35 was observed continuously on 3/17/16, from 7:05 a.m. until 9:55 a.m. and the following was observed:
At 7:05 a.m. R35 was observed sleeping lying flat on back with mouth open. R35 had oxygen via a nasal cannula in place. The head of the bed was elevated 45 degrees. At 8:51 a.m. nursing assistant (NA)-J entered the room and spoke with R35. NA-J offered to get R35 breakfast and orange juice. R35's nasal cannula was in only one nostril. R35 said "I hope I can get up today. This thing behind my ear hurts." NA-J did not ask R35 about turning or repositioning before leaving room to get breakfast tray. R35 was not repositioned. At 9:08 a.m. registered nurse (RN)-G started the nebulizer machine and applied mask. RN-G completed the wound care to R35's left heel and left without repositioning R35. At 9:23 a.m. RN-G entered and finished wound care on the other heel. RN-G left the room without repositioning R35. The heels were left flat on the mattress after the treatment had been completed. The heels were not placed in a position to relieve

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 70	F 314		

pressure. At 9:32 a.m. R35 was being fed breakfast and not been offered repositioning.

During wound care observation on 3/17/16, at 11:44 a.m. RN-G informed R35 it was time to change the dressing on her bottom. NA-J rolled R35 toward the wall and held her in place during the dressing change. NA-J opened the incontinence brief. There was brown stool on the brief. RN-G removed dressing from coccyx (tailbone). RN-G applied wound cleanser to gauze and cleansed the wound. The coccyx wound was irregularly shaped with two ovals connected by a narrow strip of slough (unhealthy) filled skin. The two ovals were filled with cream colored slough and the right oval was larger than the left oval. RN-G applied a pink dressing to R35's coccyx. NA-J cleaned stool from R35's bottom. NA-J then wiped stool off gloves with an incontinence wipe. A clean incontinence brief was placed under R35. RN-G removed the dressing from left ischial tuberosity (hip) and cleansed wound with wound cleanser. The wound was circular and approximately two centimeters in diameter. RN-G applied a pink dressing to wound. NA-J did not wipe the front of peri-area before applying incontinence product. NA-J removed gloves, washed hands and applied new gloves. RN-G said to NA-J, "usually when I do a dressing change, I wear two to three gloves so I just remove one layer at a time because after you remove your gloves you cannot put the others on."

The Nursing Weekly Skin Evaluation (NWSE) dated 2/19/16, indicated R35's skin was intact without redness.

The NWSCR dated 2/25/16, instructed staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 71	F 314		

"Measure All Wounds, Stage Pressure Wounds Only ." The NWSCR indicated R35 had a Left heel blister measuring 4 centimeter (cm) x 4 cm and the blister was Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). However, the National Pressure Ulcer Advisory Panel (NPUAP) directs professionals that "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear " should be considered a deep tissue injury. The NWSCR indicated the date the blister was first observed was 2/25/16. No individualized interventions such as specialty mattress/bed, were identified. The comment section of report instructed staff to "Keep heels dry & off load pressure while blisters intact bilateral. If either blister opens use Allevyn heel dressings topically & change every two days." A second wound was also identified on the report as a right heel blister measuring 3 cm x 4 cm and staged as a stage II pressure ulcer. The date it was first observed was listed on the report as 2/25/16. A specialty bed and wheelchair cushion were indicated as interventions. The comment section of report instructed staff to "Keep heels dry & off load pressure while blisters intact bilateral." The NWSCR indicated R35 experienced pain from both heel blisters.

The NWSE dated 2/26/16, indicated R35's skin was intact, dry but had "moist and redness on upper buttocks bilateral. Calazime (cream) applied res [resident] repositioned ."

On 2/29/16, the treatment sheet noted to keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 72	F 314		

heels dry and offload heels while blisters were intact. The care plan lacked direction for the staff on how to relieve pressure on the heels while in bed.

The Physician Progress Notes dated 3/1/16, and written by the nurse practitioner (NP), indicated yesterday R35 had requested an increase in morphine. The Progress Note also indicated R35 had "new o/a [open area] bil [bilateral] Buttocks stage 2 dark terminal Kennedy ulcers (pressure ulcers that develop when a person is actively dying)" and blisters both heels has heels floated. The NP note indicted declining terminal condition, R35 wanted comfort care and declined hospice on 2/10/16.

The NWSCR dated 3/3/16, indicated R35 had a left heel blister that now measured 5 cm x 6.4 cm and was still a stage III pressure ulcer. The wound bed was described as "slough -moist yellow or gray necrotic tissue ." The report indicated that the blister had deteriorated and to continue same treatment. The right heel blister now measured 4 cm x 4 cm and was described as a stage II pressure ulcer that was unchanged with a dark pink/red wound bed. The report included a third wound that was described as a stage I pressure ulcer (nonblanchable erythema of intact skin, the heralding lesion of skin ulceration) on R35's coccyx measuring 5 cm x 4.8 cm that was first observed on 3/1/16. The wound bed was described as pink, pale tissue with reddened surrounding skin. R35 was noted to have pain from all three wounds.

The pressure ulcer care plan dated 3/3/16, identified that "R35 has the potential for skin breakdown/bruising r/t [related to] fragility/aging,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 73	F 314		

incontinence, Prednisone [a steroid medication] use- has chronic senile purpura [a rash of purple spots on the skin caused by internal bleeding from small blood vessels] of both limbs and muscle wasting. The resident also had a diagnosis of peripheral vascular disease with the right great toe being ischemic, lower extremity edema, and history of ulceration .Resident with skin breakdown on buttock r/t refusal to turn and reposition, end of life ." The care plan instructed staff: "Creams/ointments/tx [treatments] as ordered, encourage side to side positioning - resident reluctant but encourage, encourage to sit with legs elevated as she allows, [R35] has a ROHO cushion in WC pressure reduction mattress on bed. Check cushion inflation q [every] shift, observe skin daily with cares report concerns to licensed nurse, and skin check weekly on bath day by licensed nurse, treatments per MD/NP orders ." While the care plan identified R35 as having skin breakdown on the buttocks, it did not address the heel ulcers or Kennedy Ulcer. The care plan did not address the location or stages of ulcers. The care plan was not revised to include interventions to reduce pressure on the on heels.

The NWSE dated 3/4/16, indicated R35's skin was intact with redness and that, "Buttocks/coccyx areas excoriated. Resident refused to cooperate with full skin assessment." R35's heels were not addressed on the evaluation.

Progress Note dated 3/5/16, at 1:00 p.m. indicated "Late Entry: Focus Area - Weights, Falls, Behaviors, Wounds, Restraints, Other: Open area 3/1/2016: Resident's skin around gluteal folds was darkened in color. Open areas

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 74	F 314		

measured 3 cm x 0.5 cm and 3.4 cm x 1.2 cm. Resident has been declining and refusing to be turned/ repositioned. Resident's skin on buttocks is currently being treated with topical Calazime barrier cream. Update /Progress: Resident has a diagnosis of PVD and abnormal posture. Resident is decline recently and stay in bed most of time. Resident is recently admitted to North Hospice. She refused turn and reposition and asked staff to leave her alone. NP diagnosis Kennedy ulcer Plan: New orders received from MD/NP. Care plan updated. Will monitor for healing Notes: Resident description: 'Oh please don't move me. I'm hurting so much. My legs are hurting bad. Don't make me turn please.' Continue to encourage turning/ repositioning q2 hours as resident allows to reduce pressure on buttocks. Pre-medicate 20-30 minutes before turning. Updated nursing supervisors and NP on resident's new skin condition. Received new order to clean wound and apply Allevyn dressing over o/a, change QD [every day]. Continue Calazime treatment. Updated son about open areas ." The medical record lacked any information for relieving pressure on the heels.

The NWSCR dated 3/10/16, indicated R35 had a left heel blister that measured 5 cm. x 5.3 cm and was now an unstageable pressure ulcer [full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed]. Wound bed was described as pink, pale tissue, Slough-moist yellow or grey necrotic tissue and eschar-thick hard leathery, black. The surrounding skin was described as reddened. The comment section indicated, "Resident takes iron pills, left heel is 50% granulation and eschar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 75	F 314		

[dead skin]. Unstageable. Resident has an air mattress, positioning device and is on a schedule for repositioning. Continue with current orders at this time ." The right heel blister measured 5.3 cm x 4.5 cm and was described as a stage III pressure ulcer. The wound bed was described as both pink, pale tissue and as slough-moist yellow or grey necrotic tissue with the surrounding skin reddened. A nutritional supplement was added as an intervention. The coccyx pressure ulcer was now described as a stage II with measurements of 6.8 cm x 5.5 cm x 0.3 cm. The wound bed was described as both pink, pale tissue and as slough-moist yellow or grey necrotic tissue with the surrounding skin reddened. The comment section indicated, "Resident is comfortable, repositioned q [every] 2 hrs [hours] ." R35 was noted to have pain with all three wounds.

A NWSE dated 3/11/16, indicated R35's skin was intact with no open areas. It went on to describe right heal as healing and to keep repositioning R35. The left heel with healing area noted and to keep repositioning R35, and the coccyx was described as healing. R35 was repositioned but had refused to cooperate with repositioning during the day shift.

The Visual Bedside Kardex Report sheet updated 3/17/16, 2 days following survey entrance and investigation, instructed staff to encourage R35 to allow side to side positioning, R35 "can turn and reposition using bilateral grab bars. Staff assist of two every 2 hours and PRN, per preference. Family is aware of resident refuse to turn and reposition. The risks and benefits was provided to resident and family ." In addition, staff was to check and change R35 every two hours and as needed, Keep heels dry and off load pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 76	F 314		

while blisters are intact. However the sheet lacked direction for the staff on how to relieve pressure on the heels while in bed.

During interview on 3/17/16, at 9:50 a.m. NA-J stated, "I am to turn [R35] after every two hours. I check her for incontinence in the morning at the beginning of the shift and then at the end of the shift. I turned her around 6:00 a.m. when I got here ." NA-J verified R35 had not been offered to reposition or incontinence care since 6:00 a.m.

During interview on 3/17/16, at 9:51 a.m. NA-A stated, "I don't have her. I only take care of my residents unless another aide asks me for help ."

During interview on 3/17/16, at 9:52 a.m. RN-G stated "She is supposed to be turned every two hours. The orders say as resident allows. I would expect them to offer to turn her at least every two hours. I think that it is the same for checking her for incontinence every two hours."

During interview on 3/17/16, at 10:58 a.m. family member (F)-A said that in the last three weeks she had significantly declined. :They told me she had a bed sore on her bottom." FM-A said, "No one told me about blisters on her heels ."

During interview on 3/17/16, at 11:55 a.m. RN-G said, "I brought two different pads because I did not know how big it [the wound] was. There were two wounds. I was not prepared to find two wounds. The new wound on her left ischial tuberosity is about a nickel to quarter in size. It is a stage III based on definitions. The wound is covered with yellow slough ." RN-G said, "After you left the floor [NA-J] and I spoke and he went in and changed her. She was wet but did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 77	F 314		

have any stool until we did the dressing change. I verified it had been over three hours since he last changed her ."

During interview on 3/17/16, at 12:46 p.m. with RN-E and RN-J, RN-E said "When I spoke to you Monday and today to the best of my knowledge [R35] had three pressure ulcers; one on her coccyx and two on her heels. [RN-G] told me [R35] had a new stage three wound on left lateral posterior upper thighs ." RN-E stated when a new wound was found it was facility protocol to use the risk assessment to document the wound. RN-J stated the only charting on wounds was weekly unless they had a specific order. The nurses noticed the heels first then the coccyx wound which started as a blister. RN- J said sometimes R35 would refuse to be repositioned because of pain and with appetite changing, R35 was at a higher risk so the staff were repositioning her. RN-E stated the coccyx wound started as a clear fluid filled blister. RN-E said on the 2/26/16, there was a note that there was redness on R35's bottom and the nurse got an order for Calazime. RN-J said 3/1/16 was when staff first noted the wound on her bottom. RN-J verified the note did not say it was a blister. The staff measured it as an open area. RN-E verified the care plan did not indicate R35 had pressure ulcers nor was hospice on the care plan until after survey entrance and investigation had started. RN-J stated R35's significant change in condition happened 3/16.

During interview on 3/17/16 at 3:19 pm the director of nurses (DON) said R35's change in condition started on 2/14/16, when facility started comfort care and oxygen. The DON stated on 2/15/16, hospice was discussed with R35 who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 78	F 314		

refused but on 3/2/16 R35's son suggested R35 be re-approached about hospice.

During interview on 3/18/16, at 10:04 a.m. the NP said the heels had vascular and pressure components. The NP stated, "[R35's] coccyx wound is a Kennedy terminal ulcer and is not expected to heal. They should be offering to reposition her at least every two hours and changing her every two hours. They do have orders to allow premedication before turning ."

During interview on 3/18/16 at 1:29 p.m. RN-E said, "I expect them to at least offer to reposition a resident in accordance to her care plan. I expect them to do check and change or toilet and in accordance to the care plan ."

During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) said the nurses looked at the skin weekly. The ADON said the process was for the nurse manager to enter documentation regarding wounds on the pressure/non pressure ulcer report. The ADON stated, "I would expect to a nurse to document finding a new wound and alert the nurse manager and nursing supervisor, notify hospice physician and family and put it on the 24 hour report. The nurse should pass it on in report including new open areas ."

R62's quarterly MDS dated 11/27/15, indicated he required extensive assistance from two staff for cares.

R62's Weekly Skin Report dated 12/31/15, indicated he had a pressure ulcer on his right buttock that was resolved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 79	F 314		

R62's care plan dated 1/14/16, indicated he was at risk for pressure ulcers, admitted to the facility with a pressure ulcer on his coccyx and had a history of re-opening pressure ulcers. The care planned interventions at that time directed staff to complete weekly skin checks and encourage R62 to avoid positioning on coccyx. The care plan further indicated R62 was able to reposition himself in bed. However, that contraindicated what the MDS dated 11/27/15, noted.

There was no evidence of weekly skin assessments between 12/31/16 and 1/27/16, at which time, a facility Weekly Skin Condition Report indicated a new pressure ulcer to R62's right buttock. The pressure ulcer was described as unstageable, measuring 4 cm x 4.5 cm. The pressure ulcer was first observed on 1/20/16. On 2/4/16, A Weekly Skin Condition Report indicated a pressure ulcer to R62's coccyx measuring 5.0 cm x 4.7 cm x 0.8 cm depth. On 2/10/16, R62 was assessed by VOHRA (wound care company) wound physicians. A Wound Care Specialist Evaluation on that date indicated a stage IV pressure ulcer to the right ischium measuring 4.0 cm x 3.0 cm x 1.4 cm. The Evaluation also indicated a healed shear wound (an applied force or pressure exerted against the surface and layers of the skin) of the right superior buttock present for greater than 65 days. The shear wound was not noted in the previous skin assessments. R62's care plan was updated on 2/9/16, however, no new interventions were implemented even though R62 had developed a new pressure ulcer. The care plan continued to direct staff to encourage R62 to avoid pressure to his coccyx even though his MDS indicated he required extensive assist of two staff for bed mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 80	F 314		

R62's quarterly MDS dated 2/26/16, indicated R62 was cognitively intact, required extensive assist of two staff for bed mobility and transfers, and had a stage IV pressure ulcer.

Observation on 3/16/16, at 3:06 p.m., R62 was lying in bed on his back watching television. During observations on 3/17/16, at 7:22 a.m., 7:50 am, and 8:44 a.m., R62 remained in his room lying in bed.

During an interview on 3/17/16, at 11:08 a.m., NA-K stated she was unaware of R62's skin condition. She stated, "I think there is an open area on his bottom ." She further stated, R62 had no scheduled cares and stated if he needs anything he will put his light on.

During an interview on 3/17/16, at 11:11 a.m., licensed practical nurse (LPN)-C stated, R62 had a couple of open areas to his bottom and has daily dressing changes. She stated during his dressing changes he was able to hold on to the grab bar. LPN-C further stated staff was supposed to go in and offer repositioning every two hours.

During an interview on 3/17/16, at 11:17 a.m., RN-M stated, R62 had a stage IV pressure ulcer when he moved to the unit. She stated the wound had healed on 12/31/15, and opened up again on 1/20/16.

During an interview on 3/17/16, at 3:07 p.m., the DON stated, R62 "is pretty good at repositioning himself." She stated he changed position in bed but was not sure if he was able to offload (relieve pressure).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 81 While R62 was at increased risk for pressure ulcers and required staff assistance for repositioning, the facility did not implement interventions to ensure offloading of pressure from R62's bottom. Further, while previous pressure ulcers had healed and re-opened, no new individualized interventions were implemented to prevent worsening of existing pressure ulcers or prevention of new pressure ulcers. A facility policy titled Pressure Ulcer Treatment Guidelines dated 5/13, was reviewed. The policy's purpose was to provide clinical guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy directed staff to focus on assessing the resident and the pressure ulcer, managing tissue loads, education and quality improvement.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate supervision while intoxicated for 1 of 1 resident (R104) who was known to consume alcohol	F 323	F323 R104 is receiving adequate supervision related to ETOH consumption. R 77, R 286 and R494 have been discharged. R242, R248,	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 82 (ETOH) in the facility. In addition, the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 7 of 15 residents (R77, R242, R248, R286, R429, R494, R511) who currently smoked in the facility. Findings include: Substance abuse: R104's care plan dated 10/2/15, identified R104 had a history of alcohol use, and provided interventions which included, "Frequent safety checks hourly and PRN [as needed] of resident room and room checks hourly and PRN for prohibited substances," "MD [medical doctor] orders to hold narcotic medications for lethargy," and "Update MD PRN for substance abuse." The care plan did not identify if R104's was currently using alcohol, what interventions staff should attempt if R104 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R104 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R104, or how to ensure he and others were kept safe if R104 was found to be consuming alcohol. R104's significant change Minimum Data Set (MDS) dated 2/1/16, indicated R104 diagnoses included hepatic failure (liver failure) and cirrhosis, and R104 had severe cognitive impairment. A Wandering and Elopement Evaluation dated 2/4/16, indicated under the "Orientation" section R104 was not alert and oriented x 4 (person, place, time, situation). A box indicating if the resident was educated on the signing out policy	F 323	R429, R104, and R511 are receiving supervision per smoking assessment recommendations. Current residents with a history of etoh abuse and/or smoking while residing in the community have the potential to be affected by this alleged deficiency. Residents requiring supervision related to ETOH or smoking are receiving appropriate supervision. Staff have been educated regarding supervision of residents who smoke or use ETOH. DON/designee will audit 2 residents per unit per week to ensure that supervision is provided. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 83	F 323		

and procedure was left blank. The assessment indicated the resident exhibited forgetfulness or shortened attention span and was independently mobile. The section to determine cognitive status using the Brief Inventory for Mental Status (BIMS) score section was not completed. Under the Wandering/Exit Seeking Patterns two boxes were checked "History of exit seeking at home or other setting, including current setting" and "Stays near exit doors." The summary and interventions section of the evaluation was not completed and did not indicate any initiation or review of R104's care plan. The evaluation was signed 2/6/16.

Review of R104's Progress Notes from February through March 7, 2016, did not reveal documentation of R104's alcohol use.

R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Staff reported resident appeared drunk and consumed a bottle of Volka [sic] mixed with Coke this evening. Incidence reported around 5pm. Hx [history] of alcohol abuse. Resident's speech is non-coherent. Resident was leaning on the right side of his W/C [wheelchair] but was able to propel himself." The note identified R104's hospice agency and MD were notified of the incident, an order was obtained to search R104's room for liquor, but none was found, and staff identified they would, "Monitor for s/sx [signs and symptoms] of alcohol intoxication every shift and hold narcotics as needed." Further, the note identified, "Education provided to resident about the consequences of drinking. Resident refused to cooperate at this time. Will re-approach and continue to monitor."

R104's Physician Orders dated 3/8/16, directed staff to, "Monitor for alcohol intoxications. Hold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 84	F 323		

narcotics if suspecting drunkenness. Contact MD/NP [nurse practitioner] and hospice as needed for new orders every shift for hx of alcohol abuse."

R104's undated Kardex Report directed staff under the "Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" and that R104 was "aware of the risks." The Kardex further identified "MD orders to hold narcotic medications for lethargy and updated MD PRN for substance abuse. Psych [psychiatrist] orders received." Additionally, the Kardex included "monitor for use of ETOH, NAR [nursing assistant registered] to report to nurse. Nurse if observed to have signs of impairment to ETOH, call MD for orders." The hourly checks were not documented anywhere in the medical record.

An interview on 3/17/16, at 7:45 a.m. with nursing assistant (NA)-E revealed that "a while ago" R104 "had a big problem with drinking" and he had "behaviors when drinking, he likes to swear. I think, he thinks he needs more help than he does and he gets an attitude. I'm not sure how he is getting alcohol, I haven't heard lately. He used to leave sometimes when he had a power chair to the liquor store down the road. "
- At 11:25 a.m. with registered nurse (RN)-I stated that RN-I was aware of R104's alcohol use and stated the last time R104 had used alcohol was "maybe two weeks ago."R104 had "gone out and come back drunk" and R104's physician was updated and an order was obtained to hold medications at those times and to monitor for intoxication. When asked about R104 leaving the facility, RN-I stated "He signs out up front at the desk sign out, he is able to do that and he goes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 85	F 323		

and sits out front of the facility." RN-I also stated R104 used Metro Mobility for transportation, arranged his own rides and went to the bank and went shopping.
- At 9:34 a.m. with NA-F revealed R104 refused help a lot when he had been using alcohol and noted R104 "drank liquor last week" and he "curses a lot and is very aggressive when he's been drinking." NA-F was unable to provide a date and time to R104's alcohol consumption.
- At 2:22 p.m. licensed practical nurse (LPN)-B revealed R104 "drinks all the time" and "gets drunk." LPN-B revealed the physician ordered methadone (used as a pain reliever) cannot be given if R104 has been drinking. LPN-B stated she had "been here seven months and this is an ongoing issue" (R104's alcohol use). LPN-B stated R104 had been using alcohol on her "shift for a couple months" and noted R104 to be using alcohol "multiple times per week." LPN-B further revealed that she "wouldn't be surprised" if R104 was "drunk" and he "just leans over and sleeps on the armrest" (of his w/c). When asked what she has been directed to do when R104 has been using alcohol or directed where to document the occurrence, LPN-B replied "I don't know, I would hope it would be my TAR [treatment record] and to monitor for intoxication." When asked what else she was directed to do when R104 has been using alcohol, LPN-B replied "nothing, just monitor-15 min checks, he will usually pass out in his wheelchair." LPN-B went on to say that if R104 was "belligerent, pushing, slapping, yelling or swearing" she would call the charge nurse or supervisor. LPN-B stated she had never had to call the hospital due to R104's alcohol use. When asked where R104 obtains alcohol LPN-B stated "There's a lot of suspicions that one liquor store delivers close by the front door and that one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 86	F 323		

supervisor happened to be in the front area once and confiscated it before it was open. I've never seen a visitor outside of facility and never seen him leave the facility."

An interview on 3/18/16, at 8:37 a.m. with RN-J revealed she was aware of R104's drinking and "it's been awhile since I have seen him do it." When asked what she was directed to do when R104 has been using alcohol, RN-J replied "usually" a room search was completed, no pain medications are given and we notify the physician or hospice. When asked how often room searches are completed RN-J replied "I don't know of a room search, usually if suspected drinking, that's just my guess."
- At 8:48 a.m. with NA-G revealed R104 used to drink "most of the time" and would come back from lunch "always drunk." NA-G would tell the nurse and the nurse would take R104 back to his room. NA-G stated she has not witnessed that recently, "its maybe been a month now" but she would tell the nurse and then management would be informed.
- At 8:54 a.m. with NA-H revealed R104 was often found by staff in the dining room "after he has been drinking and smells of alcohol." NA-H stated the last time that occurred was "a week and a few days ago." NA-H stated he told the nurse about R104 smelling of alcohol and the nurse brought him back to his room. NA-H stated he was not sure where R104 got the alcohol or where he drank it. NA-H stated he was unsure if R104 left the facility property as he never followed R104 down the elevator and was unsure of where he went when he was off of the nursing unit.
- At 10:13 a.m. with licensed social worker (LSW)-A indicated she "sometimes checks his [R104] room for alcohol if staff thinks he is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 323	Continued From page 87	F 323		

intoxicated. We complete random checks if we suspect intoxication; I have never found alcohol." When asked how often checks are completed LSW stated it "just depends, nurses do it too" when asked what it "depends" on she stated she was "not sure what it depends on." LSW-A went on to say she thought R104 left the building and "goes out with Metro Mobility- not with any supervision, he tells the Health Unit Coordinator [HUC] and he usually signs out. He tells the HUC or charge nurse, as long as he is signed out he can leave." When asked if there was an assessment to determine if a resident could leave the facility unsupervised, the LSW responded that it was based off a nursing assessment, and that she was not aware of any assessment or requirement for anyone to leave. The LSW also stated she had asked about the facility's alcohol policy and had "not received an answer on one."

- At 10:29 a.m. RN-K was interviewed and when asked about R104's alcohol use, RN-K replied that it was a "typical thing" for R104 and the facility did not have a policy for drinking, however it was something that was discouraged. RN-K indicated some residents have a Physician's Order to receive some alcohol but that was not of benefit to R104. RN-K went on to say staff was directed to complete random room searches for alcohol, hold narcotics and monitor the resident if he appeared intoxicated. When asked who was responsible for the room searches, RN-K replied that "typically social services" was responsible. However, she had periodically completed room searches with a second nurse and when she found alcohol she documented how much was found and emptied. RN-K indicated she had not found alcohol "lately." RN-K indicated staff was aware of R104's drinking and when R104 required an incontinent pad change staff were to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 88	F 323		

look under his cushion as he stored mini-bottles of liquor and carried "suspicious coke bottles" that staff are supposed to dispose of. RN-K indicated the facility staff had found vodka bottles outside of the facility in planters and indicated these were R104's bottles. RN-K also stated she or facility staff were not able to identify where or how R104 obtained alcohol but he was "friends with everyone" at the facility and the connected assisted living facility. RN-K indicated R104 did leave the facility unsupervised and used to leave more often before his enrollment in Hospice on 1/23/16. RN-K went on to say she could not recall any nursing assessment to determine if he could leave the facility unsupervised but that R104 had undergone "cognitive testing" and he was safe to call a cab however indicated that was "not a good idea" for R104. RN-K also indicated R104 used Metro Mobility for transportation that he set up himself, or with the social worker's assistance. When asked if there was any interventions in place to prohibit R104's alcohol use, RN-K stated R104 was encouraged to participate in more activities on the unit and that Alcoholics Anonymous (AA) had been discussed and declined by R104. RN-K also confirmed R104 had a fall on 11/5/15, while R104 was suspected to be intoxicated and did not use assistance with a transfer. RN-K indicated R104 did not have injury from the fall. RN-K was asked about the 3/8/16, Progress Note in R104's medical record and stated she was not aware of the incident and that she did not need to be informed of every time that R104 had been drinking.

Sharp Object safety:
R104's care plan further revealed R104 had pressure ulcers and identified an intervention that R104 has a pressure reducing cushion in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 89	F 323		

wheelchair. R104 "prefers to hoard objects under w/c [wheelchair] cushion including sharp objects like scissors," R104 "is aware of the risks and benefits," and R104 was "offered alternative storage of items and declined." The care plan did not identify R104's possession of sharp objects or knives, what staff should do if these items are observed in R104's possession or how to ensure he and others were kept safe if R104 had possession of sharp objects.

Review of R104's Progress Notes from February through March 7, 2016 did not reveal documentation of R104's threatened staff with the knife(s) under the w/c cushion.

R104's Progress Note dated 3/8/16, at 5:49 p.m. identified, "Resident was seen swinging a knife at other people. Knife was taken away and resident was immediately placed on 1:1 [one to one] for safety." The note identified R104's hospice agency and MD were notified of the incident. The Progress Note lacked evidence of any interventions being put into place to deter R104 from "swinging a knife at other people."

R104's undated Kardex Report directed staff under the "Safety" section to "check under w/c cushion for liquor bottles with every pad change" and "frequent safety checks hourly and PRN" also included "frequent room checks hourly and PRN for prohibited substances" and that R104 was "aware of the risks." The "Behavior" section of the Kardex identified R104 "was at risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons." The hourly checks were not documented anywhere in the medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 90	F 323		

record.

A vulnerability assessment was requested for R104. On 3/21/16, at 10:32 a.m. the director of nursing (DON) stated "Our social workers don't do a specific VA [vulnerable adults] assessment because all residents when they are admitted are VA" and stated that the "asterisks denote some vulnerability on the care plan."

An interview on 3/17/16, at 9:34 a.m. with NA-F revealed R104 refused help a lot when he had been using alcohol and noted R104 "drank liquor last week" and he "curses a lot and is very aggressive when he's been drinking." NA-F was unable to provide a date and time to R104's alcohol consumption.

An interview on 3/18/16, at 10:29 a.m. RN-K was interviewed and indicated R104 did leave the facility unsupervised and used to leave more often before his enrollment in Hospice on 1/23/16. RN-K went on to say she could not recall any nursing assessment to determine if he could leave the facility unsupervised but that R104 had undergone "cognitive testing" and that he was safe to call a cab however indicated that was "not a good idea" for R104. RN-K also indicated that R104 used Metro Mobility for transportation that he set up himself, or with the social worker's assistance. RN-K was also aware R104 often had knives in his possession and then presented to the surveyor two knives (RN-K described as steak knives) that she had removed from R104's possession that she kept locked up in her office. RN-K stated that information was on R104's care plan (regarding R104 having knives) and R104 had been talked to multiple times about it and was at risk for skin breakdown because R104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 91	F 323		

punctures his wheelchair cushion with the sharp edges.

The DON was interviewed on 3/18/16, at 11:50 a.m. regarding R104's alcohol use and sharp objects use. The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. and the DON indicated she did not recall the incident and the assistant director of nursing (ADON) was on-call that evening. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated that she believed the incident involved a box cutter, not a knife. The DON verified the box cutter did have a sharp blade end, however stated that she was not aware of R104 swinging it at others and that no one was threatened or harmed. The DON could not verify who the "other people" were and was unaware if any other staff or residents were involved with the situation. The DON confirmed there was no incident report made about the 3/8/16, occurrence and further indicated she did not expect an incident report to be completed every time R104 was intoxicated. The DON further stated that she would expect R104's nurse manager to be informed of any time that R104 is intoxicated and should be informed of what occurred on 3/8/16 at 17:49 with R104. The DON confirmed she was aware of R104's alcohol use. When asked where R104 obtained alcohol, the DON indicated the facility staff was unaware of where R104 obtained his alcohol and R104 left the building unsupervised and arranged his own transportation. The DON stated R104 purchased the alcohol himself and she was aware of a liquor store that delivered to the home. The DON also stated that having knifes or sharp objects was a "habit" of R104 and that was indicated on R104's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 92	F 323		

care plan. The DON revealed there was no assessment completed to determine if R104 was able to leave the building unsupervised. However, the DON indicated his placement in the facility (on the second floor) indicated that he was able to leave the facility unsupervised and the nurses know who was able to leave the facility safely. The DON stated R104's alcohol use was identified on his care plan. When asked where that was on R104's care plan the DON displayed the care plan and pointed to the focus of "end stage liver disease, hx of ETOH, r/t cognitive impairment, hx of coffee ground emesis, hx of ETOH. Often refuses lactulose and is aware of the risks and benefits. R104 "has a history of abnormal labs." Interventions included, "frequent safety checks hourly and PRN of resident and room checks hourly and PRN for prohibited substances. Resident is aware of the risks. MD orders to hold narcotic medications for lethargy. Update MD PRN for substance abuse. Psych orders received. Revisit and remind of activities that may interest, 1:1 visits and chaplain support PRN." The DON indicated with what was listed as interventions that "any reasonable and prudent nurse" would know that he was currently using alcohol and what to do if R104 was intoxicated at the facility. The DON further stated R104 had been offered support to discontinue drinking such as AA meetings, however that was not identified in R104's medical record. The DON further indicated room checks should be completed hourly (as identified on R104's care plan) by the nursing assistants (NA's) but that nurses could complete that as well. The DON confirmed she expected staff to be aware and follow R104's care plan. The DON confirmed the facility did not have an alcohol policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 93	F 323		

At 12:51 p.m. on 3/18/16, the surveyor was approached by the DON, along with the ADON, LSW-B and RN-H regarding the progress note written on 3/8/16, at 5:49 p.m.

The DON began to discuss RN-H charted inaccurate information in R104's medical record for the Progress Note and RN-H charted "hearsay." The DON stated RN-H never witnessed R104 with a knife but charted what she had been told by another staff member.

The surveyor then asked RN-H if that was correct, and RN-H confirmed she had charted what the ADON had told her when she was asked to come down to R104's floor to assist, as R104 was intoxicated. RN-H had been working on a different floor and was asked to come and assist with R104's transfer to the hospital as R104 was intoxicated. RN-H stated she did not witness R104 threaten anyone with a knife and stated that was told to her by the ADON on the way down to R104's floor.

The ADON then denied that, and stated she did not know where RN-H "got this information."

The ADON and LSW-B then stated they obtained a box cutter from R104 when he was in his room and R104 handed the box cutter to them without incident. The ADON and LSW-B denied that any other staff or residents were present at the time. LSW-B denied ever seeing R104 threaten anyone and also stated she locked up the box cutter. RN-H, the ADON and LSW-B stated R104 was not sent to the hospital after contacting hospice and the physician.

The DON again stated what was charted on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 94	F 323		

3/8/16, at 17:49 p.m. by RN-H was not accurate, that "hearsay" was charted and that was why she was not informed of the incident. The DON stated RN-H was re-educated about inaccurate charting and expected staff to chart accurate information.

RN-H was interviewed again on 3/21/16, at 7:42 a.m. and stated she had entered the 3/8/16, progress note in R104's chart. RN-H stated she was the charge nurse on another floor and was contacted by the ADON to come to R104's floor to assist with a transfer to the emergency room due to his intoxication. RN-H stated on the way down to R104's floor, the ADON told her the information that RN-H entered into R104's progress note. RN confirmed she had made an inaccurate progress note in R104's chart on 3/8/16, at 5:49 p.m. and again confirmed she wrote R104 had a knife and was swinging at other people because the ADON had told her that information. RN-H stated in any situation like that she would have informed her supervisor, but since her supervisor (ADON) had told her the information she did not follow up. RN-H stated by the time she got down to R104's floor, R104 was not a threat to anyone and they did not send R104 to the emergency room.

An interview with the administrator on 3/21/16, at 7:50 a.m. revealed he was contacted on the evening of 3/8/16, regarding R104 being "under the influence" and the resident had a box cutter. The administrator stated the ADON informed him R104 was upset, had a box cutter in his hands but denied R104 was threatening anyone. When asked about the 3/8/16, progress note in R104's medical record, the administrator stated what was charted in the progress note was not what he was told that evening. He stated the note was charted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 95	F 323		

inaccurately and the nurse did not observe that type of behavior from R104. The administrator stated that he expected staff to chart accurately and if that was what occurred that he should have been informed. The administrator stated RN-H was given direction from the ADON, and it would have been a good idea for the ADON to review what was written. When asked why the progress note was not followed up on and no information was provided further in the medical record, the administrator stated the facility "Can't go back and erase what was written" and was unsure about making a correction. The administrator also indicated the police would have been called if R104 had a weapon and was threatening people.

When asked about R104's alcohol use, the administrator stated R104 was non-compliant and had not been a threat towards resident or staff in any manner. He went on to say staff are directed to monitor his behavior and lethargy when alcohol use was suspected. The administrator was unaware of how or where R104 was obtaining alcohol however stated R104 had visitors and goes on outings outside of the facility. The administrator confirmed he had heard suspicions of a liquor store that delivered to the resident. The administrator stated the liquor store was contacted about not delivering to private property of the facility. Additionally, the administrator stated the facility did not have an alcohol policy, and if residents had alcohol, they would be allowed a specific amount per Physician Orders and it would be kept in the medication room and only released per what was ordered by the physician. However, the Physician's Order dated 3/8/16, did not include if R104 was to receive a specific amount of alcohol. In addition, the medical lacked evidence of any staff member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 96	F 323		

asking R104 if R104 wanted alcohol ordered by the physician and if R104 would keep the alcohol locked up in the medication room.

On 3/21/16, at 7:41 a.m. R104's progress notes were reviewed and revealed R104's Progress Note from 3/8/16, at 5:49 p.m. was not revised, edited or followed up on in R104's medical record.

R77's Admission Record dated 3/21/16, indicated R77 had diagnoses which included, restlessness, anxiety and difficult walking. R77 most current MDS dated 12/18/15, indicated R77 had moderate cognitive impairment. The MDS also indicated R77 needed staff supervision with personal hygiene, independent with transfers and mobility.

R77's record review identified a facility form titled "Smoking Evaluation" dated 12/18/15, indicated that R242 did not have any cognitive loss, visual deficit or a dexterity problem and could light own cigarette and required staff supervision while smoking.

R77's care plan dated 3/15/16, indicated R77 required staff supervision while smoking. However, the care plan was developed 88 days later after facility staff assessed R77 requiring staff supervision while smoking.

During resident room observation on 3/15/16, at 10:26 a.m. with RN-C, observed two opened packs of cigarettes in R77's night stand drawer. R242 was asked if she smoked the cigarettes that were located in her night stand R77 stated she goes out to smoke by herself and when her friend comes to visit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 97	F 323		

When interviewed on 3/15/16, at 1:06 p.m., NA-C, stated he was usually assigned to R77's group. NA-C stated he was not aware R77 needed staff supervision while smoking.

On 3/17/16, at 2:16 p.m. RN-A acknowledged that R77 was a smoker. RN-A stated that she was not aware R77 needed staff supervision while smoking.

On 3/17/16, at 2:22 p.m. NA- D stated she usually works evening shift and assigned to take care of R77. NA-D continued to state sometimes R77 goes outside to smoke independently and NA-D further stated she was not aware R77 needed staff supervision while smoking.

During interview on 3/18/16, at 10:33 a.m. RN-E acknowledged that the facility assessed R77 as unsafe to smoke independently and needed to be supervised while smoking on 12/18/15. RN-E verified that a care plan to address R77's unsafe smoking was not developed until 3/15/16 and the safe smoking interventions were not included in the NA Kardex. RN-E further stated residents needing staff supervision should not have smoking materials on their possession.

On 3/18/16, at 1:39 p.m., DON was interviewed and stated R77 was assessed to need staff supervision while smoking. DON stated the expectation is for plan of care to be developed once it has been determined that a resident was not safe to smoke independently.

R242's Admission Record dated 3/21/16, indicated R242 had diagnoses which included,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 98	F 323		

muscle weakness, tobacco use and multiple sclerosis. R242's significant change MDS dated 3/4/16, indicated R242 had severe cognitive impairment. The MDS also indicated R242 needed staff assist with transfers, personal hygiene, dressing, toileting and that he used a wheelchair for mobility.

Review of R242's progress notes from 12/21/15, to 3/21/16, revealed a progress note dated 1/13/16, written by social worker (SW) the note indicated SW observed two cigarette butts on the floor in R242's room and SW had a discussion with R242 regarding facility's smoking policy. The progress note further indicated that R242 told SW that he will be taking himself out to smoke. A progress note dated 2/16/16, indicated that staff noticed burn holes in R242's clothing, R242's family was updated and family reported to facility staff that R242 had a habit of "flicking cigarettes outside and poking holes in his pants. " A SW progress note dated 2/17/16, indicated that nursing and SW discussed safe smoking with R242. The progress note further indicated that R242 needed staff supervision with smoking.

R242's record review identified a facility form titled "Smoking Evaluation" dated 11/29/15, indicated that R242 did not have any cognitive loss, visual deficit or a dexterity problem and can light own cigarette with no adaptive safety equipment required. The Smoking evaluation dated on 2/27/16, and on 3/7/16, both of these indicated that R242 did not have any cognitive loss, visual deficit or a dexterity problem, can light own cigarette, required a smoking apron and needed staff supervision with smoking.

R242's care plan dated 3/15/16, indicated R242

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 99 required a smoking apron and staff supervision with smoking. However the care plan was developed 61 days later after facility staff first became aware of R242 unsafe smoking practices. During resident room observation on 3/15/16, at 9:55 a.m. with RN-C the following were observed on R242's clothing: - 1st pair- Red jacket noted with six cigarette burn holes on the front chest area of jacket approximately 1/4" to 1/2" in size. - 2nd pair- Gray pants had nine cigarette burn holes on the front and 2 cigarette burn holes on the back of right pant leg and three cigarette burn holes on the front of left leg. - 3rd pair- Checkered jacket five cigarette burn holes on the front chest area of the jacket. - 4th pair- Light teal/green jacket had nine cigarette burn holes on the front chest area of the jacket. - When interviewed R242 stated at times he went out to smoke without a smoking apron or staff supervision. When interviewed on 3/15/16, at 10:18 a.m. RN-C stated R242 did not have a smoking schedule. RN-C stated she was aware R242 needed an apron and staff supervision with smoking but did not know where the smoking apron was kept. RN-C further stated smoking apron was kept down stairs. When interviewed on 3/15/16, at 1:06 p.m., NA-B, stated he noticed cigarette burn holes on R242's clothing when he started working at the facility about a month ago. NA-B stated he was not aware R242 needed an apron and staff supervision with smoking.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 100 On 3/15/16, at 1:15 p.m., RN-D stated she completed a smoking assessment on 3/7/16, and assessed R242 to be unsafe to smoke independently. RN-D stated R242 needed a smoking apron and staff supervision with smoking. RN-D further stated looked at the clothing the resident had on at the time, she remembers checking R242's red jacket and the red jacket did not have any burn holes in it. On 3/15/16, at 2:22 p.m., a family member (F)-A was interviewed via phone and stated she was aware of the number of cigarette burn holes in R242's clothing. F-A stated R242 used to live at an assisted living facility, they found cigarette burn holes on his clothing too and she informed facility staff. F-A further stated R242 was to have a smoking apron and needs to be supervised while smoking, but it was "hit and miss" depending which staff was working and if they are aware where the smoking apron was kept. During interview on 3/18/16, at 10:52 a.m. RN-E acknowledged the facility became aware of unsafe smoking practices by R242 on 1/13/16. RN-E verified that a care plan to address R242's unsafe smoking was not developed until 3/15/16 and the safe smoking interventions were not included in the NA Kardex (nursing assistant assignment sheet). On 3/18/16, at 1:48 p.m., the DON was interviewed and stated R242 was assessed to need a smoking apron and staff supervision while smoking. DON stated the expectation was for plan of care to be developed once it had been determined that a resident was not safe to smoke independently. The DON further stated it was her	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 101	F 323		

expectation that a resident assessed to need a smoking apron should be readily available to resident.

R248's Admission Record dated 3/21/16, indicated R248 had diagnoses which included, chronic obstructive pulmonary disease, generalized weakness, restless leg syndrome and difficult walking. R248 most current MDS dated 1/12/16, indicated R248 was cognitively intact. The MDS also indicated R248 needed staff supervision with personal hygiene, dressing, transfers and mobility.

R248's record review identified a facility form titled "Smoking Evaluation" dated 1/22/16, indicated that R248 did not have any cognitive loss, could light own cigarette but had a visual deficit and a dexterity problem. The smoking evaluation form indicated R248 did not require any safety interventions.

R248's care plan dated 3/14/16, indicated R248 was a smoker. However, the care plan did not address R248's visual deficit and dexterity problem that were identified in the smoking assessment and the care plan was developed 52 days later after facility staff assessed R248's smoking.

On 3/16/16, at 8:40 a.m. R248 was observed smoking a cigarette by the entry way to the facility. The DON was observed to walk to R248 and was heard to tell R248 that smoking was not allowed near the building and asked R248 to put out her cigarette. R248 was observed to put out her cigarette on the wall. The DON did not correct R248 when R248 put out her cigarette on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 102 wall. During interview on 3/16/16, at 10:57 a.m. R248 stated she smokes outside of the building by the main entrance. When asked how she disposes off cigarette butts, R248 stated she throws them on the ground or in the garbage and continued to state "there is no ash tray down there." On 3/18/16, at 10:07 a.m. R248 stated the facility has cigarettes but disposal receptacles by the main entrance that was placed by the entrance after surveyor had interviewed her about cigarette disposals. When interviewed on 3/15/16, at 1:06 p.m., nursing assistant (NA)-C, stated he was usually assigned to R77's group and continued to state he was not aware R77 needed staff supervision while smoking. During interview on 3/18/16, at 10:20 a.m. RN-E acknowledged R248 was assessed to have a visual deficit and a dexterity problem. RN-E further acknowledged R248's care plan did not address R248's visual deficit and dexterity problem. On 3/18/16, at 1:17 p.m. DON stated it was not safe to dispose cigarettes on the ground or in the garbage. DON stated her expectation was for the care plan to be developed once the assessments are completed to address all concerns identified with an assessment. R286 was admitted on 1/27/16, with admission diagnoses of pneumonia, chronic obstructive pulmonary disease, cognitive communication deficit, and anxiety disorder. A smoking assessment was completed on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 103	F 323		

1/29/16, The assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette, and did not state if the resident was safe to smoke or had limitations. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community smoking rules description.

On 2/16/16 a care plan was initiated that stated resident goes outside to smoke, with a goal that the resident will follow smoking contract (which stated the facility was nonsmoking). The intervention was to remind resident to not smoke on facility grounds. On 3/14/16 a new intervention was added to state the resident will be offered nicotine patch if requests to discontinue smoking. The nursing assistant care card was requested but not provided.

On 3/15/16, at 10:07 a.m. R286 stated, smokes down the street, and has been cleaning up the TCU entrance, for days, I even was picking it up last night, it's should be cleaned up it looks terrible. TCU entrance, had more than 75 cigarette butts on the ground on 3/15/16. There was a garbage with a plastic liner covered but with open sides, and a large green bin of sidewalk salt.

R429 was admitted 2/17/16, with admission diagnoses of repeated falls, medication mismanagement, traumatic brain injury (TBI) with seizures. R429 signed smoking contract 2/17/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 104 A smoking assessment was completed on 2/19/16, The assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette, and did not state if the resident was safe to smoke or had limitations. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community smoking rules description. On 3/14/16 a smoking care plan was initiated that (after a list of smoking residents was requested by survey) and indicated resident chooses to smoke despite facility no smoking policy. Goal will be encouraged to comply with no smoking policy, Resident will be encouraged to decrease smoking. Interventions: offer nicotine patch if R429 chooses and smoking assessments quarterly. At 9:59 on 3/15/16, stated she had cigarettes and lighter in jacket pocket (jacket draped over w/c, no evidence of burns), smokes down the road away. On 3/18/16, at 10:30 a.m. the DON stated the facility had started a smoking focus group and talked to smokers, and they noted that we did not have ashtrays out. The facility was revamping policy about no smoking, people know it's a no smoking facility, and sign contract agreeing not to smoke and then go out to smoke anyway. Assessments were done on people who identify themselves as smokers on admission assessment, nurses do assessment on safe	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 105	F 323		

smoking. A new task force on smoking was developed. We are still in the process of planning and care planning.

The facility had resident smoking at the main entrance and at the TCU entrance, but lacked any safe smoking receptacles to put out cigarettes and put cigarette butts safely into.

R494 was observed on 3/15/16, at 10:49 a.m. a clean folded smoking apron was on the table in R494 room

On 3/16/16, at 8:40 a.m. R494 was observed outside with two staff members asking staff and residents if they have a cigarette to lend. R494 did not have a smoking apron on.

During random observation 3/21/16, at 7:20 a.m. R494 was observed by a surveyor smoking at the end of the sidewalk outside of facility with another resident. A staff member was supervising smoking. R494 did not have a smoking apron on.

R494 was admitted on 10/27/15, with admission diagnoses indicated on admission record dated 3/21/16, of fracture of right hip, right femur, and multiple fractures of ribs, facial bones and skull with resulting cognitive communication deficit, muscle weakness and dysphagia (swallowing difficulty).

R494's quarterly MDS dated 2/1/16, indicated R494 had moderately impaired cognition and decision making and sometimes understood others if simple and direct communication. R494's MDS indicated need for assistance with all activities of daily living including eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 106	F 323		

A Progress Note dated 3/7/16, indicated RN-M went out side with R494 to assess ability to safely smoke. The Progress Note indicated R494 was able to light cigarette and smoke it safely. It also indicated R494 struggled with figuring out how to put out the cigarette. The information was not documented on smoking assessment or care plan.

A smoking assessment was completed on 3/14/16, The assessment asked cognitive loss, visual deficit, dexterity problem, frequency of smoking, can the resident light their own cigarette and is any adaptive equipment needed. The form lacked any assessment of the ability to handle ashes, put out the cigarette. A community smoking rules applied statement lacked any indication of what that meant, the facility was unable to provide community rules description. The assessment indicated R 494 did not have cognitive loss or visual deficits but did have a dexterity problem. Frequency of R494 liking to smoke was indicated as morning evening and night. The smoking assessment also indicated R494 could safely light a cigarette and required a smoking apron and staff supervision.

On 3/14/16, a smoking care plan was initiated that indicated R494 was choosing to smoke despite facility no smoking policy. The care plan goal was R494 would be encouraged to comply with no smoking policy. Interventions identified in the care plan were R494 was to be offered nicotine patches if R494 choose to discontinue smoking, R494 would receive smoking assessments by nursing staff and that the smoking assessment deemed that R494 required supervision to smoke. Intervention initiated on 3/14/16, on R494's activities of daily living care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 107	F 323		

plan instructed staff that R494 chose to smoke and should have staff supervision. When staff see R494 propel down the hall they need to assist outside to ensure smoking safety. Care plan also informed staff that R494 would get very verbally aggressive with yelling and swearing at staff when R494 wanted to go outside to smoke. Care plan did not instruct staff to have R494 wear a smoking apron in accordance with smoking assessment.

During observation on 3/15/16, at 10:49 a.m. the Visual/Bedside Kardex Report dated 1/14/16, was posted inside R494 closet. The Visual/Bedside Kardex Report dated 1/14/16, provided staff with no instructions regarding R494's smoking. A copy of the Visual/Bedside Kardex Report dated 1/14/16, was requested but facility provided Visual/Bedside Kardex Report dated 3/21/16, which instructed staff that resident smoking assessment deemed that R494 required supervision to smoke.

During interview on 3/21/16, at 5:14 a.m. LPN-D said, "Now we need to supervise R494. Last week they started smoking aprons and supervision."

During interview on 3/21/16, at 12:55 p.m. R494 stated "I go outside to smoke. They gave me this apron to wear last week. You guys want someone to watch us so I put up with it as long as there is someone to go out with me. I go out in the evening up till about 11p.m. and then 6:20 a.m. or 6:30 a.m. I smoke sometimes without anyone there. I have been smoking for several weeks. It is all I want to do." R494's mother verified R494 had been smoking for a while and that apron and supervision was new.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 108	F 323		

R511's significant change MDS dated 1/15/16, indicated he was cognitively intact and required staff assistance for all activities of daily living. R511's care plan dated 2/5/16, did not address smoking. A North Ridge Skilled, LLC progress Note dated 1/5/16, indicated R511 told activity aide (AA)-O, "I just want to go outside and smoke."

During an observation on 3/14/16, at 8:10 p.m., R511 was outside smoking a cigarette. He was using oxygen via nasal cannula, running at four liters.

During an interview on 3/14/16, at 8:13 a.m., the administrator stated all residents sign an agreement on admission that they acknowledge the facility is smoke free. He stated if residents go outside to smoke they have been identified as able to smoke independently.

During an interview on 3/14/16 at 8:26 p.m., the DON stated R511 did not have a smoking assessment completed. She stated he had not been identified a resident who smoked. She further stated, all residents sign a smoking agreement as part of their admission.

A Smoking assessment was completed on 3/14/16, after the administrator and DON were notified of R511 smoking with his oxygen in use. The assessment indicated R511 needed reminders not to smoke with his oxygen running. Smoking safety was not added to R511's care plan.

During an interview on 3/15/16, at 10:37 a.m., R511 stated he had not been outside to smoke

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 109	F 323		

prior to the previous night. He further stated he did not know where he got the cigarette. He stated he was told on admission if he wanted to smoke he would have to go outside.

During an interview on 3/15/16, at 2:03 p.m., NA-T stated she was unsure if R511 smoked. She stated she knew he went outside but did not pay attention to whether or not he was smoking.

During an interview on 3/15/16, at 2:06 p.m., LPN-C stated R511 was asked about smoking on admission and stated he did not smoke. She stated she had never seen him smoke but stated he does spend his time out in the common area by the front door.

During an interview on 3/15/16, at 2:16 p.m., AA-O stated R511 told her he wanted to go outside and smoke. She stated she "did not remember" if she had told anyone.

During a subsequent interview on 3/15/16, at 3:23 p.m., the administrator stated the facility had identified smoking as a concern. He stated the student administrator had been completing audits and determining when residents are going outside to smoke. He stated residents will outside to enjoy the weather and then decide to smoke. He stated, "This is a major concern for us."

The facility's Smoking Policy revised 3/19/2012, directed that the facility shall establish and maintain safe resident smoking practices. The policy directed the facility will have designated smoking areas, smoking will only occur in smoking areas, facility approved ashtrays will be used and emptied into designated receptacles. The policy further indicated that residents who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 110 smoke will be evaluated for "safe smoking", any smoking restrictions/concerns shall be included in a resident's care plan and all residents requiring supervision with smoking shall have direct supervision at all times while smoking.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose	F 329	F329 R422 has been discharged. Facility has reviewed all outstanding	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 111 reduction was attempted for 1 of 5 residents (R422) reviewed for unnecessary medications. Findings include: A Pharmacy Consultation Report dated 10/1/15, indicated a recommendation to decrease R422's Remeron (an atidepressant) dose to 7.5 milligram (mg) at bedtime. The Pharmacy Report was not addressed by the facility. R422's quarterly Minimum Data Set dated 1/8/16, indicated he had no cognitive impairments, required assistance with activities of daily living and displayed no behaviors. R422's care plan dated 1/14/16, indicated use of psychotropic medications for depression and anxiety, but did not address insomnia. A review of R422's Physician's Orders dated 3/18/16, indicated he was receiving Remeron 15 mg by mouth at bed time for insomnia. During an interview on 3/14/16, at 6:33 p.m. R422 stated he prefers to stay up until 2:00 a.m. to 3:00 a.m. He stated the night staff coming at 6:00 a.m. make a lot of noise and wake him up. During an observation on 3/17/16, at 2:36 p.m. R422 was lying in bed on his left side with his eyes closed. He appeared to be sleeping. During an interview on 3/18/16, at 8:32 a.m. registered nurse (RN)-M stated, the pharmacy recommendations go to the director of nursing and then get distributed to the units. She stated she was not aware of the recommendations by the pharmacist.	F 329	gradual dose reduction requests and resolved as appropriate. All current residents using psychoactive medications have the potential to be affected by this alleged deficiency. Licensed staff have been educated regarding gradual dose reduction process. The DON/designee will audit 2 residents per unit, per month to ensure that gradual dose reduction recommendations have been addressed by the provider and processed appropriately. Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 112 During a subsequent interview on 3/18/16, at 1:13 p.m. RN-M stated, "the pharmacy recommendation was not followed up on." She stated she took care of it today. A facility policy titled, Tapering Medication and Gradual Drug Dose Reduction, dated September 2012 was reviewed. The policy indicated tapering of medications and gradual dose reductions will be completed in consultation with the physician and consultant pharmacist.	F 329		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 resident's (R4, R481, R57) were free from significant medication errors related to improper transcription. This resulted in actual harm for R4 and R481. R4 who was hospitalized related to seizure activity and R481 who suffered "almost constant pain" rated 10/10. Findings include: R4's quarterly Minimum Data Set (MDS) dated 1/8/16, indicated she had some cognitive impairment, required extensive to total assistance with all activities of daily living, and had an active diagnosis which included seizure disorder. During an observation on 3/16/16, at 2:40 p.m.,	F 333	F333 R4 has been discharged. R481 and R57 medications have been transcribed appropriately. Current residents have the potential to be affected by this alleged deficiency. Residents are receiving medications transcribed appropriately as ordered by the health care provider. Licensed staff and health unit coordinators have been educated regarding appropriate transcription of medication orders. DON/designee will review all medication errors. Results of audit will be reviewed by QAPI.	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 113	F 333		

R4 was sitting up in her wheel chair. She was alert and able to converse briefly with surveyor.

During an interview on 3/16/16, at 2:40 p.m., family member (F)-B stated R4 was more "down and depressed." F-B stated she brought R4 to an appointment with the physician who admitted R4 to the hospital. She stated during the hospital stay it was discovered that R4 was getting "too little Lamotrigine." F-B stated R4 should have been receiving 200 milligrams (mg) four times daily and an additional 50 mg as needed.

A review of facility Medication Administration Record (MAR) dated January 2016 indicated R4 was receiving Lamotrigine (Lamotrigine is an anti-convulsant drug used in the treatment of seizure disorders) 200 mg four times daily until 1/6/16. At that time the dose was decreased to 50 mg four times daily.

A review of a facility Transfer/discharge Report dated 1/5/16, indicated a new order for "Lamotrigine 25 mg tab - take two tablets by gastric (G)-tube as directed." The order did not include the time/times it should be administered. The order was transcribed by the health unit coordinator (HUC) and verified by registered nurse (RN)-L. The order was transcribed as follows: Lamotrigine 50 mg via G-tube four times a day for cluster seizures. That was a decrease from 800 mg daily to 200 mg daily. The transfer/discharge report also indicated orders for Hyaluronic acid, Prevnar, and lab draws. A review of a North Ridge Skilled, LLC Progress Note dated 1/8/16 indicated, spoke with R4's physicians office to "clarify orders for labs and Hyaluronic acid." There was no indication a clarification was requested for the dosage of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 114 Lamotrigine. A review R4's hospital history and physical (H & P) dated 2/7/16, indicated R4 had been hospitalized 2/1/16, due to atypical "withdrawn behavior, decreased interaction, and new left leg stiffness." The overall etiology of the patient's altered mental status was thought to be "multifactoral secondary to probable urinary tract infection, mild hyponatremia and/or subclinical seizures." The H&P indicated R4 had undergone an electroencephalogram (EEG). (an EEG is a test that measures and records the electrical activity of the brain and is often used to detect seizure activity) and was placed on continuous EEG monitoring as she was found to have intermittent seizures. Her Lamotrigine dose was increased and two additional anti-epileptic medications were added. During an interview on 3/18/16 at 8:06 a.m. RN-K stated she was aware of a discrepancy with R4's Lamotrigine error, but stated she was "not sure of the details." During an interview on 3/21/16 at 12:38 p.m., the director of nursing (DON) stated, "I was aware of the seizures during [R4's] hospitalization." The DON further stated RN-K should have done a full chart review when R4 returned from the hospital. During a subsequent interview on 3/18/16, at 12:51 p.m., RN-K stated she would have expected RN-L to question the decrease in R4's Lamotrigine dose and call the physician to get a clarification. R481's admission MDS dated 2/9/16, indicated	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 333	Continued From page 115	F 333		

R481 was cognitively intact, suffered from moderate/severe depression, and required assistance with all activities of daily living except eating. In addition, R481 was identified as having almost constant pain that limited her day to day activities, with the most severe pain being rated at 10/10 (on a scale where 10 is the most painful). The Physician's Admission Orders/note dated 2/2/16, indicated R481 was admitted to the facility on hospice for gastric (stomach) cancer. R481 was placed at harm as R481 did not receive the physician ordered pain medication and R481 remained in pain.

A Care Area Assessment (CAA) for pain dated 2/11/16, was completed in relation to the 2/9/16 MDS. The CAA for pain had been triggered due to R481's responses to interview questions indicating she had pain which limited her activity, was almost constant, and rated 10/10. The CAA indicated R481 had advanced metastatic (mets) adenocarcimoma with mets to lymph and bone, arthritis/ DJD (degenerative joint disease), back pain with chronic pain syndrome hx (history) and opioid dependence. The CAA further indicated Allina Hospice was closely involved and along with their consulting pharmacist are working closely to manage pain with a goal of pain < (less than) 5.

The care plan initiated 2/11/16, indicated R481 had pain related to cancer of the stomach and lymph system that had spread to the bones, and interventions instructed staff to "administer analgesia [sic] [pain killer medication] as per orders."

The post hospital Discharge Orders dated 2/2/16, indicated staff were to give R481 gabapentin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 116	F 333		

(medication to treat nerve pain) 800 mg three times daily for nerve pain, methadone (narcotic pain medication) 5 mg three times daily for severe pain, Morphine (narcotic pain medication) concentrate 20 mg/milliliter (ml) give 0.75 ml every four hours as needed for pain (PRN) or shortness of breath, and acetaminophen (a mild analgesic) 1000 mg three times daily for pain.

The Hospice Certification and Plan of Treatment dated 2/2/16, also indicated R481 was to receive gabapentin 800 mg three times a day and care planed for treatment neuropathic pain.

A review of R481's MAR indicated the gabapentin had not been identified on R481's February 2016 MAR.

The Allina Hospice and Palliative Care Facility Visit Record dated 2/3/16, patient complained of pain at 10/10. The Allina Hospice and Palliative Care Facility Visit Record dated 2/4/16, R481 indicated pain improved to 7/10. R481 received seven doses of Morphine 15 mg. in last 18 hours. New orders written to increase methadone to 10 mg three times a day and increase morphine to 20 mg every hour PRN.

Allina Hospice and Palliative Care Facility Visit Record dated 2/6/16, R481 rated pain at 6/10. Goal set to get pain down to 5/10.

Allina Hospice and Palliative Care Facility Visit Record dated 2/11/16, patient rated pain at 7/10.

The Physician Orders dated 2/11/16, indicated to discontinue Gabapentin 800 mg three times a day for nerve pain because R481 had not been receiving it, and increased Methadone to 15 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 117	F 333		

three times a day scheduled. A copy of R481's Physician Orders were requested but not provided.

A Medication Error Report dated 2/11/16, and revised 3/3/16, indicated: "Hospice nurse informed writer that resident has not received Gabapentin 800 mg TID [three times a day] since arrival. Two nurses checked and it was not transcribed into PCC [Point Click Care-electronic health record]." The report further indicated there had been no injury to the resident, but failed to address the resident's pain level. The root cause analysis section of the Error Report indicated: "resident is a new admit on 2/2/16. Resident on hospice. Resident has not received Gabapentin 800 mg TID since arrival. Medication was not given d/t [due to] the fact it was not transcribed into PCC. Educate staff update MD [medical doctor] and family." R481 was placed at harm as R481 did not receive the physician pain medication upon admission.

RN-K said R481's medication error was discovered by an evening supervisor. The admission orders had been checked by two nurses but the gabapentin was missed. RN-K said, "I think it is the consistency of having someone on the desk. My assistant can cover the desk but only to 3:30 p.m."

R57's admission MDS dated 2/9/16, indicated R57 was cognitively intact, required assistance with all activities of daily living except eating, and had diagnoses of hypertension and end stage kidney disease with dependence on dialysis.

A Geriatric Services of Minnesota (GSM) long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 118	F 333		

term care (LTC) Initial Intake form dated 2/4/16, indicated R57 had undergone a CABG x 4 (coronary artery bypass graft involving four arteries) in December of 2011.

The nursing home Admission Record, indicated R57 had been admitted to the facility 2/2/16. After Discharge Orders dated 2/2/16, indicated staff were to administer Coreg 3.125 mg by mouth three times weekly on Monday, Wednesday, Friday; and Coreg 6.25 mg by mouth with breakfast four times weekly Sunday, Tuesday, Thursday, and Saturday. The After Discharge Orders also instructed staff to give R57 Coreg 6.25 mg daily with the evening meal and indicated R57 attended dialysis Mondays, Wednesdays and Fridays at 12 :00 p.m.

The facility's Order Summary Report dated 3/21/16, indicated only Coreg 6.25 mg every day with evening meal had been entered into the electronic health record from 2/2 through 2/12/15, when Coreg 3.125 mg by month three times weekly Monday, Wednesday, Friday with breakfast; and Coreg 6.25 mg by mouth with breakfast four times weekly Sunday, Tuesday, Thursday, and Saturday were added. Review of R57's MAR indicated the resident had missed five doses of Coreg 3.25 mg, and five doses of Coreg 6.25 mg, between 2/2 and 2/12/16.

Review of R57's Weights and Vitals Summary dated 3/23/16, indicated R57's blood pressures had been checked daily, and had fluctuated, systolic 154-195, over diastolic 60-96 between 2/2 and 2/11/16. After the Coreg order had been clarified, R57's blood pressure range was identified as systolic 125-162, over diastolic 64-85 as documented 2/12 to 2/29/16. There were only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 333	Continued From page 119	F 333		

two days between 2/12 through 2/29/16, where R57's systolic blood pressure was greater than 166 compared to nine days between 2/2 through 2/11/16.

A Medication Error Report dated 2/12/16, and revised 3/11/16, indicated, "Huc [health unit coordinator] indicated that Coreg was not on PCC and need clarification. Res. missed Coreg medicalization [sic] since admit ion [sic]. Coreg order was not clarified." The report further indicated new orders received and no injury. Predisposing factors identified medications with similar names. Root cause analysis indicated, "Resident received less than prescribed dose of Coreg. NP [nurse practitioner] notified. Error occurred with follow up clarification. Resident without injury from med error. Orders clarified with provider same day. IDT [interdisciplinary team] to provide education to individual recognized as responsible for error."

During interview on 3/21/16, at 10:19 a.m. registered nurse (RN)-E said, "the process when we receive a new order is the health unit coordinator (HUC) inputs the order in to the computer and then the nurse will check it. If the HUC does not input the order, one nurse will input it into the computer and the second nurse will check it."

During interview on 3/21/16, at 10:45 a.m. RN-K nurse manager said, the process for orders when a new admit arrives were The HUC would enter the orders into PCC then the charge nurse would clarify any orders needing clarification and then perform a second check on them. We try to do the clarification and second check on the same day as admission.

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F 333	Continued From page 120 RN-K said R57's medication error occurred because, "the HUC wrote the order needed clarification and then we were without a charge nurse for several days. The nurse practitioner found the error and clarified the order." It was communicated to staff that it was not appropriate to write needs clarification. If an order has not been inputted into PCC the nurse checking the orders would enter the order and then have another nurse second check it. RN-K said, "We have not had a charge nurse consistently. The floor nurses having to pick that up." During interview on 3/21/16, at 11:09 a.m. the DON said, "We changed our process for medication errors in October. Any nurse who finds a medication error should enter it in the computer, notify the doctor and responsible party. The nurse should get new orders and any monitoring needed and any assessments needed. They would notify the supervisor and possible call the DON or Assistant DON. Then the nurse manager can view the medication error, do education, and follow up, looking at precipitating factors, root cause analysis and sometimes discipline." Once the medication errors are signed by nurse manager then the DON reviews the errors. The administrator reviews the errors then the medication errors are taken to quality assessment and assurance meeting and the minimum effective dose committee. The DON said, "Our medication error trends are transcription errors. The DON said if there was harm from a medication error, if the resident required medical attention, if the resident required increased in monitoring, or if there was a negative effect from the medication error we would report the error to the state."	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 121 Administering Medications Policy revised April 2010, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed." 3. Medications must be administered in accordance with orders, including a required time frame. 4. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facilities Medical Director to discuss the concerns."	F 333		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 334	Continued From page 122 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334		

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F 334	Continued From page 123 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R310) was offered and/or received influenza and pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: The Admission Record dated 3/21/16, indicated R310 was admitted to the facility on 11/10/15. Review of R310's facility immunization record lacked documentation if an influenza and pneumococcal vaccination had been received, contraindicated or refused. Review of R310's Minnesota Immunization Information Connection record provided by the facility indicated R310 received an influenza vaccination on 10/14/14 and lacked any documentation if he received a pneumococcal vaccination. On 3/21/16, at 2:40 p.m. the director of nursing (DON) stated documentation should be on the Informed Consent for Influenza and Pneumococcal Vaccine sheet, "but the forms change all the time and I don't know what all the forms are."	F 334	F334 R310 has been discharged All admissions will be offered the appropriate immunizations. Current residents will be audited related to their immunization status at their next quarterly MDS and appropriate immunizations offered. Licensed nurses will be educated regarding immunizations the pneumococcal and influenza immunization. DON or designee will audit the immunization status of 2 residents per unit, per week to regarding immunization status. Results of audit will be reviewed by QAPI.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 334	Continued From page 124 On 3/21/16, at 3:00 p.m. the corporate consultant (CC), stated "sometimes they have the vaccines before they are admitted or at the hospital." On 3/21/16, at 3:40 p.m. DON stated the previous infection control nurse had a log for all the residents and "we can't find it." On 3/21/16, at 4:12 p.m. CC stated they could not find an informed consent record for influenza and pneumococcal for R310, "he may have had them at the AL [assisted living], we'll find it." The facility Influenza Vaccine (Residents) - Revised September 2012 indicated residents will be offered the influenza vaccine annually, will be provided pertinent information about the significant risks and benefits of vaccines and that "between October 1st and March 31st each year, the influenza vaccine shall be offered to residents unless the vaccination is medically contraindicated or the resident has already been immunized." The facility Pneumococcal Vaccine - Revised September 2012 indicated residents will be offered the pneumococcal vaccine to aid in preventing pneumococcal infections, that prior to or upon admission, residents will be assessed for eligibility to receive it and when indicated will be offered the vaccination within thirty days of admission to the facility.	F 334		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 353	Continued From page 125 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was provided to meet the individual needs of 3 of 4 residents (R35, R62, R439) reviewed for pressure ulcers; for 3 of 3 residents (R4, R257, R481) reviewed for significant medication errors for 1 of 1 resident (R104) reviewed who was consuming alcohol in the facility and who was at risk for injury to himself and others; and for 7of 15 residents (R77, R242, R248, R286, R429, R494, R511) reviewed for unsafe smoking. Further, the facility failed to ensure adequate staffing to provide care and services to residents. Findings include:	F 353	R35 and R4 have been discharged. R62,R439, R257, and R481 have needs being met. R104 is receiving adequate supervision. R77, R42, R248, R429, R494, and R511 have been reassessed for smoking. Supervision is provided for residents who require assistance. All current residents have the potential to be affected by this alleged deficiency. Staff have been re-educated on meeting the needs of residents requiring turning and repositioning, incontinence, and supervision related to smoking and alcohol. DON/Designee will complete up to 5	

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F 353	Continued From page 126 Refer to F282: The facility failed to ensure the plan of care was implemented to ensure (R439 and R35) were repositioned in a timely manner. Refer to F314: The facility failed to ensure (R439, R35, and R62) reviewed for pressure ulcers were repositioned to promote healing and prevent deterioration of pressure ulcers. Refer to F323: The facility identified R104 was consuming alcohol in the facility but failed to provide an action plan to ensure his safety and the safety of the other resident's residing in the facility. Furthermore, the facility failed to provide safe smoking interventions for R77, R242, R286, R429, R494, and R51. Refer to F333: The facility had identified a potential quality concern regarding medication errors but failed to implement an effective process, resulting in medication transcription errors that caused actual harm for 3 of 3 residents R4, R257, and R481 in the facility. Interviews: On 3/17/16, at 2:30 p.m. the Family Council president, identified a lack of sufficient staff to get people to meals and assist them with eating, nails trimmed and dentures cared for. Concerns with timely response to call lights, toileting and falls. Significant turnover in the facility staff, the level of care had declined, and there seemed to be disconnect between the nursing assistants and the nurse staff, the ball was easily dropped with issues. On 3/17/16, at 5:54 a.m. nursing assistant (NA)-T stated she had doubled from evening shift to night shift, because there was not adequate staff	F 353	weekly audits to ensure residents are receiving care and treatment needed per the plan of care. Audits will be submitted to QAPI for review.	

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F 353	Continued From page 127	F 353		

to cover nights.
-At 6:00 a.m. NA-U stated he had picked up the shift, because there was not enough staff.
-At 6:15 a.m. registered nurse (RN)-N stated the census was down because there was flu in the building, and so some patients had chosen not to be admitted, so had to decrease the number of staff.

On 3/21/16, at 5:30 a.m. licensed practical nurse (LPN)-H stated, "Staffing is what it is, you just do your best."

On 3/21/16, at 12:30 p.m. the human resources (HR) specialist was interviewed and stated there were open shifts that equaled 42.8 FTE (Full Time Equivalent= 40 hours per week, 80 hours per pay period). A 1.4 FTE would fill one 8-hour shift for 14 days, in other words the facility lacked more than 30 full time employees in the nursing department.

The NA open shifts were 25.5 FTE's, and nurses 17.3 FTE. The HR specialist stated the facility was advertising, posting on college boards, and attending job fairs, and working to make partnerships with NA schools. The HR specialist stated that nursing recruitment and retention happened on the units and HR did not necessarily meet with nursing. The HR specialist stated she reported the open positions to the administrator and regional vice president and vice president of HR.

HR stated the turnover and new hires rates remained fairly stable:
January 2016 - New hires 22, terminations 25, and a turnover rate of 5.25%.
February 2016 - New hires 33 and terminations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 353	Continued From page 128 33, and a turnover rate of 6.94% On 3/21/16, at 1:07 p.m. the director of nursing (DON) stated they would "rely on recruiters and staff to be recruiting and the facility did use double time and overtime shifts. The DON stated the staffing was done by the department director, two full time and one part time staffers, and that the night shift was handled by the night nursing supervisor. The DON stated she saw no correlation between staffing and incidents according to the Excel [tracking program]. At 1:55 p.m. on 3/21/16, the DON verified the average number of overtime hours paid in one week was 800 hours. -At 1:26 p.m. The staffing manager stated the biggest challenge was a lack of people in the door. The facility had made a huge recruitment push, doing job fairs, the staffing manager stated the open FTE's are for full census of 341, and we are hovering at 297-305. The staffing plan was based on the number of hours required to complete patient care (PPD) and that the TCU (Transitional Care Unit) had the highest PPD. The facility plan was try to overstaff and stay ahead of turnover. The staffing manager stated weekend days were the hardest to fill, especially Sunday mornings. Care and services: R439 was admitted to the facility on 9/15/15, after extensive hospitalizations in acute care hospitals and long term acute care hospitals. R439's admission diagnosis from the Face Sheet included paraplegia [functional], pressure ulcer of sacral region, Stage 4, Type II Diabetes and morbid obesity, and major depression.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 129	F 353		

The admission Care Area Assessment (CAA) dated 9/27/15, indicated R439 was admitted with stage IV pressure ulcer to the sacrum/coccyx and two stage III pressure areas (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) to left and right buttocks. The areas had developed during prolonged hospitalization with multiple medical complications. A colostomy (intestinal diversion) and Foley catheter (urine collection system in the bladder) was initiated during the hospitalization as well as wound vac (mechanical wound management) to manage/treat pressure areas. A plastics [plastic surgery] doctor (MD) was following R439 and was considering a flap closure of the pressure ulcer (surgical covering of pressure ulcer to promote healing),and the followup scheduled for 10/1/15. A wound MD was following R439 while here and CAA indicated to see the Physician Progress Notes for measurements and debridement since admit. A Nutrition CAA had triggered as R439 had lost 150 pounds over the past six months, which was nutritionally significant, increased metabolic needs secondary to pressure areas.

The initial care plan dated 9/28/15, indicated R439 had pressure ulcers and potential for pressure ulcer development related to disease process and prolonged immobility. There was no discussion on the care plan of where the pressure ulcers were or any stages listed. The initial goal dated 9/28/15, indicated R439's pressure ulcer would show signs of healing and remain free from infection. The initial interventions dated 9/28/15, indicated staff were to assess/record/monitor

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 130	F 353		

wound healing. They were to measure length, width and depth where possible. assess and document status of wound perimeter, wound bed and healing progress. Staff were directed report improvements and declines to the MD. "Inform the resident and family/caregivers of any new area of skin breakdown. Pressure relieving/reducing device in bed/chair. Treat pain as per orders prior to treatments/turning etc. to ensure comfort." R439 required supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Staff were to educate R439/family/caregivers as to causes of skin breakdown which included transfer/positioning requirements; importance of taking care during ambulating /mobility, good nutrition and frequent repositioning.

A review of the nursing notes for R439 between 9/15/15 and 10/14/15, lacked any mention of refusals to turn or reposition.

On 2/9/16, the care plan was updated to state that the pressure ulcers were all stage IV on admission (inaccurate according to the physician progress notes), and R439 had been noncompliant with cares (the medical record lacked supporting evidence in the documentation for the statement).

The NA care card print date of 3/16/16, directed staff assist of two staff participation to reposition and turn in bed. Grab bars on bed. Turn and reposition every two hours when in bed and 30 minutes when up in wheelchair. R439 requires assist of staff for mobility. Stretcher transport to appointments.

The facility was able to print out the last 30 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 131	F 353		

of nursing assistant charting for bed mobility, turning and repositioning which revealed that out of four opportunities per shift (12 opportunities per day), a total of 360 opportunities there were 84 actual documentation as follows:
On 2/20/16, 2/2816, 3/5/16, 3/8/16, 3/11/16, and 3/17/16, the night shift nursing assistant did not document anything on R439 for turning and repositioning. On 2/21/16, 2/26/16, 3/4/16, 3/9/16, 3/10/16, and 3/18/16, the nursing assistant documented NO once, for turning and repositioning. On 2/27/16, 2/29/16, 3/9/16, 3/14/16, and 3/15/16 the nursing assistant charting indicated the resident refused to turn once per shift, however there was no evidence that the nursing assistant informed the nurse who was then expected to re-approach R439 or document the risks and benefits of refusal to turn in the nursing progress notes.

On 3/16/16, at 8:36 a.m. during a stage 1 interview the resident stated that the night shift staff do not turn him, and that he had reported to RN-N and a handful of aides was no longer able to care for him.

On 3/17/16, continuous observations for two hours and fifteen minutes from 5:45 a.m. until 8:00 a.m. the resident was not repositioned. At 6:24 RN-P knocked and entered room for blood glucose test. At 7:08 RN-P entered room without knocking, then called R439's name, she left the room within 15 seconds of entering and placed something in the treatment cart garbage.
-At 8:03 a.m. R439 was interviewed and stated he "had not been turned all night."
-At 8:05 a.m. RN-N was notified that the resident had not been turned during the time of continuous observation, and that the resident had stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 132	F 353		

had not been turned all night. RN-N stated "He should be turned every two hours."

On 3/17/16, at 11:16 RN-P stated she had entered his room the first time to get his blood sugar and the 2nd time to give insulin.
- At 11:20 a.m. NP-B stated actually most of the issue was the aides need to inform the nurses of what they see. "I rely on the nursing staff to inform me of what's happening. The aides don't take direction from the nurses."
-At 11:30 doctor (D)-C, stated you know with the changeover quality declined and it was coming back, but you have to have enough staff, and people who care what they are doing. D-C verified system breakdown in pressure ulcer care.

On 3/18/16, at 9:00 a.m. R439 stated last repositioned at 8:30 p.m. (not repositioned for 12.5 hours).
-At 9:30 NA-N was informed that the resident stated he had not been turned last night, and was asked if he had reported the allegation of neglect reported to him yesterday. NA-N stated he had reported it to the DON and consultant nurse (CN). NA-N was asked if he had interviewed the resident after the allegation of neglect was reported to him and NA-N stated he had talked to R439, but had not asked about being repositioned on the night shift.

Staffing patterns:
A review of nurse staffing sheets 3/16/16, showed on:
-Unit 01305, one LPN doubled to evenings one NA and one TMA were floated out of unit on days, one NA was floated out on evenings.
-Unit 01306, one RN and one NA were floated out on evenings. One LPN and one NA were floated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 133	F 353		

out on nights.
-Unit 01307, 11 NA doubled to evenings.
-Unit 01308, two NA doubled to nights, three NA's floated out on night shift.
-Unit 01309, one LPN doubled to evenings, one LPN floated out on days and doubled to evenings, one NA floated out. One NA doubled to nights. One NA floated out on nights.
A review of nurse staffing sheets 3/17/16, showed on:
-Unit 01305, one LPN doubled to evenings and one LPN shift was not filled, one LPN on night shift, no NA's were planned.
-Unit 01306, one NA doubled to nights, one NA was floated out on evenings, one LPN floated out on nights.
-Unit 10307, one RN doubled to evenings.
-Unit 10308, one RN floated out on evenings, one LPN and two NA's doubled to nights. Two NA's were floated out on nights.
-Unit 01309, one LPN and one NA doubled to evenings. One NA floated out on evenings.
A review of nurse staffing sheets 3/18/16, showed on:
-Unit 01306, one LPN doubled to evenings and one LPN floated out on days, one NA floated out on evenings and two NA doubled to nights, and three LPN's floated out on nights.
-Unit 01307, one NA floated out then doubled to evenings.
-Unit 01308, one NA doubled to evenings, one RN floated out on evenings. One NA floated out on nights.
-Unit 10309, 1 NA floated out on days, 1 LPN and two NA doubled to evenings. One NA doubled to night shift.

Review of random staffing sheets:
- On 1/1/16, unit 01305 one NA doubled to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 134	F 353		

evenings. 01307 one NA doubled to nights. 01308 one NA doubled to nights.
- On 1/2/16, 01305 one NA doubled to evenings, 01306 one LPN and one NA doubled to nights, 01307 one NA doubled to evenings, 01308 two NA doubled to nights and 01309 three NA's doubled to evenings, one NA doubled to nights.
- On 2/1/16, unit 01305 one LPN and two NA doubled to evenings, one NA doubled from evenings to nights, 01306 one LPN and three NA's doubled to evenings, Unit 01307 one RN doubled to evenings, and Unit 01309 one RN and one NA doubled to evenings.
- On 2/2/16, unit 01305 one RN and one NA doubled to evenings, Unit 01306 one LPN and one NA doubled to evenings, Unit 01307 two RN's doubled to evenings and one NA doubled from evenings to nights, Unit 01308 one NA doubled to nights, and unit 01309 one LPN and two NA doubled to evenings.
- On 2/3/16, Unit 01305 one LPN doubled to evenings, one NA doubled to nights, unit 01306 one LPN doubled to evenings and one NA from evenings to nights, unit 01308 two NA's doubled to evenings, and unit 01309 one LPN and one NA doubled to evenings.

CALL LIGHT OBSERVATIONS
R161's call light was continuously observed on 3/17/16, from 7:05 a.m. to 8:15 a.m. and the following was noted:
-7:05 a.m. room 319's call light was on.
-7:28 a.m. RN-G entered room and stated RN-G would tell the aide that he was needed and turned off call light. RN-G spoke to NA-J and then returned to the desk. NA-J did not enter room 319.
-8:09 a.m. NA-J brought mechanical lift to the door of room 319 and left it in the hallway. NA-J entered room 319.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 135	F 353		

-8:10 a.m. NA-J exited room 319.
-8:12 a.m. call light over door to room 319 was turned on.
-8:15 a.m. NA-C entered room 319 call light off over door. NA-C told R161 "I am here to get you washed up and dressed for breakfast." R161 said, "Thank you."

R161 Quarterly Minimum Data Set dated 1/13/16, indicated R161 was cognitively intact, able to communicate needs, and was dependent on staff to get from bed to wheel chair after being dressed. The Visual/Bedside Kardex report dated 3/21/16, instructed staff that R161 required assistance to dress in a.m. and required staff assistance and a mechanical lift to transfer.

During interview on 3/17/16, at 7:51 a.m. R161 said she had told the nurse she wanted to get up but still had not had any one come to get her up. R161 said, "This happens every morning." During the interview R161 was observed lying flat in bed without shirt on. R161 had sheet pulled up to shoulders.

Room 323
During the observation on 3/17/16 at 7:45 a.m. call light was on over the door of 323
-At 7:54 a.m. maintenance man walked by call light on door of 323 without entering room, call light still on.
-7:57 a.m. NA-A entered room 323. The call light over the door was turned off NA-A left room 323.
-8:06 a.m. NA-A entered room 323 with a breakfast tray.

During an interview on 3/21/16, at 5:14 a.m. LPN-D said,"I have one nursing assistant, it has become the new normal. My census is 29. I used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 136	F 353		

to have two aides. I am doing the aides point of care charting and then I will do the ADL charting so they do not get written up. I cannot get my work done. Sometimes you do not get a break, sometimes I am not able to get everything done. I am so frustrated that I can't get my work done. I wrote letters to my manager, my supervisor, the director of nursing and the administrator. They promised me no residents with tube feedings, no residents that require two person assist. Well I have a resident with tube feeding and several residents who are two person assists. I have people I have to 1:1 when they are out of bed, two residents on every 30 minute checks and residents who go outside to smoke every 20 minutes. Now we need to supervise R494. Last week they started smoking aprons and supervision." LPN-D said, "It is my license and I do my best but I am afraid for my residents. There will be more medication errors, more pressure ulcers, more falls.

During interview on 3/21/16, at 5:25 a.m. NA-N said, "We try our best, my nurse helps. We had two residents up most of the night until 4:00 am. I am the only aide on this unit"

During interview on 3/21/16, at 5:40 a.m. NA-M said, "I am working a double from evenings to nights. I do it sometimes because of call-ins. I can get my work done, but I can do most turns by myself."

During interview on 3/21/16, at 5:40 a.m. RN-O said, "Nights are ok because they always must be staff to PPD (per patient day)." When asked if staffing is changed if resident acuity increases, RN-O said, "We staff to PPD."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 137	F 353		

On 3/21/16, at 5:46 a.m. LPN-G said it was a good night. Sometimes I help the aides. LPN-G said, "Sometimes we go to the north building, 2N they are always short on nights. We try to help them."

On 3/21/16, at 5:56 a.m. LPN-F said, "You should check TCU they often only have one aid on nights and cannot get everything done."

During interview on 3/21/16 at 10:45 a.m. RN-K nurse manager said, the process for orders when a new admit arrives were The HUC would enter the orders into Point Click Care (PCC) then the charge nurse would clarify any orders needing clarification and then perform a second check on them. We try to do the clarification and second check on the same day as admission.

RN-K said R481's medication error was discovered by an evening supervisor. The admission orders had been checked by two nurses but the gabapentin was missed. RN-K said, "I think it is the consistency of having someone on the desk. My assistant can cover the desk but only to 3:30 p.m."

RN-K said R57's medication error occurred because, "the HUC wrote the order needed clarification and then we were without a charge nurse for several days. The nurse practitioner found the error and clarified the order." It was communicated to staff that it was not appropriate to write needs clarification. If an order has not been inputted into PCC the nurse checking the orders would enter the order and then have another nurse second check it. RN-K said, "We have not had a charge nurse consistently. The floor nurses having to pick that up."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 353	Continued From page 138 RN-K said, "currently have 67 residents, but we can have a max of 93-95. The schedule depends on the day, we work with a combination RN's, LPN's and TMA's. We are told how many hours need to be cut a day by payroll and staffing. Staffing is good when we have three nurses and two TMA's. Our per patient day staffing is 3.18." RN-K said, "We staff by PPD and not acuity."	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure resident dinnerware was clean of food debris and stagnant water to minimize the possibility of food borne illness. This had the potential to affect 288 of 293 residents in the facility who were served food out of the kitchen. Findings include: During the evening Bridgeway South (BWS) dining observation on 3/14/16, at 5:15 p.m. dietary aide (DA)-B was observed serving food to	F 371	F371 Food Procedure/store/prepare/serve Identified serviceware items were washed at the time of identification. Current residents who receive meals from the kitchen have the potential to be affected by this alleged deficiency. Dietary Staff were educated on proper practices for mechanical washing of bowls and coffee cups. Audits to be completed up to 5 times per week by Dietary Manager or designee. Audits will be brought to QAPI meeting for	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 139 three staff members who were giving the food orders at the front of the steam table. Next to the plate warmer was a deep sided yellow plastic dish rack sitting on a three shelf push cart. DA-B continually took bowls as needed out of the dish rack and filled approximately 20 food orders for the back BWS service. At 6:03 p.m. the front BWS evening service started. When DA-B pulled three bowls out of the same yellow plastic dish rack, approximately 30cc of water was observed to run out of each of the bowls. DA-B continued to use the bowls, filling them with pureed meat and/or mashed potatoes and gravy serving them to residents seated in the dining room. During interview on 3/14/16, at 6:07 p.m. DA-A verified the multiple blue serving bowls in the yellow plastic rack were not dry and should have been allowed to dry properly before use. At 6:08 p.m. DA-A removed the yellow plastic dish rack of bowls and brought a new rack of dry bowls. During interview on 3/14/16, at 6:35 p.m. DA-B stated he "tries to look out for the ones with water in them." A puddle of water approximately 8 inches in diameter was observed underneath the area where the yellow dish rack had been sitting. There were also puddles of water on the second and third shelf of the three shelf push cart. DA-A verified the water on the cart had dripped out of the yellow plastic rack of dishes. During the follow-up kitchen tour on 3/17/16, at 2:00 p.m. with the director of nutrition (DN), deep plastic dish racks were observed to contain numerous amounts of either all blue cereal bowls or a mix of blue cereal bowls and/or smaller fruit bowls or coffee mugs. The dishes were thrown into the racks, with some stored in an upright	F 371	review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 140 position. In the ten dish racks there were numerous bowls stored with water in them and at least eight cereal and fruit bowls contained dried food debris, some with water in them. The DN verified the dishes should have been stored clean of food debris and not stored wet with water in them. DN stated "we will be changing that procedure." Review of the facility Dishwashing Machine Use - Revised March 2012 included direction to "presoak dishes or pots that contain dried or burnt food, do not overcrowd racks and after running items through entire cycle, allow to air-dry." On 3/18/16, at 7:58 a.m. the DN stated she would expect the dishes to be clean and dry. DN stated "we need to do it right, I'm changing it right now."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 141 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain antibiotic as ordered for 1 of 1 resident (R305) who was diagnosed with bronchitis. Findings include: During observation on 3/16/16, at 10:57 a.m. R305 was observed to be very short of breath with audible wheezing and usage of accessory muscles. R305 was unable to complete initial interview due to shortness of breath. R305 was sitting upright in a wheelchair with oxygen on via nasal cannula. There was a nebulizer machine sitting on the table next to R305. R305's annual Minimum Data Set (MDS) dated 2/9/16, indicated R305 was cognitively intact, required assistance with all activities of daily living except for eating which required supervision. R305 did not have shortness of breath or used oxygen during the assessment reference period of the MDS. R305's annual MDS did indicate R305 had diagnoses of dementia, anxiety and asthma. The care plan initiated on 3/15/16, indicated R305 had shortness of breath when lying flat due to a diagnoses of chronic obstructive pulmonary disease, and R305 used supplemental oxygen for comfort and has a history of bronchitis.	F 425	F425 R305 has received the prescribed antibiotic. Current residents have the potential to be affected by this alleged deficiency. Emergency drugs and biological are available to residents. Licensed nurses have been educated regarding the emergency drugs and biological. DON/Designee will audit administration of stat medications weekly Results of audit will be reviewed by QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 142	F 425		

The Physician Telephone Order dated 3/15/16, indicated staff were do give Roxanol 20/milligrams(mg.)/milliliter(ml.) every hour as needed (PRN) for comfort and start oxygen at two liters by nasal cannula continuous for comfort.

The resident was seen by nurse practitioner on the evening of 3/16/16, and wrote orders for Keflex (antibiotic) 250 mg three times a day by mouth for seven days for bronchitis. "Start stat [immediately, without delay]!", albuterol neb (breathing treatment) 2.5 mg twice a day for five days stat every two hours and PRN and Prednisone (steroid that reduces inflammation) 10 mg STAT then every a.m. for four days.

The Geriatric Services of Minnesota Progress Notes dated 3/16/16, indicated (R305) alert, up and dressed cough bothering her, does want antibiotic. Lungs with diminished breath sounds and audible wheezes. Assessment was "bronchitis, not actively dying." The plan was appropriate to treat with antibiotics, prednisone, and nebulizer treatments.

A review of March 2016 Medication Administration Record did not indicate Keflex was given as ordered on 3/16/16. Prednisone 10 mg. stat was given at 6:06 p.m.

Northridge 1 SW Omnicell (automated medication dispensing system) Inventory faxed to facility on 3/18/16, at 10:23 a.m. was provided as a list of medications available in the facility for emergencies. Cephalexin (Keflex) 250 mg was on the list.

During interview on 3/16/16, at 11:00 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 143	F 425		

registered nurse (RN)-F stated R305 was very short of breath yesterday so we obtained orders yesterday for morphine. R305 did not have a fever, and the oxygen saturations are 92 percent. R305 does not normally use oxygen.

On 3/17/16, at 8:30 a.m. trained medication aide (TMA)-A asked RN-G about R305's order for Keflex three times a day. TMA-A said "none has been given and it is not due until noon"

During interview on 3/17/16, at 2:12 p.m. RN-G said, "The order was inputted incorrectly. It was set up to start at noon, so I corrected it to 9:00 a.m." RN-G verified the Keflex had not been given on 3/16/16.

During interview on 3/18/2016, at 10:03 a.m. nurse practitioner (NP) said, "I was called on the fifteenth and was told she looked like she was dying so I ordered morphine [a narcotic]. When I saw her on the sixteenth she was up in her chair having difficulty breathing but not dying, so I ordered nebs, prednisone and an antibiotic. 'STAT' does not mean start the next day. It means as soon as possible. No one notified me that there was an issue getting the antibiotic. Delays in giving STAT medications are not acceptable."

During interview on 3/18/16, at 10:55 a.m. RN-H said, "STAT means as soon as possible. There was an issue with scheduling the medication. If we start it in the evening she might not get all of her doses. There was no supply of the antibiotic until the morning. If we order a medication from the pharmacy STAT they can get it for us in four hours." RN-H was not sure if Keflex was in the emergency kit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 144 On 3/18/16, at 12:06 p.m. RN-E nurse manager said stat means now. "Sometimes we cannot get the medications from the pharmacy. I expect staff to notify the medical doctor if they cannot give a STAT medication." Administering Medications Policy revised April 2010, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed." "3. Medications must be administered in accordance with orders, including a required time frame."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consulting pharmacist failed to follow up on recommendations for a gradual dose reduction for 1 of 5 residents (R422) reviewed for unnecessary medications. Findings include: A Pharmacy Consultation Report dated 10/1/15,	F 428	F428 R422 has been discharged Current residents have the potential to be affected by this alleged deficient practice. Consultant pharmacist reports recommendations have been addressed. Unit managers have been educated regarding consultant pharmacist report recommendations DON/Designee will audit consultant	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 428	Continued From page 145 indicated a recommendation to decrease R422's Remeron (an anti-depressant) dose to 7.5 milligrams (mg) at bedtime. The Pharmacy Report was not addressed by the facility. R422's quarterly Minimum Data Set dated 1/8/16, indicated he had no cognitive impairments, required assistance with activities of daily living and displayed no behaviors. R422's care plan dated 1/14/16, indicated use of psychotropic medications for depression and anxiety, but did not address insomnia. A review of R422's Physician's Orders dated 3/18/16, indicated he was receiving Remeron 15 mg by mouth at bed time for insomnia. During an interview on 3/14/16, at 6:33 p.m., R422 stated he prefers to stay up until 2:00 a.m. to 3:00 a.m. He stated the night staff coming at 6:00 a.m. make a lot of noise and wake him up. During an observation on 3/17/16, at 2:36 a.m., R422 was lying in bed on his left side with his eyes closed. He appeared to be sleeping. During an interview on 3/18/16, at 8:32 a.m., registered nurse (RN)-M stated, the pharmacy recommendations go to the director of nursing and then get distributed to the units. She stated she was not aware of the recommendations by the pharmacist. During a subsequent interview on 3/18/16, at 1:13 p.m., RN-M stated, "the pharmacy recommendation was not followed up on." She stated she took care of it today. A facility policy titled, Tapering Medication and	F 428	pharmacist report recommendations monthly Results of audit will be reviewed by QAPI.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 428	Continued From page 146 Gradual Drug Dose Reduction, dated September 2012 was reviewed. The policy indicated tapering of medications and gradual dose reductions will be completed in consultation with the physician and consultant pharmacist.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 147 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to keep medications secured on 1 of 2 units. Findings include: During random observation on 3/14/16, at 12:50 p.m. medication cart across from room 607 was observed to be unlocked. 12:54 p.m. nursing assistant passed medication cart. 12:55 p.m. staff member passed the medication cart delivering supplies. 12:57 p.m. R388 and a visitor passed the medication cart 1:01 p.m. registered nurse (RN)-R locked medication cart. 1:04 p.m. RN-R verified medication medication cart had been unlocked and the cart contained Coumadin (blood thinner), prescription medications, over the counter medications and narcotics in the cart. During interview on 3/21/16, at 11:09 a.m. the director of nursing (DON) stated the facility had locked carts on the unit, unless the resident has a self-administration order and then they should secure them in their room. Staff should lock the medication cart if they are not able to adequately supervise it. The DON said medications that were dished up on top of the medication cart are not adequately secured if they are out of reach of the trained medication aide or nurse.	F 431	F431 Medications are secure on the unit. Current residents have the potential to be affected by this alleged deficiency. Medication is secure on all units. Nurses have been educated on securing medications. DON/designee will audit the security of medications on the unit daily. Results of audit will be reviewed by QAPI.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 149 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene, glove usage and linen handling were implemented while providing care for 2 of 3 residents (R35, R282) observed for wound or personal cares. Findings include: R35 was observed on 3/7/16, at 9:08 a.m. registered nurse (RN)-G applied a glove to the right hand without washing hands or using sanitizer. RN-G reached across R35's legs and removed left heel dressing. There was yellow and brown drainage on dressing. RN-G moved ankle to visualize the heel. R35's left heel was black. RN-G palpated the left wound edges. RN-G then removed the right heel dressing without changing gloves. RN-G pushed the right heel skin flap back and put R35's feet down so R35's bare heels were touching the bed sheets. RN-G removed gloves, washed hands. At 9:23 a.m. RN-G re-entered room. RN-G put gloves on and applied right heel dressing then taped square foam cover dressing to right heel. Without changing gloves RN-G applied left heel dressing then taped square foam cover dressing to left heel. During R35's wound care observation on 3/17/16, at 11:44 a.m. RN-G said to R35 we need to change the dressing on your bottom. RN-G applied gloves, knelt on ground and removed the heels up device from under R35's legs. RN-G put the clean dressings still in their package on a chair. Nursing assistant (NA)-J helped roll R35 toward the wall and held R35 in place during the dressing change. NA-J opened the incontinence	F 441	F441 R35 has been discharged. R282 is receiving care consistent with proper hand hygiene, glove usage, and linen handling. Current residents have the potential to be affected by this alleged deficiency. Residents are receiving care consistent with proper hand hygiene, glove usage and linen handling. Nursing staff has been educated regarding hand hygiene, glove usage, and linen handling. DON/designee will audit 2 resident care encounters per unit per week to ensure proper hand hygiene, glove usage and linen handling. Results of audit will be reviewed by QAPI.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 441	Continued From page 150	F 441		

brief. There was brown stool on the brief. RN-G removed dressing from coccyx. RN-G applied wound cleanser to gauze and cleansed the coccyx wound. Coccyx wound was irregularly shaped with two ovals connected by a narrow strip of slough filled skin. The two ovals were filled with cream colored slough and the right oval was larger than the left oval. RN-G applied a pink dressing to R35's coccyx. NA-J cleaned stool from R35's bottom. NA-J then wiped stool off gloves with an incontinence wipe. A clean incontinence brief was placed under R35. RN-G removed dressing from left ischial tuberosity and cleansed wound with wound cleanser. The wound was circular approximately two centimeters in diameter. RN-G applied a pink dressing to wound. NA-J did not wipe the front of peri-area before applying incontinence product. NA-J removed gloves, washed hands and applied new gloves. RN-G said to NA-J, "usually when I do a dressing change, I wear two to three gloves so I just remove one layer at a time because after you remove your gloves you cannot put the others on."

During interview on 3/17/16, at 11:55 a.m. RN-G verified saying "usually when I do a dressing change, I wear two to three gloves so I just remove one layer at a time because after you remove your gloves you cannot put the others on." RN-G said, "When I do a dressing change I do not wash my hands between gloves or use sanitizer. I just wash my hands when I am done."

During interview on 3/18/16, at 1:29 pm RN-E said I expect them to change gloves and wash hands after doing peri care. I expect them to change gloves and wash their hands between different wounds. We should not double glove

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 441	Continued From page 151 ever. During interview on 3/18/16, at 2:10 p.m. the assistant director of nursing (ADON) stated would expect staff to wash hands before they start treatment, explain what they are going to do, assesses for pain, use the bed side table. I expect after they remove the dressing to change their gloves and wash hands if they came in contact with anything before to put new gloves on. ADON verified expected staff to change gloves between wounds because would not want any cross contamination. ADON said there is no need to wear multiple pairs of gloves at the same time while doing cares. The ADON stated, "Staff are to wash their hands or use sanitizer after they remove gloves. Staff should remove gloves and wash hands after doing pericare or cleaning up stool. It is not acceptable to take a wipe and wipe off stool from glove." R282's Minimum Data Set (MDS) dated 10/12/15, identified R282 required extensive assistance with toileting, dressing, bathing and personal hygiene. During an observation on 3/17/16, at 8:10 a.m. nursing assistant (NA)-E provided incontinent care along with morning cares. R282 was incontinent of bowel. NA-E donned gloves to provided incontinent care. NA-E assisted R282 to turn to the right side and began to clean R282's bowel movement with wipes and then provided personal care with a washcloth and towel. After the care was provided NA-E removed the gloves, applied a clean incontinent product underneath R282 and assisted R282 to lay flat on the bed. NA-E then donned new gloves and provided peri	F 441		

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F 441	Continued From page 152 care to R282. NA-E cleaned R282's bowel movement and then provided perineal care. NA-E did not wash hands between cares. After providing perineal cares, NA-E removed gloves and donned a new pair of gloves. NA-E proceeded to assist R282 with dressing. After completion of R282's personal care and dressing, NA-E stated to R282 that there were no bags in the room (to put the dirty linen in for laundry) and R282 stated "there's nothing unusual about that." NA-E then threw R282's gown, washcloth and towel on the floor. NA-E called for additional help to transfer R282 out of bed and into the wheelchair. After the transfer was completed, NA-E brushed R282's hair and handed R282 her toothbrush. NA-E then removed her gloves and indicated that R282's morning cares were complete. An interview with registered nurse (RN)-I on 3/17/16, at 11:25 a.m. confirmed staff hands should be washed in between incontinent care, perineal care and providing other personal cares. RN-I also confirmed that each room had bags for dirty linen to be put in for laundry and soiled linen should not be thrown on the floor. A facility policy entitled Handwashing/Hand Hygiene dated April 2010, indicated that employee hands should be washed before and after assisting residents with toileting and indicated handwashing should be completed using soap and water.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 465	Continued From page 153 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure a safe, functional and sanitary environment, and resident equipment was kept in good repair for 9 of 10 residents (R10, R19, R77, R104, R118, R179, R282, R329, R368) whose rooms were reviewed for environmental concerns. In addition, the facility did not ensure a sanitary environment in 2 of 5 kitchenettes. This had the potential to affect 130 of 293 residents who were served food out of the Bridgeway South (BWS) and 2 West kitchenettes. Findings include: On 3/18/16, at 8:00 a.m. to 9:10 a.m. an environment tour was conducted with the maintenance director, director of housekeeping (DOH), maintenance staff (MS)-A, at 8:30 a.m. the facility's administrator joined the tour, during the tour the following environmental concerns were reviewed and verified. 1 South West - Room 126 closet door off track and missing handle. When asked how long it has been off track and missing the handle, the maintenance director stated he was not aware of the closet being off the track and missing handle. Maintenance director stated staff are to put in a teles work order for any items needing	F 465	F465 Safe/functional sanitary environment Environmental concerns were addressed for R10, R19, R77, R104, R118, R179, R282, R329, and R368. Current residents who reside in the rooms defined by the deficiency have the potential to be affected by the alleged deficiency. Manufacturer guidelines were reviewed form grab bar in room 224. R104□s wheelchair was cleaned. Bridgeway South kitchenette backsplash was repaired. 2 West kitchenette was cleaned. Bridgeway entrance carpet was replaced. All residents have the potential to be affected, rooms and bathrooms will be cleaned daily. Staff will be re-educated on providing a safe, functional, sanitary, and comfortable environment. Environmental audits and TELS audits will be completed weekly. Audits will be reviewed by QAPI committee.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 154 maintenance electronically. -Room 125 second bed a large gauge (approximately 8 inches by 4 inches) was noted on the wall in the room by the head of the bed. 2 West - Room 230 had a strong foul/malodorous smell in room - Room 224 had 2 large stains on the carpet on hallway by the entry into room, a large spider web in the corner above the foot of the bed, fan was noted with dirt and dust build up, and bilateral grab bars on the bed were loose. - R104's wheel chair (w/c) was noted to have a clear tape on bilateral arm rests and seat cushion was noted to be filthy with food debris. DOH stated tape on w/c was not a cleanable surface and w/c needed to be cleaned. 3 West - Room 322 had a strong urine odor in the room, the bathroom had a malodorous odor and the garbage can in the bathroom was noted to be filled with used incontinent products. - Room 338 the carpet was noted to be dirty/filthy with 3 black/brown stains on the carpet - Room 346 had a strong urine odor - 2 large black/brown stains on the carpet by the doorway to room 361 and 365 on the 3 west near north hallway. DOH stated she was aware of the stains in the hallway and the hallway was shampooed on Monday 3/14/16 but she did not check back after the carpet was shampooed. - R368's w/c brakes and left arm rest on w/c was noted to be loose, and w/c was noted to be filthy with food debris on both arm rests and on the cushion. Maintenance director verified that w/c brakes and arm rest were loose and stated they needed to be fixed.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 465	Continued From page 155 BWS - 6 dark stains on the carpet by the entry way to the BWS unit. - Room 312 had 2 black stains on the carpet and no soap dispenser in the bathroom. - Room 314- brown colored stain on the wall by the head of the bed, a large stain on the seat of wooden chair, the bathroom floor was sticky and had black/brown colored dirt buildup around the edges of the bathroom floor. Kitchenettes During the follow-up kitchen tour on 3/17/16, at 2:10 p.m., the following was observed and confirmed by the director of nutrition (DN). - The Bridgeway South kitchenette had an eight foot kitchen counter which contained an ice machine on the left and sink to the right. There was a four inch backsplash behind the entire length of the counter which had white caulking above the backsplash and where the backsplash met the counter. Approximately three feet of this caulking behind the sink was brown/yellow colored with dirt and food buildup. The wall behind the clothing protector receptacle and two waste containers was splattered with food debris. - The 2 West kitchenette had a back wall to the left and behind the toaster cart which was directly behind the serving area of the steam table. Approximately four feet by four feet of the wall to the left of the toaster cart and approximately two feet by four feet of the back wall to the right of the toaster cart was splattered with heavy dried food debris. There was a heavy buildup of black/brown grime and food debris along the perimeter of the	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 156 flooring. During an interview on 3/17/16, at 2:25 p.m., the DN verified both areas were a concern, needed cleaning and stated she would contact housekeeping who is responsible for cleaning the areas. On 3/18/16, at 9:10 a.m. DOH stated nursing staff were responsible for w/c cleaning and when asked how often w/c were cleaned, DOH stated she was not aware how often the w/c were cleaned. DOH further stated residents' rooms and bathrooms are cleaned daily. On 3/18/16, at 9:20 a.m. maintenance director stated he checked the electronic teles work order requests and could not find any teles work orders for the maintenance concerns that were identified during the environmental tour. Maintenance director further stated it ' s the expectation for staff to fill out an electronic teles work order anytime maintenance issues are identified. During interview on 3/18/16, at 1:11 p.m. the unit nurse manager RN-E stated that w/c are cleaned weekly and as needed by nursing staff on the night shift. RN-E further stated that housekeeping keeps the w/c cleaning schedules. On 3/18/16, at 2:08 p.m., the director of nursing (DON) stated that her expectation is for resident w/c to be kept clean. The facility's Cleaning/repairing Carpeting and Cloth Furnishings Policy revised 12/2009, indicated that the facility's carpeting and cloth furnishings shall be cleaned regularly according to the facility's cleaning schedules.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 157 - A routine maintenance policy was requested but none provided - A general, resident equipment, resident room and resident bathroom cleaning policy was requested but none provided.	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Quality	F 520	The facility has developed action plans for residents consuming alcohol, pressure	5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

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

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F 520	Continued From page 158 Assessment (QA) committee recognized and developed action plans to address potential for injury for one resident who was consuming alcohol, becoming intoxicated, and posed a risk for injury to himself and other residents. In addition, the QA committee failed to develop an action plan to address an identified lack of sufficient staff necessary to provide care and services in accordance with their assessed needs for 14 of 23 residents (R439, R35, R62, R104, R77, R242, R248, R286, R429, R494, R511, R4, R481, R57). These deficient practices had potential to affect all 294 residents residing in the facility. Findings include: Refer to F314: the facility failed to provide care and services to prevent worsening of pressure ulcers for 1 of 4 residents (R439). This failure to provide care resulted in actual harm, worsening of pressure ulcers for R439. In addition the facility failed to prevent development of pressure ulcers for 2 of 4 residents (R35 and R62). Refer to F323: the facility failed to ensure adequate supervision while intoxicated for 1 of 1 resident (R104) who was known to consume alcohol (ETOH) in the facility. In addition, the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 7 of 15 residents (R77, R242, R248, R286, R429, R494, and R511) who currently smoked in the facility. Refer to F333: the facility failed to ensure 3 of 3 resident's (R4, R481, and R57) were free from significant medication errors related to improper transcription. This resulted in actual harm for R4	F 520	ulcers, medication errors, and for providing adequate staffing. Current residents have the potential to be affected by the alleged deficiency. Facility staff and QAPI committee will be re-educated on the QAPI action plans to correct deficiencies. The NHA is responsible for compliance. NHA will review QAPI reports monthly to ensure compliance.	

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 520	Continued From page 159	F 520		

and R481. R4 was hospitalized related to seizure activity and R481 suffered "almost constant pain" rated 10/10.

Refer to F353: the facility failed to ensure sufficient staffing was provided to meet the individual needs of 3 of 4 residents (R35, R62, and R439) reviewed for pressure ulcers; for 3 of 3 residents (R4, R257, R481) reviewed for significant medication errors; for 1 of 1 resident R104 reviewed who was consuming alcohol in the facility and who was at risk for injury to himself and others and for 7 of 15 residents (R77, R242, R248, R286, R429, R494, and R511) reviewed for unsafe smoking. Further, the facility failed to ensure adequate staffing to provide care and services to residents.

During an interview on 3/18/16, at 8:37 a.m., the director of nursing (DON) stated she identified an ineffective process for medication error reporting. She stated during the months of August and September of 2015 she did not receive any medication error reports indicating an area for process improvement. She stated at that time she changed the process from a paper system to a computerized system. The DON stated, any of the nurses can initiate a medication error and the errors get recorded immediately. She stated she was able to track the medication errors daily. She further stated she tracked the errors on a report and brings them to QA.

While the process enabled the facility to track medication errors, it did not identify prevention of transcription errors and as a result, actual harm occurred for R4, and R481.

During an interview on 3/21/16, at 2:33 p.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 160	F 520		

administrator stated the facility QA committee met monthly to review a "multitude of projects" including infection control, pressure ulcers, medication storage, call light response times and repositioning. The administrator stated the QA committee identified staffing concerns and implemented a new performance based incentive program. He further stated the committee was currently working on a pressure ulcer project. He stated pressure ulcers are being tracked based on what comes in from outside the building, if there was improvement, how many are in the building and if they are acquired in the facility. However, he stated he did not know what particular process changes had been implemented.

While the facility identified a need for process improvement regarding pressure ulcers, there was no evidence of any recently revised systems. As a result actual harm occurred for R439.

The DON was interviewed on 3/18/16, at 11:50 a.m. regarding R104's alcohol use and aggressive tendancies, including the use of sharp objects when intoxicated. The DON was asked about R104's Progress Note dated 3/8/16, at 5:49 p.m. The DON was not informed at any time of R104 swinging a knife at other people but would expect to be informed if that happened. The DON later stated that she believed the incident involved a box cutter, not a knife. The DON confirmed there was no incident report made about the 3/8/16, occurrence and further indicated she did not expect an incident report to be completed every time R104 was intoxicated. The DON indicated with identified care plan interventions, "any reasonable and prudent nurse" would know he was currently using alcohol and what to do if

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	245183	A. BUILDING _____ B. WING _____	03/21/2016

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F 520	Continued From page 161 he was intoxicated. The DON confirmed the facility did not have a policy related to resident use of alcohol. A facility QA policy was requested, but none received.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

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

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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, State Fire Marshal Division on March 16, 2016. 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:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2016

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.

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@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.	K 000		

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to meet the requirements of NFPA 101, 2000 Edition Sections 19.2.2.2.6 and 7.2.1.8.2. This deficient practice could affect 19 residents. Findings include: On facility tour on March 15, 2016 between the hours of 10:00 AM and 11:00 AM and on March 16, 2016 between the hours of 9:30 AM and 3:30 PM, observation revealed that the fire doors for the 2-hour fire rated separation between the west building and the apartment building did not have	K 021	K21 Smoke detector will be added to the West building on the apartment side within 5 feet of the door. Additional smoke detector was added to the West side of the building to activate automatic door release. All residents are potentially impacted, although none were impacted. Maintenance staff were educated on K21. EII met with Fire Marshal to ensure compliance with regulation prior to installation of smoke detectors. Maintenance Director or designee will audit placement of all smoke detectors.	5/3/16

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

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K 021	Continued From page 3 smoke detection within five feet of the doors. It was also revealed that the closest smoke detector was operated by the apartment building fire alarm system and did not release the fire doors upon activation. This deficient practice was verified by the Director of Maintenance at the time of the inspection.	K 021	Audits will be reviewed by QAPI.	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, policy review and staff interview, the facility failed to follow policy for the designated resident smoking in accordance with NFPA LSC (00) Edition Section 19.7.4, and the facility's smoking policy. This deficient practice could affect all 298 residents.	K 066	K66 Facility updated smoking policy. Facility added butt receptacles to the designated smoking area that are cleaned weekly. Smoking area was relocated in area where there is no oxygen in use. Cigarette butts were swept in the area. Non smoking areas were identified.	5/3/16

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 066	Continued From page 4 Findings include: On facility tour on March 15, 2016 between the hours of 10:00 AM and 11:00 AM and on March 16, 2016 between the hours of 9:30 AM and 3:30 PM, It was observed that the facility has a no smoking policy. 1) There are designated smoking areas with butt receptacles, even though the policy states no smoking on the premises. 2) It was also observed that a resident was smoking next to a no smoking sign, while on oxygen, and unsupervised. 3) Cigarette butts were also found disposed of throughout exterior trash cans in no smoking areas. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 066	Residents who smoke were identified and re-educated on the smoking policy. Resident council was educated on the smoking policy. Staff were educated on the smoking policy. Audits will be completed on smoking compliance. Audits will be submitted and reviewed by QAPI.	
K 146 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1 1/2 hour after loss of the normal source 3-6. (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the alternate source of power (generator) in accordance with NFPA 99, Section 3.6.3.1.1. This deficient practice could affect 298 residents. Findings include: On facility tour on March 15, 2016 between the hours of 10:00 AM and 11:00 AM and on March 16, 2016 between the hours of 9:30 AM and 3:30	K 146	K146: Facility will update generator with automatic switch capability. All residents in the West building have the potential to be impacted. Maintenance staff were educated on automatic switch requirements for the generator. Initial generator inspection will be completed upon install and audited monthly with load transfer. Results will be submitted to the QAPI for review.	5/3/16

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

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K 146	Continued From page 5 PM, observation revealed that the emergency generator in the west building transfer switch does not automatically transfer to emergency power. During a directed test of the system it was observed that manual transfer was required to switch over to emergency power. This deficient practice was verified by the Director of Maintenance at the time of the inspection.	K 146		