

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

CC: Office of Ombudsman for Long-Term Care

Hally Kranz

Mary Absolon, Program Manager

Maria King, Assistant Program Manager

Licensing and Certification File

PRINTED: 01/13/2017 FORM APPROVED OMB NO. 0938-0391

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F 000	INITIAL COMMENT	-S	F 00	0		
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the form. Your electronic be used as verification	·				
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with				
		rvey was conducted and tion(s) were also completed at dard survey."				
	completed. The cor	complaint, H5183122 was nplaint was substantiated. ed at F353, F282, F312 and				
	completed. The cor	complaint, H5183121 was nplaint was substanitated. ed at F353, and F312.				
		complaint, H5183110 was nplaint was not substantiated.				
F 157 SS=D	completed. The cor 483.10(b)(11) NOT		F 15	7		5/3/16
	,	ediately inform the resident;				
ABORATOR\	Z DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

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

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.

Electronically Signed

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F 157	known, notify the ror an interested far accident involving injury and has the intervention; a sign physical, mental, of deterioration in he status in either life clinical complication is significantly (i.e., a existing form of the consequences, or treatment); or a deterioration in the status in either life clinical complication is significantly (i.e., a existing form of the consequences, or treatment); or a deterioration in the resident from the status in either life clinical complications and, if known, the or interested family change in room or specified in §483. resident rights under regulations as specified in §483. resident rights under the address and plegal representation. The facility must rethe address and plegal representation. This REQUIREMED by: Based on observative in the address and plegal representation in the status in either life clinical complete.	sident's physician; and if resident's legal representative mily member when there is an the resident which results in potential for requiring physician nificant change in the resident's or psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ons); a need to alter treatment a need to discontinue an eatment due to adverse to commence a new form of ecision to transfer or discharge the facility as specified in Ilso promptly notify the resident resident's legal representative y member when there is a roommate assignment as 15(e)(2); or a change in der Federal or State law or ecified in paragraph (b)(1) of ecord and periodically update hone number of the resident's re or interested family member. ENT is not met as evidenced ation, interview, and document ed to notify family of the essure ulcer on resident heels (R35). In addition, the facility medical doctor (MD) of the	F 15	Preparation, submission and implementation of thie plan of does not constitute an admiss agreement with the facts and set forth in the statement of de	ion of or conclusions	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMI	E SURVEY PLETED
		245183	B. WING		03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 157	7:05 a.m. until 9:55 observed: - 7:05 a.m. R35 wa on back with mouth was elevated 45 deplace via nasal can-8:51 a.m. nursing room and spoke wi R35 breakfast and cannula only in one get up today. This to NA-J did not ask R repositioning before tray. R35 remained at 7:05 a.m 9:08 a.m. register nebulizer machine nebulizer machine nebulization chamber RN-G completed the heel and left withous - 9:23 a.m. RN-G completed the other heel and repositioning R35. During interview on member (F)-A said she [R35] had gotte she knew everything sore on her bottom about blisters on her The facility provided F-A which indicated	continuously on 3/17/16, from a.m. and the following was sobserved sleeping lying flat open. The head of the bed grees. R35 had oxygen in nula. assistant (NA)-J entered the th R35. NA-J offered to get orange juice. R35's nasal onostril. R35 said "I hope I can hing behind my ear hurts." as about turning or eleaving room to get breakfast in same position as observed and applied mask with per attached to resident's face. The wound care to R35's left of the repositioning R35 off bottom. The ament of finish wound care on the ament of the last three weeks on so bad. "Three weeks ago g. They told me she had a bed." F-A said, "No one told me or heels." It was also aware of the her heels as the staff updated	F 15	and licensing violations stated her This plan of correction is prepared executed as a means to continuous improve the quality of care, to com all applicable state and federal regrequirements and constitutes the fallegation of compliance. F 157 R35 family has been notified 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 nee alter treatment significantly, or a d to transfer or discharge, will have and MD notification and is potential related to this alleged deficiency. Licensed staff have been reeducal regarding notification of changes. Don/designee will audit 2 residents unit per week to ensure that notific has occurred. Results of audit will be reviewed by	and/or usly with pulatory acilities d. R305 d to ecision family al at risk ted s per cation	

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F 157	stated, "They called spoke with me and ulcers." R305 was observed be very short of bre usage of accessory complete initial inte breath. R305 was swith oxygen on via nebulizer machines R305. R305 was seen by evening of 3/16/16, (antibiotic) 250 milliby mouth for seven read, "Start stat [im albuterol nebulizer mg twice a day for and as needed (PR that reduces inflam a.m. for four days. The Geriatric Servic Notes dated 3/16/1 and dressed cough antibiotic. Lungs wir and audible wheeze bronchitis, not activate the with antibiotics treatments. Review of the Marce.	3/24/16, at 9:05 a.m. F-A me the next day after you told me about all of her d on 3/16/16, at 10:57 a.m. to eath with audible wheezing and muscles. R305 was unable to rview due to shortness of sitting upright in a wheelchair nasal cannula. There was a sitting on the table next to the nurse practitioner on the and wrote orders for Keflex grams (mg) three times a day days for bronchitis. The order mediately, without delay]!" (neb-breathing treatment) 2.5 five days stat every two hours (N) and "Prednisone (steroid mation) 10 mg stat" then every ces of Minnesota Progress 6, indicated (R305) "alert, up bothering her, does want the diminished breath sounds es. Assessment was vely dying'." The plan was to so, prednisone, and nebulizer	F 1:	57			
		ord (MAR) did not indicate the sordered on 3/16/16.					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03	/21/2016	
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F 157	Prednisone 10 mg On 3/17/16, at 8:30 aide (TMA)-A aske Keflex three times been given and it is During interview or said, "The order waset up to start at no a.m." RN-G verified given on 3/16/16. During interview or practitioner (NP) safifteenth and was to dying so I ordered saw her on the sixt having difficulty breordered nebs, pred 'STAT does not me as soon as possible there was an issue in giving stat medicallity on 3/18/16, a list of medication emergencies. Cepton the list. During interview or said, STAT meant was an issue with swe start it in the event of the process. There we until the morning. It	stat was given at 6:06 p.m. a.m. the trained medication d RN-G about R305's order for a day. TMA-A said "None has not due until noon." a 3/17/16, at 2:12 p.m. RN-G as inputted incorrectly. It was none, so I corrected it to 9:00 d that Keflex had not been a 3/18/16, at 10:03 a.m. nurse aid, "I was called on the hold she looked like she was Morphine (a narcotic). When I neenth she was up in her chair neathing but not dying, so I denisone and an antibiotic. It means the early the antibiotic. Delays cations are not acceptable." a micell (Southwest automated sing system) Inventory faxed to at 10:23 a.m. was provided as a savailable in the facility for halexin (Keflex) 250 mg was a 3/18/16, at 10:55 a.m. RN-H as soon as possible. "There	F 15	7			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 225 SS=D	emergency kit. On 3/18/16, at 12:0 said STAT meant in get the medications staff to notify the migive a STAT medical Administering Medicates and timely may 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INITED The facility must not been found guilty or mistreating resident had a finding entered registry concerning of residents or misal and report any known court of law against indicate unfitness for the facility staff to or licensing authority. The facility must entitle involving mistreatm including injuries of misappropriation of immediately to the stoother officials in a staff to other officia	not sure if Keflex was in the 6 p.m. RN-E nurse manager ow. "Sometimes we cannot is from the pharmacy. I expect edical doctor if they cannot ation." cations Policy revised 2010, ions shall be administered in a nner, and as prescribed." (c)(2) - (4) PORT DIVIDUALS It employ individuals who have if abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a it an employee, which would or service as a nurse aide or ithe State nurse aide registry ties. Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law it procedures (including to the	F 19	57		5/3/16
	The facility must ha	ve evidence that all alleged				

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F 225	violations are thorous prevent further pote investigation is in potential to the administrator representative and with State law (includent, and if the appropriate correct. This REQUIREMED by: Based on observative, the facility finvestigate an incident intoxicated resident threatening others. Findings include: R104's Progress Nidentified, "Staff redunk and consum with Coke this ever around 5 pm. Hx [habuseResident wother people. Knife was immediately placed by the sident's speech leaning on the right but was able to proindicated R104's he physician were not "Received order to result in the sident's resident to proindicated R104's he physician were not "Received order to result in the sident to proindicated R104's he physician were not "Received order to result in the sident to proindicated R104's he physician were not "Received order to result in the sident to proindicated R104's he physician were not "Received order to result in the sident to res	ughly investigated, and must ential abuse while the rogress. vestigations must be reported or or his designated to other officials in accordance uding to the State survey and or within 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced tion, interview and document ailed to report and thoroughly lent involving 1 of 1 (R104) to documented to be with a knife. ote dated 3/8/16, at 5:49 p.m. ported resident appeared ed a bottle of Volka [sic] mixed hing. Incidence reported	F 22	F225 R104 Behavioral episode vereported and thoroughly investigated current resident have the potentiaffected by this alleged deficiency. Alleged violations are thoroughly investigated and measures put in prevent potential abuse during the investigation. Results of investigations are reported administrator or his designee State agency within 5 working daincident. Staff have been reeducated regareporting and investigating. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by the state of audit will be reviewed by the	tted. al to be // place to e orted to and the ys of the rding	

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F 225	min [minute] check (nursing assistant) found no liquorOh hour for the next 2 24 hours. Monitor for alcohol intoxicatinarcotics as neederesident about the Resident refused to re-approach and conterventions which checks hourly and room and room cheprohibited substant orders to hold narcand "Update MD Ploare plan did not id when R104's was atto do if R104 was for room or on him, if housume alcohol, ademonstrated while on how to handle a symptoms for R104 others were kept saconsumption. R104's care plan furthers were kept saconsumption.	/S [vital signs] and place on 15 for safety. Writer and NAR searched resident's room and to monitor VS q [every] 1 hours then check VS q shift x or s/sx [signs and symptoms] ons every shift and hold d. Education provided to consequences of drinking.	F 22	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		····	03/:	21/2016
	PROVIDER OR SUPPLIER			543	REET ADDRESS, CITY, STATE, ZIP CODE 80 BOONE AVENUE NORTH W HOPE, MN 55428		
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F 225	should do if sharp R104's possessior of other residents. R104's significant indicated R104 dia failure, cirrhosis, a impairment. On 3/18/16 at 10:2 the 3/8/16 Progres alcohol use and systated she was now would not be infor been drinking. RN-was identified as a immediate report y supervisor, assista and DON, and stathe resident. RN-K from 3/8/16 was a reported, a full inversident in the ADON had been DON further stated any time of R104 sand would have exhad happened. The incident report con 3/8/16, and no rep DON also verified objects was a "hab identified on R104"	e plan did not identify what staff objects were observed in n, or how to ensure the safety change MDS dated 2/1/16, gnoses included hepatic (liver) and severe cognitive 19 a.m. RN-K was asked about s Note regarding the resident's vinging of a knife, and RN-K to aware of the incident, and med every time R104 had anger to self or others, an would be made to the ant director of nursing (ADON), if would ensure the safety of stated that the progress note "unique situation" but if it was estigation should be completed. 15 a.m., the DON was asked a Note dated 3/8/16, regarding a sumption and knife. The DON recall the incident, but stated an on-call that evening. The dishe'd never been informed at a swinging a knife at other people are the people of the incident of ort was made to the SA. The that having knifes or sharp bit" of R104 that had been	F 2	225			

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F 225	requested to discus documentation from surveyor. The DOI inaccurate information because what RN-I The DON stated RI with a knife but charted what the AI was asked to come to R104's intoxicatia a different floor and assist with R104's to R104 was intoxicat witness R104 threa stated that was who on the way down to denied that, and stated that was who on the way down to denied that, and stated that was who on the way down to denied that, and stated they R104 when he was the box cutter to the ADON and LSW-B residents were presidented ever seeing stated she locked to ADON and LSW-B the hospital after cophysician. The DOI 3/8/16, at 17:49 p.m. "Hearsay" was chanot informed of the RN-H was re-educated and her expectation accurate informatic confirmed that had would have expected.	ker (LSW)-B and RN-H ss the Progress Note in 3/8/16, at 5:49 p.m. with the N stated RN-H had charted ition in R104's medical record H had been charted "hearsay." N-H never witnessed R104 inted what she had been told imber. RN-H then stated she'd DON had told her when she is to R104's floor to assist due on. RN-H had been working on it was asked to come and iransfer to the hospital as ed. RN-H stated she did not itten anyone with a knife and at she was told by the ADON in R104's floor. The ADON then inted she did not know where irmation." The ADON and obtained a box cutter from in his room and R104 handed in his room and R104 handed in without incident. The denied that any other staff or is ent at the time. LSW-B R104 threaten anyone and in the box cutter. RN-H, the stated R104 was not sent to intacting hospice and the N again stated the charting on in. by RN-H was not accurate. Inted and that was why she was incident. The DON stated ated about inaccurate charting in was staff was to chart in. The DON additionally this incident occurred she and the information to be ininistrator, law enforcement	F 2	225		

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F 225	a.m. and stated sh another floor and we come to R104's floothe emergency room RN-H stated on the ADON told her the into R104's progreshad made an inaccentry on 3/8/16, at ADON was now reconfirmed she wrowswinging at other putold her that informentry was made. Rethat she would have since her the ADOI been the one to report follow up. RN-HR104's unit, R104's they did not send FA interview with they did not send FA interview	-	F 2	25			

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F 225 F 226 SS=D	given direction from been a good idea for was written. When was not followed up provided further in administrator stated and erase what wa about making a conindicated that police R104 had a weapo and reports would happropriate agency. A facility policy titled Agencies and Othe 3/16 indicated: All si will be immediately Additionally, the podefinition of "verbal written or gestured disparaging and detheir families. 483.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negle	inistrator stated RN-H was a the ADON, and it would have or the ADON to review what asked why the progress note of and no information was the medical record, the did the facility "Can't go back is written" and was unsure rection. The administrator also is would have been called if in and was threatening people have been filed to the discovered incidents of abuse reported to the stated agency. It is a sany use of oral, language that willfully includes rogatory terms to residents or incidents of abuse reported to the stated agency. It is an any use of oral, language that willfully includes rogatory terms to residents or incidents of abuse reported to the stated agency. It is an any use of oral, language that willfully includes rogatory terms to residents or incidents of abuse of oral, and abuse of residents extended that the prohibit extended that abuse of residents	F 225		5/3/16	
	This REQUIREMEI by: Based on observareview, the facility f	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 t (R104) reported to be		F226 R104 Behavioral episode wa reported to the state agency and administrator.	S	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	threatening others reported to the admagency (SA). Findings include:	age 12 with a knife was immediately ninistrator and the State d Abuse Prevention Program,	F 2	26	Current residents have the potentia affected by this alleged deficiency. Allegations of mistreatment, negled abuse of residents and misappropr of resident supported to the administrator and Supports.	et, iation ediately	
	dated 3/16, and indright to be free from policy titled Reporti management- Revi report any suspected. The policy indicated "neglect" the failure services necessary Additionally, the podefinition of "verbal written or gestured disparaging and detheir families. A fact Abuse to State Age Entities/Individuals, suspected incidents reported to the SA.	icated, residents have the n abuse and neglect. A facility ng Abuse to Facility sed 9/12, directed staff to ed abuse to the administrator. It the following definition: to provide the goods and to avoid physical harm. Ilicy indicated under the abuse" as any use of oral, language that willfully includes rogatory terms to residents or ility policy titled Reporting			Staff have been reeducated regard implementation of the abuse and n policy and procedure. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by	eglect	
	identified, "Staff rep drunk and consume with Coke this ever around 5 pm. Hx [h abuseResident w other people. Knife was immediately pl Resident's speech leaning on the right but was able to pro indicated R104's ho physician were noti	ported resident appeared ed a bottle of Volka [sic] mixed ning. Incidence reported					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03	/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,,_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	remove any alcohol monitor residents' \ min [minute] check (nursing assistant) found no liquorOk hour for the next 2 24 hours. Monitor for alcohol intoxication narcotics as needed resident about the consident refused to re-approach and consuming alcohol, any behavious and to have a sident resident refused to re-approach and consuming alcohol, any behavious and to have a found	found and continue to /S [vital signs] and place on 15 for safety. Writer and NAR searched resident's room and a to monitor VS q [every] 1 hours then check VS q shift x or s/sx [signs and symptoms] ons every shift and hold d. Education provided to consequences of drinking. o cooperate at this time. Will	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03	/21/2016		
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CC 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 226	not identify R104's knives, what staff s observed in R104's he and others were possession of sharp R104's significant of indicated R104 diagfailure, cirrhosis, arimpairment. On 3/18/16, at 10:2 (RN)-K was asked Note in R104's med was not aware of the need to be informed been drinking. RN-I was a danger to se report would be may and DON and staff resident. RN-K states 3/8/16 referred to a reported a full investigation. The DON was asked dated 3/8/16, at 5:4 she did not recall the on-call that evening at any time of R104 people but would exhappened. The DON versharp blade end, he aware of R104 swir one was threatened not verify who the "unaware if any other was threatened not verify who in the	possession of sharp objects or hould do if these items are possession or how to ensure kept safe if R104 had o objects. hange MDS dated 2/1/16, gnoses included hepatic (liver)		26				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZII 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 226	incident of 3/8/16 a state agency (SA). having knifes or sha R104 and that was At 12:51 p.m. on 3/ licensed social worl requested to discus 3/8/16, at 5:49 p.m. The DON began to inaccurate informat for the Progress No The DON stated R1 with a knife but chaby another staff me charted what the AI was asked to come R104 was intoxicate on a different floor a assist with R104's t R104 was intoxicate witness R104 threa stated that was who on the way down to denied that, and star RN-H "got this infor LSW-B stated they R104 when he was the box cutter to the ADON and LSW-B residents were presidents were presidents were presidents were presidents after cophysician. The DON 3/8/16, at 17:49 p.m.	nt report completed for the nd no report was made to the The DON also stated that arp objects was a "habit" of identified on R104's care plan. 18/16, the DON, ADON, ker (LSW)-B and RN-H as the progress note written on	F 2	26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 226	RN-H was re-education accurate information confirmed that had would have expected reported to the admand the state agence. RN-H was interview a.m. and stated she another floor and word wome to R104's floot the emergency room RN-H stated on the ADON told her the into R104's progress had made an inaccuration 3/8/16, at SADON was now reponsification and the swinging at other potold her that informate entry was made. RI that she would have since her the ADON been the one to repont follow up. RN-H R104's unit, R104 with the control of the influence with the control of the influence and the influence and the influence and the control of the influence and the control of the influence and the influence and the control of the influence and the infl	incident. The DON stated ated about inaccurate charting in was staff was to chart in. The DON additionally this incident occurred she additionally the information to be ininistrator, law enforcement	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 226	charted in the prog told that evening. H inaccurately and th type of behavior fro stated he expected that was what occu informed. The adm given direction from been a good idea for was written. When was not followed up provided further in administrator stated and erase what wa about making a con indicated that police R104 had a weapo	administrator stated what was ress note was not what he was le stated the note was charted e nurse did not observe that m R104. The administrator staff to chart accurately and if rred that he should have been inistrator stated RN-H was a the ADON, and it would have or the ADON to review what asked why the progress note or and no information was the medical record, the did the facility "Can't go back is written" and was unsure rection. The administrator also be would have been called if an and was threatening people have been filed to the	F 22	26		
F 250 SS=D	Agencies and Othe 3/16 indicated: All swill be immediately Additionally, the podefinition of "verbal written or gestured disparaging and detheir families. 483.15(g)(1) PROVRELATED SOCIAL The facility must preservices to attain or	ovide medically-related social r maintain the highest I, mental, and psychosocial	F 25	50		5/3/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/2	21/2016	
	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 250	Continued From pa	age 18	F 250				
	by: Based on interview facility failed to ide appropriate interve utilization of interna of 1 resident (R104 related to alcohol i Findings include: R104's significant dated 2/1/16, indic hepatic (liver) failu severe cognitive in R104's Progress Nidentified, "Staff redrunk and consum with Coke this eve around 5 pm. Hx [I abuseResident wother people. Knife was immediately president's speech leaning on the righ but was able to proindicated R104's highly sician were not "Received order to remove any alcohomonitor residents' min [minute] check (nursing assistant) found no liquorO hour for the next 2	lote dated 3/8/16, at 5:49 p.m. ported resident appeared ed a bottle of Volka [sic] mixed ning. Incidence reported		F250 R104 is receiving medically social services including utilization internal and external resources as appropriate. Current resident with a history of E abuse have the potential to be affet this alleged deficiency. Residents ETOH use/abuse are receiving merelated social services including ut of internal and external resources appropriate. LSW s have been reeducated receptorision of medically related social services including utilization of internal external resources. Lead Social worker/designee will at to 2 residents per unit, per week. Results of audits will be reviewed to QAPI.	TOH cted by with dically dization as larding al rnal udit up		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	of alcohol intoxication narcotics as needed resident about the of Resident refused to re-approach and conterventions which checks hourly and froom and room cheprohibited substant orders to hold narcotand "Update MD Procare plan did not idwhen R104's was at to do if R104 was for room or on him, if home consume alcohol, and demonstrated while on how to handle as symptoms for R104 others were kept saconsuming alcohol. R104's care plan fupressure ulcers and R104 has a pressure wheelchair. R104 "gw/c [wheelchair] custom like scissors," R104 benefits," and R104's like scissors," R104's knives, what staff sobserved in R104's others what s	ons every shift and hold d. Education provided to consequences of drinking. It cooperate at this time. Will ontinue to monitor." ated 10/2/15, identified R104 ohol use, and provided included, "Frequent safety PRN [as needed] of resident tecks hourly and PRN for ees," "MD [medical doctor] of the medications for lethargy," RN for substance abuse." The entify interventions to assist ctively drinking alcohol, what bund to have alcohol in his to ewas assessed to be safe to any behaviors R104 econsuming alcohol, direction may potential withdrawal expensive the safe and the if R104 was found to be arther revealed R104 had didentified an intervention that are reducing cushion in his prefers to hoard objects under shion including sharp objects are shion including sharp objects or should do if these items are possession or how to ensure kept safe if R104 had	F 2	50		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245183	B. WING _		0;	03/21/2016	
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 250	R104's undated Ka under the "Safety" cushion for liquor band "frequent safet that R104 was "aw further identified "Medications for lett for substance abus received." Addition "monitor for use of registered] to report to have signs of im orders." The "Behaidentified R104 "waincreased anger, lathreatened by othe someone, possess could be used as wwere not document record. A vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) stated to a specific VA [vulnerability asser R104. On 3/21/16, nursing (DON) s	age 20 ardex Report directed staff section to "check under w/c bottles with every pad change" by checks hourly and PRN" and are of the risks." The Kardex and D orders to hold narcotic chargy and updated MD PRN be. Psych [psychiatrist] orders ally, the Kardex included at ETOH, NAR [nursing assistant at to nurse. Nurse if observed pairment to ETOH, call MD for avior" section of the Kardex as at risk for harming others: abile mood or agitation, feels are or thoughts of harming aion of weapons or objects that are apons." The hourly checks are anywhere in the medical assment was requested for at 10:32 a.m. the director of at 10:32 a.m. with nursing assment was requested for at 10:32 a.m. with a go" at 10:32 a.m. with nursing are admitted are are stated the "asterisks arability on the care plan." 7/16, at 7:45 a.m. with nursing avealed that "a while ago" R104 with drinking" and had arinking, he likes to swear. I are a while ago and the content of a week a work he had a power chair to a when he road. " At 11:25 a.m.		50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/;	21/2016
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	aware of R104's altime R104 had use weeks ago." R104 drunk." R104's phy order was obtained times and to monit about R104 leaving signs out up front at to do that and he gfacility." RN-I also shobility for transport and went to the bata.m. NA-F revealed he had been using "drank liquor last wis very aggressive NA-F was unable to R104's alcohol corlicensed practical round and the physical ast a pain reliever) been drinking. LPN seven months and LPN-B stated R104 her shift "for a couple using alcohol "rulph-B further revesurprised" if R104 over and sleeps or asked about the specific would be my TAF monitor for intoxical she was directed to using alcohol, LPN monitor-15 min chemonitor-15 min chemonitor-15 min chemonitors.	cohol use and stated the last and alcohol was "maybe two had "gone out and come back sician was updated and an it to hold medications at those or for intoxication. When asked the facility, RN-I stated "He at the desk sign out, he is able oes and sits out front of the stated R104 used Metro ortation, arranged his own rides ink and went shopping. At 9:34 d R104 refused help a lot when alcohol and noted R104 reek" and he "curses a lot and when he's been drinking." To provide a date and time to issumption. At 2:22 p.m. hurse (LPN)-B revealed R104 and "gets drunk." LPN-B cian ordered methadone (used cannot be given if R104 has I-B stated she had "been here this is an ongoing issue." If had been using alcohol on the months" and noted R104 to nultiple times per week." aled that she "wouldn't be was "drunk" and he "just leans in the armrest" of his w/c. When becific interventions for R104 and how/where to document ided "I don't know, I would hope at [treatment record] and to attoin." When asked what else to do when R104 has been a B replied "nothing, just eacks, he will usually pass out in the R104 has been and to say that if	F 2	250			

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		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,_,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	or swearing" she was upervisor. LPN-B call the hospital duasked where R104 stated "There's a lost store delivers close supervisor happen and confiscated it is seen a visitor outsi him leave the facili On 3/18/16, at 8:33 aware of R104's draince I have seen has done when R1 replied "usually" and pain medication or hospice was not room searches we don't know of a rood drinking, that's just NA-G revealed R1 time" and would codrunk." NA-G would would take R104 bashe has not witnes been a month now and then managen 8:54 a.m. NA-H revelops staff in the dinindrinking and smells last time that occur days ago." NA-H si R104 smelling of a him back to his roos sure where R104 gdrank it. NA-H states.	ent, pushing, slapping, yelling rould call the charge nurse or stated she had never had to e to R104's alcohol use. When obtained alcohol LPN-B ot of suspicions that one liquor by the front door and that one ed to be in the front area once pefore it was open. I've never de of facility and never seen	F 25	50		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZII 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X) (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 250	went when he was a.m. licensed social she "sometimes chestaff thinks he is intrandom checks if wonever found alcoholochecks are completed depends, nurses do "depends" on she sit depends on." LSV thought R104 left the Metro Mobility- not the Health Unit Coosigns out. He tells the long as he is signed asked if there was a resident could lead LSW-A responded that assessment, and the assessment or requested assessment or requested. SW-A stated she halcoholopolicy and honone." At 10:29 a when asked about the replied that it was a went on to say staff random room searches, social services" was the facility staff four facility in planters at R104's bottles. RN-to identify where or but he was "friends and the connected."	ge 23 Ind was unsure of where he off of the nursing unit. At 10:13 I worker (LSW)-A indicated ecks his room for alcohol if oxicated. We complete the suspect intoxication; I have I. "When asked how often the LSW stated it "just to it too" when asked what it tated she was "not sure what V-A went on to say she the building and "goes out with with any supervision, he tells ordinator [HUC] and he usually the HUC or charge nurse, as dout he can leave." When an assessment to determine if the the facility unsupervised, that it was based off a nursing that it was interviewed and R104's alcohol use, RN-K "typical thing" for R104. RN-K was directed to complete these for alcohol, hold narcotics ident if he appeared asked who was responsible for RN-K replied that "typically is responsible. RN-K indicated the vodka bottles outside of the not indicated these were K also stated staff was unable how R104 obtained alcohol with everyone" at the facility assisted living facility. When any interventions in place to	F 2	50			

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		245183	B. WING		ļ	03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD IE APPROPF	BE	(X5) COMPLETION DATE
F 250	was encouraged to on the unit and that had been discussed was aware R104 of possession and preas steak knives, that R104's possession office. RN-K stated R104's care plan ar multiple times abour risk for skin breakdhis wheelchair cush. On 3/18/16 at 11:50 was aware of R104 where R104 obtained his alcohounsupervised and a transportation. The the alcohol himself store that delivered stated R104 had be discontinue drinking however that was n record. The DON alsharp objects was a indicated on R104's asked about R104's at 5:49 p.m. and the recall the incident. Thursing (ADON) was DON was not inform swinging a knife at to be informed if that	phol use, RN-K stated R104 participate in more activities Alcoholics Anonymous (AA) but declined by R104. RN-K ten had knives in his sented two knives described at she had removed from that she kept locked up in her the knives were identified on and R104 had been talked to tit. In addition, R104 was at own because R104 punctured alion with the sharp objects. In a.m. the DON confirmed she is alcohol use. When asked alcohol, the DON indicated unaware of where R104 I and R104 left the building	F 2	50			

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		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		5430 BOC	DDRESS, CITY, STATE, ZIP CODE DNE AVENUE NORTH DPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	licensed social work requested to discus 3/8/16, at 5:49 p.m. The DON began to inaccurate informat for the Progress Not The DON stated RN with a knife but chaby another staff me charted what the AI was asked to come R104 was intoxicated on a different floor a assist with R104's t R104 was intoxicated witness R104 threa stated that was who on the way down to denied that, and sta RN-H "got this infor LSW-B stated they R104 when he was the box cutter to the ADON and LSW-B residents were presidented ever seeing stated she locked un ADON and LSW-B the hospital after cophysician. The DON 3/8/16, at 17:49 p.m. "Hearsay" was chain not informed of the RN-H was re-educated and her expectation accurate information.	18/16, the DON, ADON, ker (LSW)-B and RN-H is the progress note written on	F 2	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		54	FREET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	RN-H was interview a.m. and stated she another floor and w come to R104's floot the emergency room RN-H stated on the ADON told her the into R104's progres had made an inaccordart on 3/8/16, at SADON was now repronsimed she wroth swinging at other pertold her that informate entry was made. Rifthat she would have since her the ADON been the one to reprotofollow up. RN-H R104's unit, R104 with the removal of the possession. No new R104's care plan for R104 had a signific consumption, aggres intoxicated, and created when the safety to ensure the safety	ed the information to be inistrator, law enforcement	F 2	250			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03.	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 279 SS=E	to develop, review a comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, a needs that are idented assessment. The care plan must to be furnished to a highest practicable psychosocial well-by §483.25; and any serious be required under §483.10, including under §483.10, including under §483.10(b)(4) This REQUIREMED by: Based on observative platesidents (R511, Resmokers. Findings include: R511 was observed outside smoking a oxygen via nasal care	the results of the assessment and revise the resident's in of care. Evelop a comprehensive care ent that includes measurable stables to meet a resident's ind mental and psychosocial stified in the comprehensive it describe the services that are attain or maintain the resident's physical, mental, and seing as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.)	F 2	F279 R511 and R429 have comprehensive care plans to smoking. Current resident who smoke residing at the community hotential to be affected by the deficiency. Residents who comprehensive that include smoking. Licensed staff have been expressed to smoke the comprehensive control include smoking. Licensed staff have been expressed to smoking. Lead Social worker/designer	that include e while lave the his alleged choose to e care plans ducated are plans that	5/3/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING		·····	03/2	21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	told activity aide (A/and smoke." R511's significant c (MDS) dated 1/15/1 cognitively intact an all activities of daily 2/5/16, did not addr. During an interview administrator stated agreement on admithe facility is smoke outside to smoke indepuring an interview director of nursing (have a smoking asstated he had not b who smoked. She sign a smoking agreadmission. A Smoking assess 3/14/16, after the account of R511 sm. The assessment increminders not to sm however, smoking s R511's care plan. During an interview R511 stated he had prior to the previous did not know where	hange Minimum Data Set 6, indicated he was id required staff assistance for living. R511's care plan dated ess smoking. on 3/14/16, at 8:13 a.m., the dall residents sign an ission that they acknowledge free. He stated if residents go iey have been identified as bendently. on 3/14/16, at 8:26 p.m., the DON) stated R511 did not sessment completed. She een identified as a resident further stated, all residents ement as part of their ment was completed on diministrator and DON were oking with his oxygen in use. dicated R511 needed noke with his oxygen running, safety was not added to on 3/15/16, at 10:37 a.m., 1 not been outside to smoke is night. He further stated he he got the cigarette. R511 on admission if he wanted to	F 2	779	to 2 smoking residents per unit per for comprehensive smoking care p Results of audit will be reviewed by	lans.	

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COL 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	nursing assistant (NR511 smoked. She outside but did not he was smoking. During an interview licensed practical nasked about smokidid not smoke. She him smoke but statin the common area. During an interview AA-O stated R511 outside and smoke remember" if she h During a subseque p.m., the administratidentified smoking as subseque p.m., the administration of the subsequence of the subse	on 3/15/16, at 2:03 p.m., NA)-T stated she was unsure if stated she knew he went pay attention to whether or not on 3/15/16, at 2:06 p.m., urse (LPN)-C stated R511 was ng on admission and stated he estated she had never seen ed he does spend his time out a by the front door.	F 27	9		
	and determining whoutside to smoke. It to enjoy the weather the stated, "This is While R511 was obwith his oxygen rundesire to smoke, the reminders regarding there was no evide updated to include R429 was admitted diagnoses of repeatmismanagement, to seizures. R429 significant significant seizures.	nen residents are going He stated residents will outside er and then decide to smoke. a major concern for us." eserved smoking a cigarette ning, and had expressed a e facility assessed a need for g smoking with oxygen but nce R511's care plan was				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	visual deficit, dexte smoking, can the re and is any adaptive lacked any assess ashes, put out the othe resident was sa A community smok lacked any indication facility was unable rules description. On 3/14/16, a smol (after surveyor interesident chooses to smoking policy. The comply with no smowould be encourag Interventions were chooses and the sr R429 did not have smoking in the median at 9:59 on 3/15/16, lighter in jacket poon of evidence of burnaway. On 3/15/16, at 10:0 entrance, had more ground on 3/15/16, plastic liner covered large green bin of significant started smokers. They not ashtrays out. The face of the results	sment asked cognitive loss, rity problem, frequency of esident light their own cigarette equipment needed. The formment of the ability to handle cigarette, and did not state if afe to smoke or had limitations. In grules applied statement on of what that meant, the to provide community smoking care plan was initiated exention) and indicated exention) and indicated exention) and indicated exention) and indicated exention and indicated exercises smoking. It is a stated to decrease smoking. It is exercised to extend the exercise smoking assessments quarterly an identified care plan for dical record. Stated she had cigarettes and exet (jacket draped over w/c, exercise), smokes down the road exet (jacket draped over w/c, exercised exercised exercises and exet (jacket draped over w/c, exercised exercises exercises and exet (jacket draped over w/c, exercised exercises exe		79		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 280 SS=D	and then go out to a assessments were themselves as smo assessment, nurses smoking. A new tas developed. We are and care planning." smoking at the main entrance, but lacked receptacles to put to butts safely into. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannic changes in care and A comprehensive as interdisciplinary teal physician, a registe for the resident, and disciplines as deter and, to the extent put the resident, the resident and revised by a teal each assessment.	ntract agreeing not to smoke smoke anyway. The done on people who identify kers on admission is do assessment on safe k force on smoking was still in the process of planning. The facility had residents in entrance and at the TCU down any safe smoking but cigarettes and put cigarette. O(k)(2) RIGHT TO NNING CARE-REVISE CP in the laws of the State, to ing care and treatment or down treatment. Are plan must be developed the completion of the essment; prepared by an interest must be developed the treatment or down the includes the attending interest must be developed to the resident's needs, racticable, the participation of sident's family or the resident's resident's family or the residen	F 2			5/3/16
	This REQUIREMEN	NT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/21/20	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	, 55/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	review, facility faile of 2 residents (R35 care required with ulcers and decline facility failed to rev of 5 residents (R10 currently using alcothe wheelchair (w/c Findings include: R35 was observed 7:05 a.m. until 9:55 observed: - 7:05 a.m. R35 was on back with mouth was elevated 45 deplace via nasal cares:51 a.m. nursing room and spoke w R35 breakfast and cannula only in one get up today. This NA-J did not ask Frepositioning befor tray. R35 remained at 7:05 a.m 9:08 a.m. registernebulizer machine nebulization chaml RN-G completed the land left withors 19:23 a.m. RN-G of the other heel and repositioning R35. mattress after the	ation, interview and document d to revise the care plans for 2 5, R62) to reflect changes in development of pressure in condition. In addition, the ise the plan of care (POC) for 1 04) who were identified to be chol and carried a knife under c) cushion. continuously on 3/17/16, from 5 a.m. and the following was as observed sleeping lying flat in open. The head of the bed egrees. R35 had oxygen in	F 28	F280 R35 is discharged. R62 are have had their care plans revised reflect current status. Current resident with skin breakd who have a history of etoh abuse potential to be affected by this all deficiency. Residents who have ulcerations or consume alcohol hereviewed and care plans revised appropriate. Licensed staff have been educate regarding care plan revisions for with skin alterations and resident consume alcohol. DON/designee will audit up to 2 reper unit per week to ensure appropriate appropriate in the provisions of care plan. Results of audit will be reviewed in the provisions of care plan.	own or have the eged skin ave been as ed residents s who esidents opriate	

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	PROVIDER OR SUPPLIER			54	TREET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	not one offered to The annual Minima 2/5/16, indicated F Independence with required occasions maneuvering in be bed to chair or wal assistance with dre R35 was incontine had a history of fal identified as at risk pressure ulcers. R diagnosis of heart vascular disease, dysphagia (difficult R35's Pressure UI (CAA) dated 2/12/ pressure ulcers re bladder, below nor with bed mobility. O intact and free of b had a ROHO cush pressure on bottor would care plan in factors for skin bre R35's Urinary CAA was frequently increasist with toileting and incontinent pa would care plan in incontinence wher for complications re	s being fed breakfast and still reposition her. um Data Set (MDS) dated as was modified decision making. R35 al assistance of one person in a dand while transferring from king with walker. R35 required essing, toileting and hygiene. In of bowel and bladder. R35 als in the last 90 days and was a for the development of 35's MDS indicated R35 had failure, anemia, peripheral arthritis, dementia, and arthritis, dementia, and arthritis, dementia, and arthritis, and reak as seen and reduced to being incontinent of a mal weight, and needing assist CAA also indicated skin was breakdown. CAA indicated R35 ion (air filled cushion to reduce me while sitting) in chair and terventions to minimize risk	F 2	280			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		, - 1, - 0 1 0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 280	incontinence, Preduse- has chronic smuscle wasting. Tidiagnosis of periphright great toe beinedema, and historyskin breakdown or reposition, end of I staff: "Creams/oint ordered, encouragresident reluctant with legs elevated ROHO cushion in mattress on bed. C [every] shift, obserconcerns to licensweekly on bath dayper MD/NP orders R35 as having skirdid not address he The care plandid stages of ulcers. Tinclude intervention on heels. On 2/29/16, the treheels dry and offlointact. The care plandid intact.	_	F 28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIF 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		, = 1, = 0	
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F 280	of resident refuse to and benefits was pure In addition, staff we every two hours and and off load pressure. However the sheet on how to relieve pure bed. A Progress Note day please don't move legs are hurting back. The note indicated encourage turning/ as resident allowed buttocks. The medi information of relieve During interview on RN-E and RN-J, RN Monday and today [R35] had three precoccyx and two on [R35] had a new staposterior upper thing new wound is found use risk assessment RN-E verified the chad current pressure the care plan until a stated R35's significant to a significant to the control of the contro	turn and reposition. The risks rovided to resident and family." re to check and change R35 d as needed, Keep heels dry re while blisters are intact. lacked direction for the staff ressure on the heels while in the distance of the heels of the heels. The heels of the heels	F 2	280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

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245183 B. WING 03	3/21/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
expect to a nurse to document finding a new wound and allert 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 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,	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	necrosis, or dama supporting structu Undermining and associated with St During an observa R62 was lying in betelevision. During 7:22 a.m., 7:50 an in his room lying in During an interview nursing assistant (of R62's skin condis an open area or stated, R62 had not he needed anythin During an interview licensed practical a couple of open adaily dressing changes grab bar, she furth go in and offer rep However, there was interventions directly stated RN-M was During an interview registered nurse (IV pressure ulcer stated the wound opened up again of During an interview director of nursing an interview director of nursing	nsive destruction, tissue ge to muscle, bone, or res (e.g., tendon, joint capsule). Sinus tracts also may be age 4 pressure ulcers). Ition on 3/16/16, at 3:06 p.m., ed on his back watching observations on 3/17/16, at n, and 8:44 a.m., R62 remained n bed. If you on 3/17/16, at 11:08 a.m., (NA)-K stated she was unaware lition. She stated, "I think there in his bottom." She further oscheduled cares and stated if ing he would put his light on. If you on 3/17/16, at 11:11 a.m., nurse (LPN)-C stated, R62 has areas to his bottom and has inges. She stated during his he is able to hold on to the iter stated staff are supposed to ite is a stated staff are supposed to ite is a stated of the care plan. If you on 3/17/16, at 11:17 a.m., and staff to do that. LPN-C responsible for the care plan. If you on 3/17/16, at 11:17 a.m., RN)-M stated, R62 had a stage when he moved to the unit. She had healed on 12/31/16, and	F 2	280			

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F 280	was able to offload. risk for pressure ulcassistance for repoimplement intervent pressure from R62' previous pressure tre-opened, the care new interventions to pressure ulcers or pulcers. R104's significant of dated 2/1/16, indicatincluded hepatic fair also revealed R104 impaired. R104's progress not identified, "Staff report of the properties of the	bed but was not sure if he While R62 was at increased bers and required staff sitioning, the facility did not tions to ensure offloading of s bottom. Further, while alcers had healed and be plan was not revised with corevent worsening of existing brevention of new pressure thange MDS assessment atted R104 had diagnoses that alure and cirrhosis. The MDS 's cognition was severely the dated 3/8/16, at 5:49 p.m. borted resident appeared and a bottle of Volka [sic] mixed and cirrhosis. The MDS orted resident appeared and a bottle of Volka [sic] mixed and story] of alcohol abuse swinging a knife at other aken away and resident was on 1:1 [one to one] for safety. Is non-coherent. Resident was side of his W/C [wheelchair] bel himself." The note arch R104's room for liquor, It, and staff identified they s/sx [signs and symptoms] of every shift and hold narcotics arch note identified, did to resident about the rinking. Resident refused to one. Will re-approach and	F 2	280			

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	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428	1 00/1	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 280	liver disease, hx [h cognitive impairme hx of ETOH. Often of the risks and be abnormal labs." In safety checks hour resident and room prohibited substancisks. MD [medical medications for let substance abuse. and remind of activisits and chaplain The care plan faile alcohol use, what i attempt if R104 waroom or on him, if consume alcohol, ademonstrated while on how to handle a symptoms for R10 others were kept sconsuming alcohol R104's care plan fupressure ulcers an R104 has a pressumheelchair. R104 w/c cushion includi R104 "is aware of R104 was "offered and declined." The care plan did rof knives, what sta observed in R104's he and others were possession of share and statement of share and statement of share plan did rof share served in R104's he and others were possession of share and statement of share and statement of share possession of share and statement of share possession of share and others were possession of share and statement of the statement of share and others were possession of share and statement of the stateme	dentified R104 had "end stage istory] of ETOH [alcohol], r/t ent, hx of coffee ground emesis, refuses lactulose and is aware nefits. R104 "has a history of nterventions include " frequent rly and PRN [as needed] of checks hourly and PRN for ces. Resident is aware of the doctor] orders to hold narcotic hargy. Update MD PRN for Psych orders received. Revisit vities that may interest, 1:1 support PRN. " d to identify R104's current nterventions staff should as found to have alcohol in his he was assessed to be safe to any behaviors R104 e consuming alcohol, direction any potential withdrawal 4, or how to ensure he and afe if R104 was found to be 1. Lurther revealed R104 had didentified an intervention that are reducing cushion in his "prefers to hoard objects undering sharp objects like scissors" the risks and benefits" and alternative storage of items are as possession or how to ensure the kept safe if R104 had	F 280			

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY PROVIDER'S PLAN OF CORRECT OF CORR		HOULD BE	(X5) COMPLETION DATE		
F 280	"Safety" section to liquor bottles with a "frequent safety chincluded "frequent for prohibited subs "aware of the risks" MD orders to hold lethargy and updat abuse. Psych orde Kardex included "nto report to nurse. signs of impairmer" The "Behavior" sthat R104 "was at increased anger, lathreatened by othe someone, possess could be used as a Information identifithe "Safety" section care plan. A vulnerability asses R104. On 03/21/20 stated that "Our specific VA assess when they are admand stated that "as vulnerability on the An interview with Frevealed that RN-h progress note in R that she was not as she did not need to R104 had been drithat R104 often had then presented to it described as steak from R104's posses	"check under w/c cushion for every pad change" and ecks hourly and PRN" also room checks hourly and PRN tances" and that R104 was ". The Kardex further identified d narcotic medications for ed MD PRN for substance rs received. " Additionally, the nonitor for use of ETOH, NAR Nurse if observed to have not to ETOH, call MD for orders. ection of the Kardex identified risk for harming others: abile mood or agitation, feels ars or thoughts of harming sion of weapons or objects that weapons". ed on the Kardex Report under n was not identified on R104's essment was requested for 16 at 10:32 a.m. the DON ocial workers don't do a ment because all residents nitted are vulnerable adults" terisks denote some	F 28	30			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03	03/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	knives) and R104 htimes about it and ibecause R104 purwith the sharp edge. The DON confirme R104's alcohol use obtains alcohol, the staff is unaware of alcohol and that R1 unsupervised and a transportation. The purchases alcohol of a liquor store tha stated that having he "habit" of R104 and R104's care plan. An interview with thon 3/18/16 at 11:30 no assessment corwas able to leave the however indicated if facility (on the secon able to leave the facility (on the secon able to leave the facility (on the secon able to leave the facility was on R104's the care plan and pstage liver disease, impairment, hx of cetto and benefit abnormal labs". Into safety checks hour room checks hourly substances. Reside orders to hold narce	n (regarding R104 having has been talked to multiple is at risk for skin breakdown ctures his wheelchair cushion es. If that she was aware of the was aware of DON indicated that the facility where R104 obtains his 04 leaves the building	F 2	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03	03/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	that may interest, 1 PRN". The DON in listed as intervention prudent nurse" wou using alcohol and v intoxicated at the fat that R104 has been discontinue drinking however this was n record. The DON fu checks should be co on R104's care plan (NA's) but that nurs well. The DON com be aware and follow confirmed that the fat policy. POLICY A policy entitled Ca dated November 20 comprehensive car assessment that in the MDS and physi residents are ongoi as information abou condition change." that "each resident's co designed to: a. Incorporate ident b. Incorporate risk fi identified problems c. Build on the resid regarding care and e. Reflect treatmen objectives in measu	evisit and remind of activities :1 visits and chaplain support andicated that with what was ans that "any reasonable and ald know that he is currently what to do if R104 was acility. The DON further stated a offered support to g such as AA meetings, ot identified in R104's medical urther indicated that room completed hourly (as identified an) by the nursing assistants sees could complete this as firmed that she expects staff to by R104's care plan. The DON facility did not have an alcohol are Plans-Comprehensive on a thorough cludes, but is not limited to, cians orders. Assessments of any and care plans are revised at the resident and resident's The policy further indicates mprehensive care plan is tified problem areas; factors associated with the streatment goals if applicable; togoals, timetables and	F 28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/:	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282 SS=D	levels; g. Enhance the optiresident". A facility policy labe Comprehensive, da The Care Panning/responsible for the care plnas: when the change in the resid desired outcome is 483.20(k)(3)(ii) SEPPERSONS/PER CATThe services provided by the control of the contr	I status and/or functional mal functioning of the led Care Plans- ted November 2012, indicated nterdisciplinary team is priodic review and updating of ere has bee a significant ents condition, and when the not met. RVICES BY QUALIFIED	F 28			5/3/16	
	by: Based on observat review, the facility fa (R439) was repositi plan; the facility fails care for 1 of 1 resid was dependent upo according to the pla failed to provide am improve or maintain 1 resident (R179) a Findings include: Repositioning:	ion, interview and document ailed to ensure 1 of 3 residents oned as directed by the care ed to provide personal hygiene ent in the sample (R35) who in staff for personal cares in of care; and the facility ibulation assistance to a each resident's ability for 1 of eccording to the plan of care.		F282 R439 and R179 are receiving services by qualified persons per caplan. R35 has been discharged. Current resident have the potential affected by this alleged deficiency. Residents are receiving services by qualified persons per care plan incompersonal hygiene, turning and repositioning and ambulation assist 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	to be y lluding tance.		

NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB (24) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 paraplegial flunctional), 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 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 will show signs of healing and remain free from	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			245183	B. WING	B. WING		03/21/2016	
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 will show signs of healing and remain free from			REHAB		5430 BOONE AVENUE NORTH	•		
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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE IATION) TAG CROSS-REFERENCED TO THE APPROPRIATE				
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	F 282	extensive hospitalizand long term acuta and long term acuta admission diagnos included paraplegis sacral region Stage extensive destructive to muscle, bone, or tendon, joint capsus tracts also may be pressure ulcers), ty obesity, and major. The initial care planed and pressure ulcers desprocess, prolonged discussion on the culcers were or any dated 9/28/15, indicting will show signs of hinfection. The initial indicated, "Assess healing. Measure lepossible. Assess a perimeter, wound be Report improvement and pressure comfort. Edas to causes of skintransfer/positioning taking care during anutrition and frequence.	exations in acute care hospitals are care hospitals. 439's is from the Face Sheet a [functional], pressure ulcer of a 4 (full thickness skin loss with on, tissue necrosis, or damage r supporting structures (e.g., le). Undermining and sinus associated with Stage 4 rpe II diabetes and morbid depression. In dated 9/28/15, indicated a ulcers and potential for velopment related to disease I immobility. There was no eare plan of where the pressure stages listed. The initial goal cated R439's pressure ulcer realing and remain free from I interventions dated 9/28/15, sorecord/monitor wound be and healing progress. Into and family/caregivers of any reakdown. Pressure device in bed/chair. Treat pain to treatments/turning etc. to lucate R439/family/caregivers in breakdown; including: a requirements; importance of ambulating/mobility, good ent repositioning. "	F 2	appropriate provision of care persons.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03	03/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	and entered room a.m. RN-B entered called R439 by nan seconds of entering treatment cart garb stated she had entered get his blood sugar insulin. At 8:03 a.m. interviewed and state the night shift. At 8 that the resident had time of continuous resident had stated night. RN-N stated two hours. " On 3/18/16, at 9:08 and stated he had from North Memori had been assessed department. When turned, R439 responses a.m. notified Furned since 830 p. nurse had shown hoursing assistant creating and stated the resident should benefits of refusal of the resident should benefits of refusal of and benefits and refusal cand be accompany to the resident should be accompany t	age 45 ered nurse (RN)-P, knocked for blood glucose test. At 7:08 room without knocking, then he, she left the room within 15 g and placed something in the bage. At 11:16 a.m. RN-B ered his room the first time to rand the second time to give at resident R439 was ated he had not been turned on to 5 a.m. RN-N was notified ad not been turned during the observation, and that the land he had not been turned all "He should be turned every B a.m. R439 was interviewed returned to facility last night al Medical Center where he do in the emergency asked when he had last onded last night at 8:30 p.m. At RN-N, that resident stated not a.m. RN-N stated the charge him in point of care (POC desident), that rn. RN-N opened the POC last turned at 11:09 p.m. at the should inform the nurse do (because aides cannot an yes or no). RN-N did verify labe given the risks and of repositioning and the risks after a should be documented and the risks and of repositioning and the risks after a should be documented and the risks and of repositioning and the risks and of repositioning and the risks after a should be documented and the risks and of repositioning and the risks are all repositioning and the risks and re	F 28	2			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183 B.			03	03/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 282	the orders for NA to care plan, I told nur " At 11:04 a.m. RN R439 who told him him at night." The facility was abl of NA charting for brepositioning which opportunities per shat total of 360 opportunities per	continue repositioning on the ses to document if he refused. I-N, stated he had interviewed "They [staff] do not reposition to to print out the last 30 days ed mobility, turning and revealed that out of four nift (12 opportunities per day), tunities there were 84 actual ollows: 6, 3/5/16, 3/8/16, 3/11/16, and hift NA did not document or turning and repositioning. 16, 3/4/16, 3/9/16, 3/10/16, A documented "NO" once, ositioning. 16, 3/9/16, 3/14/16, and arting indicated the resident eper shift, however there was enal benefits of refusal to turn ress Notes. 4 p.m. the director of nursing poke to the evening of frequently refused to be	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 282	place via nasal can - 8:51 a.m. nursing room and spoke wing R35 breakfast and cannula only in one get up today. This is NA-J did not ask R remained in same a.m 9:08 a.m. register nebulizer machine nebulization chamber RN-G completed the not offer to check a - 9:23 a.m. RN-G of the other heel and repositioning R359:32 a.m. R35 was not one offered to reheck and change. The annual Minimus 2/5/16, indicated R independence with required occasional maneuvering in bed bed to chair or wall assistance with dre R35 was incontined had a history of fall identified as at risk pressure ulcers. R3 diagnosis of heart if vascular disease, a dysphagia (difficulty R35's Urinary CAA	egrees. R35 had oxygen in anula. assistant (NA)-J entered the of the R35. NA-J offered to get orange juice. R35's nasal enostril. R35 said "I hope I can thing behind my ear hurts." 35 about toileting needs. R35 position as observed at 7:05 red nurse (RN)-G started and applied mask with per attached to resident's face. The wound care to R35's and did and change R35. The ame to finish wound care on left the room without the serious proposition her nor did the staff her. Im Data Set (MDS) dated 35 was modified decision making. R35 all assistance of one person in d and while transferring from king with walker. R35 required the sing, toileting and hygiene. The sing with walker of bowel and bladder. R35 in the last 90 days and was for the development of 85's MDS indicated R35 had failure, anemia, peripheral arthritis, dementia, and	F 2	282			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER			543	EET ADDRESS, CITY, STATE, ZIP CODE O BOONE AVENUE NORTH W HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	and incontinent pay would care plan in incontinence where for complications or Care plan revised Self Care Perform weakness/anemia chronic obstructive was revised on 3/1 to include "residen Memorial Hospice plan interventions R35 is checked are hours and PRN. Care sheet dated and check and change needed, Keep hee while blisters are in During interview of stated, "I am to turn check her for incontinence care During interview of stated "She is suphours. I think that if for incontinence expended in the went in and the went in and the stated in the stated incontinence expended in the stated in th	g, managing clothing, peri care d. R35's CAA indicated facility terventions to manage it occurs and reduce potential elated to incontinence. 2/15/16, indicated R35 had a ance Deficit related to pain, congestive heart failure, pulmonary disease. Care plan 5/16, after the survey started tis currently enrolled on North. Decline expected." The care written 3/15/16, instructed staff: d changed by staff every two 3/17/16, instructed staff to R35 every two hours and as ls dry and off load pressure intact. 1. 3/17/16, at 9:50 a.m. NA-J in [R35] after every two hours. Intinence in the morning at the infit and then at the end of the around 6:00 a.m. when I got had not offer to reposition or do R35 since 6:00 a.m. 1. 3/17/16, at 9:52 a.m. RN-G posed to be turned every two tis the same for checking her	F 2	282			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		245183	B. WING _		03	3/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	dressing change. I hours since he last During interview or said, "I expect them a resident in accordexpect them to do in accordance to the During interview or assistant director of expect them to follow to detect them to follow the detect them to follow to detect them to follow the detect them to follow them to detect them to follow them to detect them to follow them	verified it had been over three changed her." 1 3/18/16, at 1:29 p.m. RN-E in to at least offer to reposition dance to her care plan. I check and change or toilet and he care plan." 1 3/18/16, at 2:10 p.m. the if nursing (ADON) said "I would ow the check change or in the c	F 28	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _	· · · · · · · · · · · · · · · · · · ·	03	/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	walker to transfer s shower chair. At 9: the dining room for offers by staff to ar room. When interviewed verified R179 was further stated it had R179 had walked t On 3/17/16, at 11:3 (RN)-A stated she a walking program Kardex. After chec verified R179 was stated she had wor and had never see further stated that I responsible for am During interview or nurse manager RN R179 was respons RN-E further stated to follow resident's refusals and report During interview or facility's director of expected staff to for resident refuses can urse and nurse to medical record. The facility's Rehal revised 4/2007, income	self from the bed and onto a 00 a.m. R179 wheeled self to breakfast. There were no abulate R179 to the dining on 3/17/16, at 11:21 a.m. NA-A not walked to meals. NA-A deen several weeks since the dining room. So a.m. registered nurse was not aware if R179 was on and needed to check the king R179's Kardex, RN-A to be walked to meals. RN-A ked on the unit for six months in R179 walked to meals. RN-A NA assigned to R179 was bulating R179. In 3/18/16, at 11:13 a.m. unit I-E stated NA assigned to ible for ambulating R179. If the expectation was for staff care plan, document any to the nurse. In 3/18/16, at 11:30 a.m. the nursing (DON) stated she ollow resident's care plan, if the sylvant in the resident's care policy licated that the facility's	F 28				
		ng care program is designed to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE : COMPI	
		245183	B. WING		03/2	1/2016
	PROVIDER OR SUPPLIER	REHAB	5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	optimal level of self	ge 51 -care and independence. The bilitative nursing care to be	F 282			
F 311 SS=D	performed daily for services.	residents who require such IMENT/SERVICES TO	F 311		5	5/3/16
22=0	A resident is given t services to maintain	the appropriate treatment and or improve his or her abilities uph (a)(1) of this section.				
	by: Based on observate review, the facility for assistance to improper ability for 1 of 1 resignation with act of the findings include: R179's physical the note dated 7/31/15, therapy goals and five with instructions for unit to ambulate R1 R179's care plan, la R179 was to ambul wheeled walker and R179's current Mini 1/29/16, indicated Fidementia, had mild required one staff at transfers, dressing,	ast revised on 8/8/15, indicated ate to all meals with a front		F311 R179 is has been reevaluate physical therapy and is receiving ambulation services per recommen Current resident receiving restorative ambulation programs have the potence of the affected by this alleged deficient. Appropriate residents are ambulated Nursing staff have been educated regarding ambulating residents. DON/designee will audit 2 residents unit per week to ensure appropriate residents ambulate. Results of audit will be reviewed by	dation. ve ential to cy. ed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 311	one staff with ambu- R179's Kardex (nur- sheet) dated 3/10/1 to meals with a fror walking device) and During observations R179 was observed At 11:07 a.m. staff into the dining room to ambulate R179 t On 3/17/16, at 7:53 was observed to as NA-A applied a tran- and assisted R179 walker to transfer s shower chair. At 9:0 the dining room for offers by staff to an room. When interviewed overified R179 was r further stated it had R179 had walked to On 3/17/16, at 11:3 (RN)-A stated she wa a walking program Kardex. After check verified R179 was t stated she had wor and had never seen	R179 required assistance of ulation. rsing assistant assignment 6, indicated R179 was to walk at wheeled walker (an assistive d wheelchair to follow. s on 3/16/16, at 11:04 a.m. d to wheel self in the hallway. were observed to wheel R179 a. There were no offers by staff to the dining room. a.m. nursing assistant (NA)-A sist R179 with morning cares. asfer belt around R179's waist as he utilized a front wheeled elf from the bed and onto a 00 a.m. R179 wheeled self to breakfast. There were no abulate R179 to the dining and 3/17/16, at 11:21 a.m. NA-A been several weeks since of the dining room. 5 a.m. registered nurse was not aware if R179 was on and needed to check the king R179's Kardex, RN-A o be walked to meals. RN-A ked on the unit for six months an R179 walked to meals. RN-A A assigned to R179 was	F 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 311 F 312 SS=D	nurse manager RN R179 was responsi RN-E further stated to follow resident's refusals and report During interview on facility's director of expected staff to for resident refuses canurse and nurse to medical record. The facility's Rehabilitative nursing assist each resident optimal level of self policy directed rehaperformed daily for services. 483.25(a)(3) ADL CDEPENDENT RESIDEPENDENT RES	3/18/16, at 11:13 a.m. the unit -E stated the NA assigned to ble for ambulating R179. If the expectation was for staff care plan, document any to the nurse. 3/18/16, at 11:30 a.m. the nursing (DON) stated she llow resident's care plan, if res NA are to report to the document in the resident's care plan, if you can be a signed to at to achieve and maintain an are and independence. The abilitative nursing care to be residents who require such	F 31:		al to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	cares. Findings include: R35 was observed 7:05 a.m. until 9:55 observed: - 7:05 a.m. R35 wa on back with mouth was elevated 45 de place via nasal can - 8:51 a.m. nursing room and spoke wi R35 breakfast and cannula only in one get up today. This t NA-J did not ask R3 remained in same pa.m 9:08 a.m. register nebulizer machine in nebulization chamb RN-G completed th not offer to check a - 9:23 a.m. RN-G c the other heel and I repositioning R359:32 a.m. R35 was not one offered to r check and change The annual Minimu 2/5/16, indicated R3 independence with required occasiona maneuvering in bed bed to chair or walk assistance with dre	continuously on 3/17/16, from a.m. and the following was sobserved sleeping lying flat open. The head of the bed grees. R35 had oxygen in nula. assistant (NA)-J entered the th R35. NA-J offered to get orange juice. R35's nasal nostril. R35 said "I hope I can hing behind my ear hurts." 35 about toileting needs. R35 position as observed at 7:05 and applied mask with er attached to resident's face. e wound care to R35's and did nd change R35. The ame to finish wound care on eft the room without the being fed breakfast and still eposition her nor did the staff her. In Data Set (MDS) dated	F3	12	Dependent residents who are incorare receiving care. Nursing staff have been educated regarding the provision of incontine for dependent residents. DON or designee will audit 2 deper residents per unit per week for the provision of incontinent care. Results of audit will be reviewed by	ent care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		. 0	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STAT 5430 BOONE AVENUE NOR' NEW HOPE, MN 55428	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 312	had a history of falls identified as at risk pressure ulcers. R3 diagnosis of heart for vascular disease, and dysphagia (difficulty) R35's Urinary CAA was frequently incompassist with toileting, and incontinent pactors would care plan into incontinence when for complications recomplications recomplica	s in the last 90 days and was for the development of 5's MDS indicated R35 had ailure, anemia, peripheral rthritis, dementia, and a swallowing). dated 2/12/16, indicated R35 intinent of bladder and needed managing clothing, peri care l. R35's CAA indicated facility erventions to manage it occurs and reduce potential elated to incontinence. 1/15/16, indicated R35 had a nice Deficit related to pain, congestive heart failure, pulmonary disease. Care plan 5/16, after the survey started is currently enrolled on North Decline expected." The care written 3/15/16, instructed staff: If changed by staff every two 1/17/16, instructed staff to R35 every two hours and as a dry and off load pressure fact. 3/17/16, at 9:50 a.m. NA-J [R35] after every two hours. I tinence in the morning at the fit and then at the end of the round 6:00 a.m. when I got ad not offer to reposition or do	F3	12		

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING	·····	03	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	During interview on stated "She is supphours. I think that it for incontinence even buring interview on said, "After you left and he went in and but did not have an dressing change. I hours since he last buring interview on said, "I expect them a resident in accordance to the buring interview on assistant director of expect them to do a cin accordance to the buring care plan." Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores.	3/17/16, at 9:52 a.m. RN-G osed to be turned every two is the same for checking her ery two hours." 3/17/16, at 11:55 a.m. RN-G the floor [NA-J] and I spoke changed her. She was wet y stool until we did the verified it had been over three changed her." 3/18/16, at 1:29 p.m. RN-E to to at least offer to reposition dance to her care plan. I check and change or toilet and e care plan." 3/18/16, at 2:10 p.m. the foursing (ADON) said "I would low the check change or toilet and low the check change or to	F 3			5/3/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Based on observareview, the facility monitoring and assideterioration of presidents (R439) reulcers. The failure resulted in actual hulcers deteriorated prevent developmer residents (R62). Findings include: R439 was interviewand stated "The nig R439 stated he hanurse, and several to care for him. R439 was admitted extensive hospitaliand long term acut admission diagnos included paraplegis sacral region, Stagwith extensive des damage to muscle (e.g., tendon, joint sinus tracts also more pressure ulcers), to obesity, and major. The admission Cadated 9/27/15, indistage IV pressure with exposed bone eschar may be preundermining and to	ation, interview and document failed to provide care including sessment, to prevent essure ulcers for 1 of 4 eviewed who had presssure to provide adequate care for R439 whose pressure. In addition the facility failed to ent of pressure ulcers for 1 of 4 eviewed on 3/16/16, at 8:35 a.m. of the shift does not turn me." It is dreported that to the head aides were no longer allowed at the facility on 9/15/15, after exactions in acute care hospitals are care hospitals. R439's is from the Face Sheet are [functional], pressure ulcer of the IV (full thickness skin loss truction, tissue necrosis, or bone, or supporting structures capsule). Undermining and any be associated with Stage IV ype II diabetes and morbid	F3	314	F314 R35 has been discharged. R and R439 are receiving treatment at services to prevent/heal pressure so Current residents with pressure ulcerisk risk of pressure ulcers have the potential to be affected by this allege deficiency. Residents are receiving treatment of pressure ulcers and prevention of pressure ulcers. Nursing staff have been educated regarding the prevention and treatm pressure ulcers. DON/designee will audit 2 residents unit per week to ensure that care is provided to treat pressure ulcers or prevent pressure ulcers. Results of audit will be reviewed by the service of the service	nd pres. ers or ed ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	bone, tendon or may be present but tissue loss. May intunneling) to left are had developed dur with multiple medic (intestinal diversion collection system in during the hospital (mechanical wound manage/treat pressurgery] doctor (Miconsidering a flap of (surgical covering of healing), and the form of the considering and the considering and the considering and the considering of the	caneous fat may be visible but uscle are not exposed. Slough to does not obscure the depth of clude undermining and and right buttocks. The areas ing prolonged hospitalization cal complications. A colostomy of and Foley catheter (urine of the bladder) was initiated ization as well as wound vact domanagement) to sure areas. A plastics [plastic of pressure ulcer to promote of the pressure ulcer of pressure ulcer to promote of the Physician Progress ments and debridement since of the past six months, which gorificant, increased metabolic	F3	14		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	area of skin breakd relieving/reducing of as per orders prior ensure comfort." R protein, amino acid ordered to promote educate R439/famiskin breakdown what transfer/positioning taking care during nutrition and frequent the Physician Proggoing forward were followed: On 9/16/15, initial admission to facility management of Sapressure ulcer with (infection in the borrequiring tracheost Chronic pain due to Fentanyl patch (eximith Dilaudid (oral pain. A colostomy a started to promote reports patient has since admission. P stage IV which was and complicated he by a wound vac an Air mattress to ass continue physical therapy [OT]." On 9/17/15, VOH specializes in wour note: "Consult required."	mily/caregivers of any new down. Pressure device in bed/chair. Treat pain to treatments/turning etc. to 439 required supplemental is, vitamins, minerals as a wound healing. Staff were to dily/caregivers as to causes of hich included requirements; importance of ambulating /mobility, good	F 3	14		

OLIVILI	10 I OIT WILDIOAITE	A MEDICAID SETVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245183	B. WING	i		03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	cm [centimeters] x serous exudate, 10 dressing negative p (wound vac). Stage ischium 4 cm x 4 cm serous exudate, thi necrotic tissue 90% Wound debrided visubcutaneous tissue tissue. Post debride Foam once daily, Sonce daily. Stage II ischium 4 cm x 5.5 serous exudate. The necrotic tissue 90% Wounds debrided visubcutaneous tissue. Post debride foam once daily, Sa Alginate (provide an infection, absorb exenvironment to produce of the point of th	pressure ulcer of the sacrum 7 11.5 cm x 0.5 cm moderate 0% granulation tissue, pressure three times per week all pressure ulcer of the right m x 1.5 cm with moderate ck adherent devitalized as urgical excision and the removed along with necrotic ement depth 1.6 cm. Dressing antyl (helps clean wound) I pressure ulcer of the left cm x 2 cm with moderate tick adherent devitalized to, granulation tissue 10%. The pressure ulcer of the left cm x 2 cm with moderate tick adherent devitalized to, granulation tissue 10%. The pressing antyl once daily, Calcium the properties and maintain a moist mote rapid healing) once daily. The progress note: and on 9/17/15, (transported to the promised they will work staff would be available to the promised they will wor	F	314			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(3) DATE SURVEY COMPLETED
		245183	B. WING			03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B	
F 314	"Stage IV pressure x 1.5 cm moderate granulation tissue, three times per wed generalized decline Stage III pressure ux 5 cm x 0.5 cm with thick adherent devirgranulation tissue 1 pressure ulcer of the with moderate sero devitalized necrotic 10%. Improved, derong 9/30/15, VOHI note read, "Stage IV 8.2 x 14.8 x 1.6 cm 100% granulation tipressure three time change. Stage III prischium 5.0 cm x 4.4 decreased depth. Selft ischium 4 x 6 x granulation." On 10/1/15, Plasti "[R439], last seen 1 was never made, uproviders at facility, substantially improviders at facility substantially improviders at facility in the significant progress is chial tuberosity promited to wors "When I saw him lace contributed to wors "When I saw him lace an and his left si wound." "Now both both have necrotic	ulcer of the sacrum 10 x 11.5 serous exudate, 100% dressing negative pressure ek (wound vac) deteriorated to of patient. Optimize nutrition. ulcer of the right ischium 5 cm h moderate serous exudate, talized necrotic tissue 90%, 0%. No change. Stage III e left ischium 4 x 6 x 0.6 cm us exudate. Thick adherent tissue 90%, granulation tissue	F3	314		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION			E SURVEY PLETED
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 314	is under the care of a wound-care nurse feel like the cares at to me." Lastly, "[Dr - On 10/1/15, Wour Surgery Clinic, Dr F the 4 page report with the impression and - On 10/6/15, NH proposition of the impression and - On 10/6/15, NH proposition of the impression and - On 10/6/15, NH proposition of the impression and - On 10/6/15, NH proposition of the impression and consideration of the impression and consideration of the impression and consideration of the impression of the	te manner to my opinion." "He a wound care nurse, but how e can look at his wounds and re appropriate is not adequate F.] will see him today." Id Clinic Initial Note of Plastic E: Requested, but page 3 of as missing, which included plan of care. Togress note: seen by the ist (transported to notern for patient wound, ections were given during that dressing continues with eported bilateral ischial gout excessive drainage and turse had already completed day. Poor wound healing. In the lowest of the three major of each half of the pelvis of the three major of each half of the pelvis of the dressings, unable to a normal mood and affect, ormal. Sacral ulcer stage IV, aling. Patient also had bilateral of partial thickness skin loss of dermis, or both. The ulcer is the entire clinically as an abrasion, water] which is now draining malodorous drainage. Low and nausea over the ound cultures [to look for ext dressing change and blood	F3	14			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING		03	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	unstageable ischial draining copious, m drainage few days a which came back w klebsiella pneumon growth of enterobac bacteria] and heavy Beta hemolytic (S. / bacteria]. Poor wou house psych [psychantidepressants and with mixed growth, [antibiotic]. Continuedaily per wound spector on 10/15/15, NH pthe bilateral unstage draining copious madrainage. On 10/21/15, Nurs report (pressure an Sacrum measured stage IV, the left IT 5.0 cm x 5.0 cm x 1 the third ulcer on th 4.0 cm x 1.25 cm a on 11/19/15, Nurs report (pressure an Sacrum measured and the stage was not documented. The nor the staging and R439's wounds. In notes for R439 between the sack was between the sack wounds. In notes for R439 between the sack was between the sack wounds. In notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented. The notes for R439 between the sack was not documented.	l: brogress note: "Bilateral wound which was noted to be alodorous greenish yellow ago. Wound culture collected with moderate growth of iae [bacteria], moderate beter aerogenes [gram negative or growth of streptococcus B Agalactiae) [gram positive and healing. Agrees to see in alologist] and increase d pain control. Wound culture sensitive to tetracycline e to change wound dressing	F3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	12/15/15, indicated intact and had majdue to pressure ulc two with turning an resist cares. On 2/9/16, the care pressure ulcers we which directly confl Progress Notes an The care plan iden noncompliant with record lacked evided ocumentation for care plan lacked direfuse cares, espe of his wounds. In a risk/benefit assess with R439. The nursing assists 3/16/16, directed s and turn in bed. grareposition every two minutes when up in assist of staff for m to appointments. On 3/16/16, at 8:36 shift staff did not tut that to registered in the care with the care into a programment in the care into a programment in the care into a pointments.	mum Data Set (MDS) dated I R439 was fully cognitively or depression, was on bedrest ters, required assistance of d repositioning and did not e plan was updated to state the ere all stage IV on admission, licted with the Physician d admission assessments. tified R439 had been cares, however the medical	F 31	4		
	hours and fifteen m	uous observations for two ninutes from 5:45 a.m. until ent was not repositioned. At				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245183	B. WING			03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 314	glucose test. At 7:0 without knocking, continuous the room within 15 a.m. R439 was intered all notified the resident the time of continuous resident stated he resident stated he resident stated the stated the stated the stated the wounds resident the assistant of the stated the wounds resident the differ R439 had D-A and that accounted for the actually did the mean have not changed as September 2015. Walter allow the stated she first saw wounds have decreated she first saw wounds have decreate	ge 65 I and entered room for blood 8 RN-P entered the room alled R439's name, and left seconds of entering. At 8:03 rviewed and stated he "had night." At 8:05 a.m. RN-N was thad not been turned during bus observation, and the nad not been turned all night. Hould be turned every two may a pressure ulcer table to be obtained. At 11:00 lirector of nursing (ADON) have not changed in staging, rence between wound clinics. How had D-D and so maybe the difference, but RN-N assurements. RN-N stated they stages since he started in When interviewed at 11:16 she had entered R439's room for an and the second time to give may an anothe second time to give may an anothe second time to give may an anothe second time to give may anothe the second time to give may be the deep tunneling. An elimaging (MRI) was done on osteomyelisitis (in the ischialmen the results arrived today mospital to receive intravenous atted the aides need to inform they see, because NP-B relied to inform her of what's es don't take direction from the p quality declined, but was have to have enough staff, re what they are doing." D-C	F3	14			

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		543	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	stated there was a ulcer care in the fact stated the wound hime she saw it, as "charge nurse", stated aily, and the facilit doctor measures at stated there had be providers for the fawith a new wound of the MRI exam combilateral deep ulcer inferomeidal buttoc anteriorly along the tuberosities, concert (infection in the born North Memorial Me (NMMC) emergency indicated the resident the evening of 3/17 indicated the osteonew concern as stated the was repositioned of 12.5 hours assistant (NA)-Q states this unit and didn't is care card on the doreposition every two repositioned 15-20 9:30 a.m. RN-N was he had not been turif he had reported to him yes	system breakdown in pressure bility. At 12:00 p.m. RN-N ad changed a lot since the last it was oozing a lot more. RN-P ted nursing does wound care y did wound rounds as the nd RN-P wrote it down. RN-P ten three different wound icility, they had just started doctor during the current week. In pleted 3/14/16, identified ative changes at the k soft tissue with extension medial aspect of both ischial rning for osteomyletitis ine) and he was admitted to dical Center for IV antibiotics. It was sent back to the facility was sent back to the facility was chronic and not a	F3	3114			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	resident after the all reported. RN-N star had not asked about night shift. At 10:24 spoke to the evenir frequently refused to the night supervistated R439 "told might." At 2:04 p.m. two hour turn and recom, because he to informed this morning had not been turned the nurse at home, requested not to be p.m. R439 stated histurbed at night. Frefused to turn, because he to turn, because he to turn, because he to turn and not been turned the nurse at home, requested not to be p.m. R439 stated histurbed at night. Frefused to turn, because he sore. R439 stated better." On 3/21/16, at 5:10 R439's unit, until RI announcement to wate the facility. At 5:10 refused the midnight a.m. turn and got p. 4:00 a.m. turn but rat 6:00 a.m. LPN-H meds whenever he she would turn R43 who was working whallway (one of four now. At 5:30 a.m. Land asked if the aid	he had interviewed the ellegation of neglect was ted he had talked to R439, but ut being repositioned on the a.m. the DON stated she ag supervisor and R439 to be turned at night, according sor. At 11:04 a.m. RN-N, he he was not being turned at RN-N stated he put an every eposition sheet up in R439"s took it very seriously when any that R439 again stated he dagain last night. RN-N called who told him R439 had a disturbed at night. At 2:10 he had never asked to not be the may have occasionally cause his shoulders may have build not say what shift that the arified it was not very many "I know I have to turn to get a.m. no staff was observed in N-T made a facility wide welcome the health department a.m. LPN-H, stated R439 had at turn, and accepted the equested not to be awakened a stated R439 was offered pain as a say a say of the was helping in the 800 and hell was helping in the 800 and hell was helping in the 800 and hell was there with them, both 35 a.m. the director of nursing the say and the say and the director of nursing the say and the say and the director of nursing the say and the say a	F 3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,21,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	(DON) came to R4: LPN-H. At 5:42 a.m turn R439, LPN-I st removed, he didn't and it's whatever m 6:53. a.m. LPN-I as you, we were lookir was taking my brea asked how many tir night, and she state acknowledged she hallway to know wh opportunity or not. A there must be a lan R439's room right a the DON was inforr repositioning conce R62's quarterly MD required extensive cares. R62's Weekly Skin indicated he had a buttock that was re- R62's care plan dat at risk for pressure with a pressure ulco history of re-openin planned interventio complete weekly sk to avoid positioning further indicated R6 himself in bed. How what the MDS date	39's unit and spoke with a. LPN-H and LPN-I offered to cated "he just wanted the pillow want to turn to the other side, takes him comfortable". At sked NA-S "Hey where wereing for you". NA-S stated, "I ak." At 6:54 a.m. NA-Q was mes R439 was turned last ed "hmm 3 or 4," however, had not been down the tether R439 turned the forth At 6:00 a.m. the DON stated aguage barrier, as RN-N was in away at 8:00 a.m. At that time med RN-N did not discuss the ern with R439. S dated 11/27/15, indicated he assistance from two staff for Report dated 12/31/15, pressure ulcer on his right solved. Red 1/14/16, indicated he was ulcers, admitted to the facility er on his coccyx and had a genesure ulcers. The care ns at that time directed staff to kin checks and encourage R62 on coccyx. The care plan 62 was able to reposition vever, that contraindicated di 11/27/15, noted.	F 31	4		
	assessments between	een 12/31/16 and 1/27/16, at				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	Report indicated a right buttock. The pas unstageable, me pressure ulcer was 2/4/16, A Weekly Sa pressure ulcer to cm x 4.7 cm x 0.8 cm was assessed by V wound physicians. Evaluation on that comes are ulcer to the cm x 3.0 cm x 1.4 cm indicated a healed sor pressure exerted layers of the skin) corpressure exerted layers of the skin) corpressure exerted layers of the skin) corpressure ulcer wound was not not assessments. R62' 2/9/16, however, not implemented even new pressure ulcer direct staff to encoun his coccyx even the required extensive mobility. R62's quarterly MD R62 was cognitively assist of two staff for and had a stage IV Observation on 3/1 lying in bed on his key During observations 7:50 am, and 8:44 aroom lying in bed. During an interview During an interview of the pressure was a stage IV Observation on 3/1 lying in bed on his key During observations 7:50 am, and 8:44 aroom lying in bed.	new pressure ulcer to R62's pressure ulcer was described pasuring 4 cm x 4.5 cm. The first observed on 1/20/16. On kin Condition Report indicated R62's coccyx measuring 5.0 cm depth. On 2/10/16, R62 OHRA (wound care company) A Wound Care Specialist date indicated a stage IV to eright ischium measuring 4.0 cm. The Evaluation also shear wound (an applied force of against the surface and of the right superior buttock than 65 days. The shear ted in the previous skin is care plan was updated on the previous were sthough R62 had developed a county. The care plan continued to brough his MDS indicated he assist of two staff for bed. Since dated 2/26/16, indicated by intact, required extensive or bed mobility and transfers,	F 3	14		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	condition. She state area on his bottom no scheduled cares anything he will put. During an interview licensed practical na couple of open ardaily dressing changes his grab bar. LPN-C fursupposed to go in a two hours. During an interview RN-M stated, R62 his when he moved to had healed on 12/3 1/20/16. During an interview DON stated, R62 himself." She stated but was not sure if pressure). While R62 was at in ulcers and required repositioning, the fainterventions to ensfrom R62's bottom. pressure ulcers had new individualized in implemented to prepressure ulcers or pulcers. A facility policy titled.	ed, "I think there is an open ." She further stated, R62 had and stated if he needs his light on. on 3/17/16, at 11:11 a.m., urse (LPN)-C stated, R62 had eas to his bottom and has ges. She stated during his he was able to hold on to the other stated staff was and offer repositioning every on 3/17/16, at 11:17 a.m., and a stage IV pressure ulcer the unit. She stated the wound 1/15, and opened up again on on 3/17/16, at 3:07 p.m., the spretty good at repositioning the changed position in bed he was able to offload (relieve staff assistance for acility did not implement sure offloading of pressure Further, while previous the healed and re-opened, no	F3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03/:	21/2016	
	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314 F 323 SS=E	care of existing preprevention of additional policy directed staff resident and the properties of the	vide clinical guidelines for the ssure ulcers and the onal pressure ulcers. The focus on assessing the essure ulcer, managing tissue and quality improvement.	F 31			5/3/16	
	by: Based on observa review, the facility f supervision while ir (R104) who was kr (ETOH) in the facili to provide adequat to ensure safe smoresidents (R77, R2 R511) who currentl Findings include: Substance abuse: R104's care plan d had a history of alc interventions which checks hourly and	NT is not met as evidenced tion, interview, and document ailed to ensure adequate noxicated for 1 of 1 resident flown to consume alcohol ty. In addition, the facility failed as supervision and interventions sking practices for 7 of 15 42, R248, R286, R429, R494, by smoked in the facility. ated 10/2/15, identified R104 ohol use, and provided included, "Frequent safety PRN [as needed] of resident ecks hourly and PRN for		F323 R104 is receiving adequate supervision related to ETOH consumption. R 77, R 286 and R4 have been discharged. R242, R24 R429, R104, and R511 are receiving supervision per smoking assessment recommendations. Current residents with a history of abuse and/or smoking while residing the community have the potential to affected by this alleged deficiency. Residents requiring supervision releitoh or smoking are receiving appropriate supervision. Staff have been educated regarding supervision of residents who smok use ETOH. DON/designee will audit 2 residents	es, and		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245183	B. WING		03/2	21/2016	
	PROVIDER OR SUPPLIER	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	orders to hold narce and "Update MD PF care plan did not idusing alcohol, what attempt if R104 was room or on him, if he consume alcohol, a demonstrated while on how to handle as symptoms for R104 others were kept sa consuming alcohol. R104's significant of (MDS) dated 2/1/16 included hepatic fair cirrhosis, and R104 impairment. A Wandering and E 2/4/16, indicated un R104 was not alert place, time, situation resident was educa and procedure was indicated the reside shortened attention mobile. The section using the Brief Invescore section was rewarded. "History of setting, including ou exit doors." The sur section of the evaluation of the evaluation tindicate any	res," "MD [medical doctor] offic medications for lethargy," RN for substance abuse." The entify if R104's was currently interventions staff should in found to have alcohol in his the was assessed to be safe to my behaviors R104 of consuming alcohol, direction my potential withdrawal the if R104 was found to be	F3	223	unit per week to ensure that superv provided. Results of audit will be reviewed by		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245183	B. WING _		0;	3/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Review of R104's F through March 7, 2 documentation of F R104's Progress N identified, "Staff red drunk and consume with Coke this ever around 5pm. Hx [hi Resident's speech leaning on the right but was able to pro- identified R104's ho notified of the incid search R104's roor found, and staff ides s/sx [signs and syn- every shift and hold Further, the note id- to resident about the Resident refused to re-approach and con- R104's Physician C staff to, "Monitor fon arcotics if suspect MD/NP [nurse prace needed for new ord alcohol abuse." R104's undated Ka under the "Safety" cushion for liquor be and "frequent safet that R104 was "aw- further identified "N- medications for lett for substance abuse	Progress Notes from February 016, did not reveal	F 33	23		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, C 5430 BOONE AVEN NEW HOPE, MN		, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOUL ERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 323	"monitor for use of registered] to report to have signs of imporders." The hourly anywhere in the me. An interview on 3/1 assistant (NA)-E re "had a big problem "behaviors when dr think, he thinks he and he gets an attit getting alcohol, I haleave sometimes with that RN-I was awar stated the last time "maybe two weeks come back drunk" a updated and an ord medications at thos intoxication. When facility, RN-I stated desk sign out, he is and sits out front of R104 used Metro Marranged his own ri went shopping. At 9:34 a.m. with I help a lot when he noted R104 "drank" curses a lot and is	ETOH, NAR [nursing assistant to nurse. Nurse if observed pairment to ETOH, call MD for checks were not documented edical record. 7/16, at 7:45 a.m. with nursing vealed that "a while ago" R104 with drinking" and he had inking, he likes to swear. I needs more help than he does ude. I'm not sure how he is even't heard lately. He used to hen he had a power chair to		23	BEHOLINGTY		
	- At 2:22 p.m. licens revealed R104 "drir drunk." LPN-B reve	04's alcohol consumption. sed practical nurse (LPN)-B nks all the time" and "gets aled the physician ordered is a pain reliever) cannot be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
F 323	she had "been her ongoing issue" (Restated R104 had been accouple month alcohol "multiple ti revealed that she was "drunk" and hon the armrest" (oshe has been directly using alcohol or dioccurrence, LPN-Ender hope it would be not to monitor for intotelse she was directly using alcohol, LPN monitor-15 min chois wheelchair." LFR 104 was "belliger or swearing" she was using alcohol, LPN monitor-15 min chois wheelchair." LFR 104 was "belliger or swearing" she was using alcohol, LPN monitor-15 min chois wheelchair." LFR 104 was "belliger or swearing" she was using alcohol, LPN monitor-15 min chois where R104 "There's a lot of sudelivers close by the supervisor happer and confiscated it seen a visitor outs him leave the facil. An interview on 3/revealed she was "it's been awhile si When asked what R104 has been us "usually" a room si medications are gior hospice. When	been drinking. LPN-B stated be seven months and this is an 104's alcohol use). LPN-B een using alcohol on her "shift as" and noted R104 to be using mes per week." LPN-B further 'wouldn't be surprised" if R104 e "just leans over and sleeps if his w/c). When asked what cted to do when R104 has been rected where to document the 3 replied "I don't know, I would by TAR [treatment record] and cication." When asked what ted to do when R104 has been I-B replied "nothing, just ecks, he will usually pass out in PN-B went on to say that if rent, pushing, slapping, yelling would call the charge nurse or stated she had never had to be to R104's alcohol use. When I obtains alcohol LPN-B stated aspicions that one liquor store are front door and that one led to be in the front area once before it was open. I've never ide of facility and never seen	F 32:	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,,_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	drinking, that's just - At 8:48 a.m. with drink "most of the t from lunch "always nurse and the nurse room. NA-G stated recently, "its maybe would tell the nurse be informed At 8:54 a.m. with often found by staff has been drinking at stated the last time and a few days ago nurse about R104 nurse brought him he was not sure where he drank it. R104 left the facilit R104 down the ele he went when he w - At 10:13 a.m. with (LSW)-A indicated [R104] room for alc intoxicated. We consuspect intoxication when asked how of LSW stated it "just when asked what it was "not sure what on to say she though "goes out with Metisupervision, he tell [HUC] and he usual or charge nurse, as can leave." When assessment to determine the supervision of the supervisio	arch, usually if suspected	F3	23		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3)	DATE SURVEY COMPLETED
		245183	B. WING			03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	she was not aware requirement for any stated she had ask policy and had "not - At 10:29 a.m. RN-asked about R104's that it was a "typica facility did not have it was something the indicated some resion order to receive so benefit to R104. RN directed to complet alcohol, hold narcothe appeared intoxic responsible for the that "typically social However, she had psearches with a section alcohol she of found alcohol she of found alcohol "lately aware of R104's drivequired an inconting look under his cush of liquor and carried staff are supposed the facility staff had of the facility staff had of the facility in plar R104's bottles. RN-staff were not able obtained alcohol be everyone" at the facility unmore often before he 1/23/16. RN-K went	ge 77 ursing assessment, and that of any assessment or one to leave. The LSW also ed about the facility's alcohol received an answer on one." K was interviewed and when a alcohol use, RN-K replied I thing" for R104 and the a policy for drinking, however at was discouraged. RN-K dents have a Physician's me alcohol but that was not of I-K went on to say staff was e random room searches for cics and monitor the resident if eated. When asked who was room searches, RN-K replied services" was responsible. Deriodically completed room cond nurse and when she documented how much was RN-K indicated she had not by." RN-K indicated staff was nking and when R104 ment pad change staff were to ion as he stored mini-bottles at suspicious coke bottles" that to dispose of. RN-K indicated found vodka bottles outside there and indicated these were the K also stated she or facility to identify where or how R104 the was "friends with cility and the connected ty. RN-K indicated R104 did supervised and used to leave his enrollment in Hospice on to no to say she could not recall ment to determine if he could	F3	23		

245183 B. WING 03/2*	03/21/2016	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323 Continued From page 78 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		

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	identified, "Residen other people. Knife was immediately pl safety." The note id agency and MD we Progress Note lack interventions being from "swinging a kr R104's undated Ka under the "Safety" scushion for liquor b and "frequent safet included "frequent of for prohibited subst "aware of the risks. Kardex identified R others: increased a feels threatened by someone, possess could be used as w were not document record. A vulnerability asse R104. On 3/21/16, nursing (DON) stated a specific VA [vulnerability on the An interview on 3/1 revealed R104 refulbeen using alcohol	ote dated 3/8/16, at 5:49 p.m. It was seen swinging a knife at was taken away and resident aced on 1:1 [one to one] for lentified R104's hospice re notified of the incident. The ed evidence of any put into place to deter R104 hife at other people." Index Report directed staff section to "check under w/c ottles with every pad change" y checks hourly and PRN" also room checks hourly and PRN ances" and that R104 was "The "Behavior" section of the 104 "was at risk for harming nger, labile mood or agitation, others or thoughts of harming ion of weapons or objects that reapons." The hourly checks ed anywhere in the medical ssment was requested for at 10:32 a.m. the director of ed "Our social workers don't illnerable adults] assessment its when they are admitted are the "asterisks denote some	F 32	3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, 5430 BOONE AVENUE NOT NEW HOPE, MN 5542	IORTH		
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F 323	unable to provide a alcohol consumption. An interview on 3/1 interviewed and individual facility unsupervise often before his entered RN-K went on to sa nursing assessment leave the facility unundergone "cognitive safe to call a cabe had a good idea" for R1 R104 used Metro Markov has et up himself, cassistance. RN-K with knives in his possest the surveyor two knives in his possest the surveyor two knives in his possest that should be a surveyor that should	e's been drinking." NA-F was date and time to R104's	F3	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245183	B. WING		08	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 323	sharp blade end, he aware of R104 swir one was threatened not verify who the "unaware if any othe involved with the sithere was no incide 3/8/16, occurrence not expect an incide every time R104 was further stated that smanager to be info intoxicated and sho occurred on 3/8/16 confirmed she was When asked where DON indicated the where R104 obtain the building unsupe transportation. The the alcohol himself store that delivered stated that having k "habit" of R104 and care plan. The DOI assessment compliable to leave the buthe DON indicated (on the second floot to leave the facility know who was able The DON stated Ridentified on his carthat was on R104's the care plan and p stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment, hx of control in the second stage liver disease impairment stage liver disease impairmen	rified the box cutter did have a cowever stated that she was not riging it at others and that no dor harmed. The DON could other people" were and was er staff or residents were tuation. The DON confirmed ent report made about the and further indicated she did ent report to be completed as intoxicated. The DON she would expect R104's nurse rmed of any time that R104 is build be informed of what at 17:49 with R104. The DON aware of R104's alcohol use. R104 obtained alcohol, the facility staff was unaware of ed his alcohol and R104 left ervised and arranged his own DON stated R104 purchased and she was aware of a liquor to the home. The DON also knifes or sharp objects was a that was indicated on R104's N revealed there was no eted to determine if R104 was uilding unsupervised. However, his placement in the facility or) indicated that he was able unsupervised and the nurses et to leave the facility safely. 104's alcohol use was re plan. When asked where care plan the DON displayed on the tothe focus of "end, hx of ETOH, r/t cognitive offee ground emesis, hx of es lactulose and is aware of	F3	23		

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 323	abnormal labs." Into safety checks hour room checks hourly substances. Reside orders to hold narc Update MD PRN for orders received. Rethat may interest, 1 PRN." The DON in interventions that "a nurse" would know alcohol and what to the facility. The DO been offered supposas AA meetings, ho in R104's medical rindicated room che hourly (as identified nursing assistants complete that as wexpected staff to be care plan. The DOI have an alcohol po At 12:51 p.m. on 3/approached by the LSW-B and RN-H written on 3/8/16, a The DON began to inaccurate informat for the Progress No "hearsay." The DO witnessed R104 with ad been told by an The surveyor then a	itis. R104 "has a history of erventions included, "frequent ly and PRN of resident and y and PRN for prohibited ent is aware of the risks. MD otic medications for lethargy. It is substance abuse. Psych evisit and remind of activities and chaplain support dicated with what was listed as any reasonable and prudent that he was currently using the door of R104 was intoxicated at the first of the discontinue drinking such the was not identified the ecord. The DON further cks should be completed on R104's care plan) by the (NA's) but that nurses could ell. The DON confirmed she is aware and follow R104's N confirmed the facility did not licy.	F 32	3		

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with the state of	o come down to Fivas intoxicated. R different floor and with R104's transferent stated. RN-H R104 threaten any was told to her by R104's floor. The ADON then do not know where Right and R104 handed incident. The ADO other staff or residual so stated should be also stated by the Also st	ad told her when she was asked R104's floor to assist, as R104 N-H had been working on a was asked to come and assist er to the hospital as R104 was stated she did not witness one with a knife and stated that the ADON on the way down to enied that, and stated she did N-H "got this information." SW-B then stated they obtained R104 when he was in his room the box cutter to them without N and LSW-B denied that any ents were present at the time. Er seeing R104 threaten anyone e locked up the box cutter. and LSW-B stated R104 was spital after contacting hospice	F3	23			

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		245183	B. WING			03/2	21/2016
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F 323	progress note. RN of inaccurate progress 3/8/16, at 5:49 p.m. wrote R104 had a k other people because information. RN-H is she would have infosince her supervisor information she did the time she got do not a threat to anyor R104 to the emerge. An interview with the 7:50 a.m. revealed evening of 3/8/16, represented the influence and to the influence and the influence and the influence and the influence and the charted in the progress that the experience of behavior from the stated that he experience and if that was what been informed. The was given direction have been a good in what was written. We note was not follow was provided further administrator stated and erase what was about making a correction in the progress of the state and erase what was about making a correction.	-H entered into R104's confirmed she had made an anote in R104's chart on and again confirmed she chife and was swinging at see the ADON had told her that stated in any situation like that formed her supervisor, but r (ADON) had told her the not follow up. RN-H stated by wento R104's floor, R104 was ne and they did not send	F3	23			

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F 323	R104 had a weapo When asked about administrator stated had not been a threany manner. He we to monitor his behause was suspected unaware of how or alcohol however stagoes on outings ou administrator confinof a liquor store that administrator stated contacted about not of the facility. Addit stated the facility. Addit stated the facility diand if residents had allowed a specific and it would be ken only released per with physician. However 3/8/16, did not incluse specific amount of medical lacked evid asking R104 if R10 the physician and it locked up in the medical lacked and Note from 3/8/16, at edited or followed a record. R77's Admission R R77 had diagnoses anxiety and difficulting and states.	R104's alcohol use, the d R104 was non-compliant and eat towards resident or staff in ent on to say staff are directed vior and lethargy when alcohol and the eat towards resident or staff in ent on to say staff are directed vior and lethargy when alcohol and the eat towards resident was where R104 was obtaining eated R104 had visitors and the eat to the facility. The entered he had heard suspicions at delivered to the resident. The difference of the private property ionally, the administrator difference of an alcohol policy, difference of an alcohol orders of the Physician's Order dated alcohol. In addition, the dence of any staff member 4 wanted alcohol ordered by R104 would keep the alcohol	F 32	3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	` '	TE SURVEY MPLETED
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F 323	indicated R77 neer personal hygiene, mobility. R77's record reviee "Smoking Evaluation that R242 did not hat required staff super However, the care later after facility sistaff supervision with RN packs of cigarettes R242 was asked if that were located in she goes out to singuish friend comes to vision When interviewed NA-C, stated he with group. NA-C stated needed staff super On 3/17/16, at 2:16 R77 was a smokel	e impairment. The MDS also ded staff supervision with independent with transfers and widentified a facility form titled on" dated 12/18/15, indicated have any cognitive loss, visually problem and could light own ired staff supervision while staff supervision while staff assessed R77 requiring hile smoking. In observation on 3/15/16, at N-C, observed two opened in R77's night stand drawer. She smoked the cigarettes in her night stand R77 stated noke by herself and when her sit. In on 3/15/16, at 1:06 p.m., as usually assigned to R77's die was not aware R77 revision while smoking. In p.m. RN-A acknowledged that it. RN-A stated that she was not	F 32	23		
	she goes out to sm friend comes to vis When interviewed NA-C, stated he w group. NA-C stated needed staff super On 3/17/16, at 2:16 R77 was a smoker aware R77 needed smoking.	noke by herself and when her sit. on 3/15/16, at 1:06 p.m., as usually assigned to R77's d he was not aware R77 rvision while smoking. 6 p.m. RN-A acknowledged that				

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F 323	goes outside to she staff supervision while supervised was not a safe smoking was not a safe smoking was not a safe smoking materials. On 3/18/16, at 1:3 and stated R77 was upervision while expectation is for ponce it has been and safe to smoke. R242's Admission indicated R242 has muscle weakness sclerosis. R242's supervisions. R242's supervision while supervisions. R242's Admission indicated R242 has muscle weakness sclerosis. R242's supervision wheelch staff assis hygiene, dressing, wheelchair for model of R242's to 3/21/16, revealed 1/13/16, written by indicated SW observations.	moke independently and NA-D was not aware R77 needed while smoking. In 3/18/16, at 10:33 a.m. RN-E the facility assessed R77 as independently and needed to be smoking on 12/18/15. RN-E plan to address R77's unsafe developed until 3/15/16 and the eventions were not included in N-E further stated residents ervision should not have on their possession. In 9 p.m., DON was interviewed as assessed to need staff smoking. DON stated the plan of care to be developed eletermined that a resident was independently. Record dated 3/21/16, dignoses which included, tobacco use and multiple significant change MDS dated R242 had severe cognitive MDS also indicated R242 twith transfers, personal toileting and that he used a	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 323	that he will be taking progress note date noticed burn holes family was updated staff that R242 had outside and poking progress note date nursing and SW di R242. The progres R242 needed staff R242's record revititled "Smoking Evindicated that R242 loss, visual deficit equipment required dated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requipment required ated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requipment required ated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requipment required ated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requipment required ated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requipment required ated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requipment required ated at the reconstruction of the reconstru	age 88 her indicated that R242 told SW high himself out to smoke. A ed 2/16/16, indicated that staff in R242's clothing, R242's d and family reported to facility d a habit of "flicking cigarettes holes in his pants." A SW ed 2/17/16, indicated that scussed safe smoking with so note further indicated that supervision with smoking. Lew identified a facility form aluation" dated 11/29/15, 2 did not have any cognitive or a dexterity problem and can with no adaptive safety d. The Smoking evaluation and on 3/7/16, both of these 2 did not have any cognitive or a dexterity problem, can light uired a smoking apron and revision with smoking.	F 32	23				
	required a smoking with smoking. How developed 61 days	g apron and staff supervision vever the care plan was later after facility staff first R242 unsafe smoking						
	9:55 a.m. with RN- on R242's clothing - 1st pair- Red jack holes on the front of approximately 1/4" - 2nd pair- Gray pa	ket noted with six cigarette burn chest area of jacket						

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F 323	the back of right particles on the front of a 3rd pair- Checker holes on the front of 4th pair- Light tear cigarette burn hole jacket. - When interviewed out to smoke without to smoking but did not a pron was kept. Risport was kept downwas kept downwa	ant leg and three cigarette burn of left leg. The distribution of left leg. The distribution of left leg. The distribution of the leg and the leg area of the jacket. If green jacket had nine is on the front chest area of the leg area of the distribution of the leg area	F 3:	23		

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F 323	R242's clothing. Fan assisted living fourn holes on his of facility staff. F-A fural smoking apron a while smoking apron a while smoking which saware where the surface where the surface smoking pracknowledged the unsafe smoking pracknowledged that unsafe smoking wand the safe smoking was included in the NA assignment sheet) On 3/18/16, at 1:48 interviewed and staneed a smoking apsmoking. DON staneed a smoking was smoking. DON staneed was smoking was smoking was smoking apsmoking. DON staneed was smoking apsmoking was smoking was smoking apsmoking was smoking was smo	A stated R242 used to live at acility, they found cigarette clothing too and she informed rther stated R242 was to have nd needs to be supervised it was "hit and miss" taff was working and if they are moking apron was kept. a 3/18/16, at 10:52 a.m. RN-E facility became aware of actices by R242 on 1/13/16. a care plan to address R242's as not developed until 3/15/16 ing interventions were not Kardex (nursing assistant	F 3.	23		
	indicated R248 had chronic obstructive generalized weakn and difficult walkind dated 1/12/16, indi intact. The MDS al	Record dated 3/21/16, d diagnoses which included, e pulmonary disease, ess, restless leg syndrome g. R248 most current MDS cated R248 was cognitively so indicated R248 needed staff ersonal hygiene, dressing, ility.				

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F 323	titled "Smoking Eva indicated that R248 loss, could light own deficit and a dexteri evaluation form indi any safety intervent R248's care plan dawas a smoker. How address R248's visi problem that were it assessment and the days later after facilismoking. On 3/16/16, at 8:40 smoking a cigarette facility. The DON wand was heard to te allowed near the buout her cigarette. Rher cigarette on the R248 when R248 pwall. During interview on stated she smokes main entrance. Whoff cigarette butts, Fon the ground or in state "there is no as 3/18/16, at 10:07 a. cigarettes but disponentrance that was pentrance that was pentr	w identified a facility form luation" dated 1/22/16, did not have any cognitive n cigarette but had a visual ity problem. The smoking icated R248 did not require	F 3	23		

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F 323	nursing assistant (Nassigned to R77's of he was not aware fively aware for while smoking. During interview on acknowledged R24 visual deficit and a further acknowledged address R248's vising problem. On 3/18/16, at 1:17 safe to dispose cigarbage. DON staticare plan to be devare completed to awith an assessment R286 was admitted diagnoses of pneur pulmonary disease deficit, and anxiety A smoking assessmant 1/29/16, The assess visual deficit, dexter smoking, can the reand is any adaptive lacked any adaptive lacked any assessmants, put out the of the resident was safe accommunity smok lacked any indication facility was unable from 12/16/16 a care properties.	on 3/15/16, at 1:06 p.m., NA)-C, stated he was usually group and continued to state R77 needed staff supervision 3/18/16, at 10:20 a.m. RN-E 8 was assessed to have a dexterity problem. RN-E ed R248's care plan did not ual deficit and dexterity 7 p.m. DON stated it was not arettes on the ground or in the ed her expectation was for the eloped once the assessments ddress all concerns identified t. I on 1/27/16, with admission monia, chronic obstructive, cognitive communication	F3	23			

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F 323	the resident will follostated the facility wintervention was to on facility grounds. was added to state nicotine patch if red The nursing assistate but not provided. On 3/15/16, at 10:0 down the street, an TCU entrance, for clast night, it's should terrible. TCU entrarcigarette butts on the was a garbage with	ow smoking contract (which as nonsmoking). The remind resident to not smoke On 3/14/16 a new intervention the resident will be offered juests to discontinue smoking. Int care card was requested 7 a.m. R286 stated, smokes d has been cleaning up the days, I even was picking it up d be cleaned up it looks ince, had more than 75 in ground on 3/15/16. There a plastic liner covered but	F3	323			
	R429 was admitted diagnoses of repea mismanagement, tr seizures. R429 sign A smoking assessn 2/19/16, The asses visual deficit, dexter smoking, can the reand is any adaptive lacked any assess ashes, put out the cesident was sat A community smok lacked any indication	2/17/16, with admission ted falls, medication raumatic brain injury (TBI) with ned smoking contract 2/17/15. The ent was completed on sment asked cognitive loss, rity problem, frequency of esident light their own cigarette equipment needed. The formment of the ability to handle sigarette, and did not state if fe to smoke or had limitations. Ing rules applied statement on of what that meant, the oprovide community smoking					

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F 323	(after a list of smok by survey) and indic smoke despite facil be encouraged to concentrate Resident will be encouraged to concentrate Resident will be encouraged to concentrate Resident will be encouraged to concentrate Resident Residen	ing care plan was initiated that ing residents was requested cated resident chooses to ity no smoking policy. Goal will omply with no smoking policy, couraged to decrease ons: offer nicotine patch if smoking assessments stated she had cigarettes and ket (jacket draped over w/c, is), smokes down the road o a.m. the DON stated the a smoking focus group and and they noted that we did not The facility was revamping bking, people know it's a no d sign contract agreeing not to out to smoke anyway, done on people who identify	F 3	23			

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		245183	B. WING		03	3/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	,,=0.0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	residents if they had did not have a small resident. A staff m smoking. R494 did not not not did not	raff members asking staff and ave a cigarette to lend. R494 oking apron on. servation 3/21/16, at 7:20 a.m. ed by a surveyor smoking at the k outside of facility with another ember was supervising d not have a smoking apron on. d on 10/27/15, with admission ed on admission record dated e of right hip, right femur, and of ribs, facial bones and skull nitive communication deficit, and dysphagia (swallowing MDS dated 2/1/16, indicated tely impaired cognition and nd sometimes understood and direct communication. ated need for assistance with y living including eating. Mated 3/7/16, indicated RN-M R494 to assess ability to safely ess Note indicated R494 was the and smoke it safely. It also uggled with figuring out how to the tender of the information was not moking assessment or care	F3	23		
	smoking, can the i	erity problem, frequency of resident light their own cigarette e equipment needed. The form				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245183	B. WING			03/2	21/2016
_	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 323	ashes, put out the comoking rules application of what the unable to provide on the assessment in cognitive loss or vision dexterity problem. It is moke was indicated night. The smoking R494 could safely I smoking apron and that indicated R494 despite facility no signal was R494 wou with no smoking pot the care plan were nicotine patches if I smoking, R494 wou assessments by not smoking assessments.	ment of the ability to handle bigarette. A community lied statement lacked any mat meant, the facility was community rules description. It dicated R 494 did not have sual deficits but did have a requency of R494 liking to lied as morning evening and assessment also indicated light a cigarette and required a	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND			STREET ADDRESS, CITY, STATE, ZIP CC 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Kardex Report date no instructions reg of the Visual/Bedsid 1/14/16, was reque Visual/Bedside Karwhich instructed st assessment deem supervision to smooth buring interview or said, "Now we nee week they started supervision." During interview or stated "I go outside apron to wear last to watch us so I pure someone to go out evening up till about 6:30 a.m. I smoke there. I have been is all I want to do." had been smoking supervision was not staff assistance for R511's care plan designations and smoking. A North Rote dated 1/5/16, aide (AA)-O, "I just smoke."	ed 1/14/16, provided staff with arding R494's smoking. A copy de Kardex Report dated ested but facility provided rdex Report dated 3/21/16, aff that resident smoking ed that R494 required ke. a 3/21/16, at 5:14 a.m. LPN-D d to supervise R494. Last smoking aprons and a 3/21/16, at 12:55 p.m. R494 et to smoke. They gave me this week. You guys want someone t up with it as long as there is with me. I go out in the ut 11p.m. and then 6:20 a.m. or sometimes without anyone smoking for several weeks. It R494's mother verified R494 for a while and that apron and	F 32	23		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED
	245183	B. WING _	····	03	/21/2016
NORTH RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 98			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
During an interview administrator stated agreement on adm the facility is smoke outside to smoke independent of the been identified a refurther stated, all refurther stated, all refurther stated, all refurther stated, after the anotified of R511 sm. The assessment in reminders not to sm. Smoking safety warplan. During an interview R511 stated he had prior to the previous did not know where stated he was told a smoke he would have been administrated she was told another stated she was told another sta	on 3/14/16, at 8:13 a.m., the diall residents sign an ission that they acknowledge free. He stated if residents goney have been identified as pendently. on 3/14/16 at 8:26 p.m., the did not have a smoking eted. She stated he had not sident who smoked. She esidents sign a smoking of their admission. ment was completed on dministrator and DON were toking with his oxygen in use. dicated R511 needed moke with his oxygen running, is not added to R511's care on 3/15/16, at 10:37 a.m., if not been outside to smoke is night. He further stated he is he got the cigarette. He on admission if he wanted to ave to go outside. on 3/15/16, at 2:03 p.m., as unsure if R511 smoked. It was a sked about smoking on was asked about smoking on	F 32	3		
admission and state	ed he did not smoke. She				
	PROVIDER OR SUPPLIER RIDGE HEALTH AND SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa During an interview administrator stated agreement on adm the facility is smoke outside to smoke th able to smoke inde During an interview DON stated R511 cassessment comple been identified a refurther stated, all reagreement as part A Smoking assessor 3/14/16, after the accomplete of R511 sm The assessment in reminders not to sm Smoking safety wa plan. During an interview R511 stated he had prior to the previous did not know where stated he was told of smoke he would had During an interview R511 stated she was She stated she kne pay attention to who During an interview LPN-C stated R511 admission and state	PROVIDER OR SUPPLIER RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 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	PROVIDER OR SUPPLIER RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 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. 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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	PROVIDER OR SUPPLIER RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DOREIC) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 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 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. 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She	ROUDER OR SUPPLIER RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIN 5428) REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 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 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 inglit. 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 now smoking on admission and stated he did not smoke. She

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	NORTH RIDGE HEALTH AND REHAB (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 99			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	he does spend his to by the front door. During an interview AA-O stated R511 to outside and smoke remember" if she houring a subsequer p.m., the administratidentified smoking a student administratidentified smoking a student administratidentified smoking are student administration determining whoutside to smoke. He stated, "This is a The facility's Smoking directed that the fact maintain safe residential policy directed the from smoking areas, smoking areas, fact used and emptied in The policy further in smoke will be evaluated smoking restrictions a resident's care plas supervision with smosupervision at all times.	on 3/15/16, at 2:16 p.m., old her he wanted to go. She stated she "did not ad told anyone. Int interview on 3/15/16, at 3:23 ator stated the facility had as a concern. He stated the or had been completing audits are residents are going he stated residents will outside a major concern for us." In g Policy revised 3/19/2012, cility shall establish and ent smoking practices. The acility will have designated oking will only occur in the designated receptacles. Indicated that residents who lated for "safe smoking", any soloncerns shall be included in an and all residents requiring toking shall have direct nes while smoking.	F 32			5/3/16
SS=D	Each resident's dru unnecessary drugs drug when used in duplicate therapy);					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	` '	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 329	indications for its us adverse consequents should be reduced combinations of the Based on a compressident, the facility who have not used given these drugs us therapy is necessal as diagnosed and crecord; and resider drugs receive gradibehavioral intervents	se; or in the presence of nces which indicate the dose or discontinued; or any	F 32	29		
	by: Based on observareview, the facility freduction was atter (R422) reviewed for Findings include: A Pharmacy Consumindicated a recomm Remeron (an atide (mg) at bedtime. The addressed by the face R422's quarterly Mindicated he had no	NT is not met as evidenced tion, interview and document ailed to ensure a gradual dose inpted for 1 of 5 residents r unnecessary medications. Illation Report dated 10/1/15, nendation to decrease R422's pressant) dose to 7.5 milligram ne Pharmacy Report was not acility. Inimum Data Set dated 1/8/16, o cognitive impairments, e with activities of daily living		F329 R422 has been discharge Facility has reviewed all outstand gradual dose reduction requests resolved as appropriate. All current residents using psych medications have the potential to affected by this alleged deficient Licensed staff have been educat regarding gradual dose reduction The DON/designee will audit 2 reper unit, per month to ensure the dose reduction recommendation been addressed by the provider processed appropriately. Results of audit will be reviewed	ding and oactive o be y. ed o process. esidents at gradual s have and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE	(X5) COMPLETION DATE
F 329	dated 1/14/16, indice medications for dependent address insommedications for dependent address insommedications for dependent address insommedications for dependent address insommedicated hem government at the make a lot of noise. During an observat R422 was lying in beyon and the perfect and then get distribusible was not aware the pharmacist. During a subsequence p.m. RN-M stated, recommendation with the stated she took care. A facility policy titled Gradual Drug Dose	chaviors. R422's care plan cated use of psychotropic pression and anxiety, but did nia. Physician's Orders dated ne was receiving Remeron 15 ditime for insomnia. If on 3/14/16, at 6:33 p.m. R422 of stay up until 2:00 a.m. to 3:00 night staff coming at 6:00 a.m. and wake him up. If on 3/17/16, at 2:36 p.m. need on his left side with his peared to be sleeping. If on 3/18/16, at 8:32 a.m. IN)-M stated, the pharmacy go to the director of nursing uted to the units. She stated of the recommendations by Int interview on 3/18/16, at 1:13 of the pharmacy as not followed up on." She e of it today. It d. Tapering Medication and Reduction, dated September	F3	329	DEFICIENCY)		
F 333 SS=G	of medications and	DENTS FREE OF	F3	33			5/3/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 333	The facility must en any significant med This REQUIREMEN by: Based on observat review, the facility for resident's (R4, R48 significant medicati transcription. This reand R481. R4 who seizure activity and constant pain" rated Findings include: R4's quarterly Minimality for the facility and constant pain and and constant pain and con	Issure that residents are free of ication errors. NT is not met as evidenced alled to ensure 3 of 3 o	F 3:	,	otential to be iency. lications ordered by it cated ription of medication	
	it was discovered the Lamotrigine." F-B s receiving 200 milling an additional 50 mg	stated during the hospital stay nat R4 was getting "too little tated R4 should have been rams (mg) four times daily and g as needed. Medication Administration				

-	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	<u> </u>	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 333	Record (MAR) date was receiving Lamo anti-convulsant dru seizure disorders) 2 1/6/16. At that time mg four times daily A review of a facility dated 1/5/16, indica "Lamotrigine 25 mg gastric (G)-tube as include the time/tim The order was transcoordinator (HUC) nurse (RN)-L. The follows: Lamotrigine a day for cluster se from 800 mg daily to transfer/dischargen Hyaluronic acid, Proof a North Ridge Stated 1/8/16 indica physicians office to Hyaluronic acid." The clarification was recompliated 2/1/16, inchospitalized 2/1/16, inchospit	od January 2016 indicated R4 otrigine (Lamotrigine is an g used in the treatment of 200 mg four times daily until the dose was decreased to 50	F3				

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	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	seizure activity) and EEG monitoring as intermittent seizure increased and two amedications were a During an interview RN-K stated she was R4's Lamotrigine er sure of the details." During an interview director of nursing (the seizures during DON further stated chart review when I During a subsequent 12:51 p.m., RN-K sexpected RN-L to put Lamotrigine dose a clarification. R481's admission R481 was cognitive moderate/severe deassistance with all a eating. In addition, almost constant paractivities, with the nat 10/10 (on a scale painful). The Physic dated 2/2/16, indicated indicated as placed a R481 was placed a R481 was placed a recommendation of the	It was placed on continuous she was found to have so the Lamotrigine dose was additional anti-epileptic dded. on 3/18/16 at 8:06 a.m. as aware of a discrepancy with the ror, but stated she was "not on 3/21/16 at 12:38 p.m., the DON) stated, "I was aware of [R4's] hospitalization." The RN-K should have done a full R4 returned from the hospital. In the interview on 3/18/16, at tated she would have uestion the decrease in R4's and call the physician to get a pression, and required activities of daily living except R481 was identified as having an that limited her day to day nost severe pain being rated a where 10 is the most cian's Admission Orders/note ated R481 was admitted to the or gastric (stomach) cancer. It harm as R481 did not an ordered pain medication	F3	333			

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F 333	2/11/16, was comple MDS. The CAA for to R481's response indicating she had provided was almost constart indicated R481 had adenocarcimoma warthritis/ DJD (degenation with chronic parameters) opioid dependence Allina Hospice was with their consulting closely to manage provided the pain related to lymph system that hinterventions instruct analgesia [sic] [pair orders." The post hospital Dindicated staff were (medication to treat times daily for nerver pain medication) 5 severe pain, Morph concentrate 20 mg/every four hours as shortness of breath analgesic) 1000 mg. The Hospice Certificated 2/2/16, also in	sment (CAA) for pain dated eted in relation to the 2/9/16 pain had been triggered due s to interview questions pain which limited her activity, at, and rated 10/10. The CAA advanced metastatic (mets) with mets to lymph and bone, enerative joint disease), back ain syndrome hx (history) and an arreading pharmacist are working pain with a goal of pain < (less eted 2/11/16, indicated R481 cancer of the stomach and and spread to the bones, and acted staff to "administer in killer medication] as per espain, methadone (narcotic mg three times daily for ine (narcotic pain medication) milliliter (ml) give 0.75 ml needed for pain (PRN) or and acetaminophen (a mild of three times daily for pain. Cation and Plan of Treatment indicated R481 was to receive three times a day and care	F 3:	33		

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY MPLETED
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F 333	A review of R481's had not been identi MAR. The Allina Hospice Visit Record dated pain at 10/10. The Allina Hospice Visit Record dated pain at 10/10. The Allina Hospice and Record dated 2/6/1 Goal set to get pair Allina Hospice and Record dated 2/6/1 Goal set to get pair Allina Hospice and Record dated 2/11/ The Physician Orded discontinue Gabape for nerve pain becareceiving it, and incompared the times a day set of the physician Orders with the physicia	MAR indicated the gabapentin fied on R481's February 2016 and Palliative Care Facility 2/3/16, patient complained of Allina Hospice and Palliative Record dated 2/4/16, R481 oved to 7/10. R481 received rphine 15 mg. in last 18 hours. to increase methadone to 10 ay and increase morphine to PRN. Palliative Care Facility Visit 6, R481 rated pain at 6/10.	F 3:	33		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	hospice. Resident I 800 mg TID since a given d/t [due to] the into PCC. Educate doctor] and family.' R481 did not receive medication upon as RN-K said R481's adiscovered by an eadmission orders hourses but the gab said, "I think it is the someone on the deak but only to 3:30 R57's admission MR57 was cognitivel with all activities of had diagnoses of his kidney disease with A Geriatric Service term care (LTC) Initindicated R57 had (coronary artery by arteries) in Decement	admit on 2/2/16. Resident on has not received Gabapentin arrival. Medication was not he fact it was not transcribed staff update MD [medical "R481 was placed at harm as we the physician pain dmission. medication error was evening supervisor. The had been checked by two apentin was missed. RN-K e consistency of having esk. My assistant can cover the 30 p.m." IDS dated 2/9/16, indicated y intact, required assistance daily living except eating, and hypertension and end stage in dependence on dialysis. Is of Minnesota (GSM) long itial Intake form dated 2/4/16, undergone a CABG x 4 mass graft involving four liber of 2011. Admission Record, indicated nitted to the facility 2/2/16. After	F3	333	DENOTITY		
	were to administer three times weekly Friday; and Coreg breakfast four time Thursday, and Sati	dated 2/2/16, indicated staff Coreg 3.125 mg by mouth on Monday, Wednesday, 6.25 mg by mouth with s weekly Sunday, Tuesday, urday. The After Discharge sted staff to give R57 Coreg					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03	3/21/2016	
AND PLAN OF CORRECTION DENTIFICATION NUMBER: 245183 B. WING 0 0 0 0 0 0 0 0 0							
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE	
F 333	6.25 mg daily with R57 attended dialy and Fridays at 12: The facility's Order 3/21/16, indicated with evening meal electronic health rewhen Coreg 3.125 weekly Monday, Wbreakfast; and Corbreakfast four time Thursday, and Sat R57's MAR indicat doses of Coreg 3.2 6.25 mg, between Review of R57's Wdated 3/23/16, indihad been checked systolic 154-195, o 2/2 and 2/11/16. At clarified, R57's bloidentified as systolic as documented 2/1 two days between R57's systolic bloo 166 compared to m 2/11/16. A Medication Error	the evening meal and indicated rsis Mondays, Wednesdays 00 p.m. Summary Report dated only Coreg 6.25 mg every day had been entered into the ecord from 2/2 through 2/12/15, mg by month three times rednesday, Friday with eg 6.25 mg by mouth with es weekly Sunday, Tuesday, urday were added. Review of ed the resident had missed five 25 mg, and five doses of Coreg 2/2 and 2/12/16. Reights and Vitals Summary cated R57's blood pressures daily, and had fluctuated, ver diastolic 60-96 between fter the Coreg order had been	F 3:	33			
	coordinator] indica and need clarificati medicalization [sic order was not clari indicated new order Predisposing factor	ted that Coreg was not on PCC ion. Res. missed Coreg since admit ion [sic]. Coreg fied." The report further ers received and no injury. rs identified medications with ot cause analysis indicated,					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		5430 BOO	DDRESS, CITY, STATE, ZIP CODE NE AVENUE NORTH PE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL OSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 333	"Resident received Coreg. NP [nurse p occurred with follow without injury from with provider same team] to provide ed recognized as responding interview on registered nurse (R we receive a new occordinator (HUC) is computer and then HUC does not inputify into the computer check it." During interview on nurse manager said a new admit arrives the orders into PCC clarify any orders not perform a second of the clarification and day as admission. RN-K said R57's m because, "the HUC clarification and the nurse for several day found the error and communicated to sto write needs clarification forders would enter another nurse second control or the clarification and the nurse for several day and the error and communicated to sto write needs clarification forders would enter another nurse second	less than prescribed dose of ractitioner] notified. Error or up clarification. Resident med error. Orders clarified day. IDT [interdisciplinary ucation to individual onsible for error." 3/21/16, at 10:19 a.m. N)-E said, "the process when reder is the health unit inputs the order in to the the nurse will check it. If the the order, one nurse will input and the second nurse will 3/21/16, at 10:45 a.m. RN-K is the process for orders when were The HUC would enter then the charge nurse would be eding clarification and then heck on them. We try to do second check on the same edication error occurred wrote the order needed in we were without a charge ays. The nurse practitioner clarified the order." It was taff that it was not appropriate ication. If an order has not of the order and then have ind check it. RN-K said, "We rege nurse consistently. The	F3	33			

ND PLAN ((X3) DATE SURVEY COMPLETED	
	03/21/2016	
NAME OF	DDE	
(X4) ID PREFIX TAG	TION (X5) JLD BE COMPLETION OPRIATE DATE	
F 333		

AND BLAN OF CORRECTION		` '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE AP	JLD BE	(X5) COMPLETION DATE
F 333		ge 111 sident's Attending Physician or al Director to discuss the	F 3	33		
F 334 SS=D		NZA AND PNEUMOCOCCAL	F 3	34		5/3/16
	that ensure that (i) Before offering the each resident, or the representative receiveness and potentimmunization; (ii) Each resident is immunization October annually, unless the contraindicated or timmunized during the contraindication; and (iv) The resident's representative has immunization; and (B) That the resident representative was the benefits and point immunization; and (B) That the resident influenza immunization; and that ensure that (i) Before offering the immunization, each immunization, each	offered an influenza over 1 through March 31 over 1 th				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (:	X3) DATE SURVEY COMPLETED
		245183	B. WING		03/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	00,23,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 334	immunization; (ii) Each resident immunization, unler medically contrained already been immunization; and (iii) The resident or epresentative has immunization; and (iv) The resident's documentation that following: (A) That the resident expresentative was the benefits and proposed immunication or (v) As an alternation and practitioner represents following the immunization, unler immun	otential side effects of the soffered a pneumococcal less the immunization is dicated or the resident has unized; or the resident's legal is the opportunity to refuse medical record includes at indicated, at a minimum, the dent or resident's legal is provided education regarding otential side effects of munization; and dent either received the munization or did not receive immunization due to medical refusal. If ye, based on an assessment commendation, a second munization may be given after 5 a first pneumococcal less medically contraindicated or resident's legal representative	F 334		
	by: Based on intervie facility failed to ensure was offered and/or	eNT is not met as evidenced w and document review, the sure 1 of 5 residents (R310) received influenza and ecinations as recommended by see Control (CDC).		F334 R310 has been discharged All admissions will be offered the appropriate immunizations. Current residents will be audited related to the immunization status at their next qual MDS and appropriate immunizations	arterly

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
_		REHAB		STREET ADDRESS, CITY, STATE, 3 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 334	Findings include: The Admission Rec R310 was admitted Review of R310's falacked documentat pneumococcal vaccontraindicated or recontraindicated or recontraindicated or recontraindicated or recontraindicated or recontraindicated R3 vaccination Connect facility indicated R3 vaccination on 10/1 documentation if he vaccination. On 3/21/16, at 2:40 (DON) stated docu Informed Consent in Pneumococcal Vaccination are." On 3/21/16, at 3:00 (CC), stated "some before they are administration control nuresidents and "we con 3/21/16, at 4:12 find an informed connection control of the AL [assisted].	cord dated 3/21/16, indicated I to the facility on 11/10/15. acility immunization record ion if an influenza and cination had been received, refused. Minnesota Immunization ction record provided by the 10 received an influenza 4/14 and lacked any received a pneumococcal received a pneumococcal p.m. the director of nursing mentation should be on the for Influenza and recine sheet, "but the forms and I don't know what all the p.m. the corporate consultant times they have the vaccines mitted or at the hospital." I p.m. DON stated the previous ree had a log for all the can't find it." I p.m. CC stated they could not onsent record for influenza and R310, "he may have had them	F 33	offered. Licensed nurses will be regarding immunization: pneumococcal and influimmunization. DON or designee will auimmunization status of 2 unit, per week to regard status. Results of audit will be results of audit will be results.	s the enza Idit the 2 residents per ing immunization	

	OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/21/2016
	PROVIDER OR SUPPLIER	REHAB	į	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 371 SS=E	provided pertinent i significant risks and "between October of the influenza vaccir unless the vaccinat contraindicated or t immunized." The facility Pneumo September 2012 in offered the pneumo or upon admission, eligibility to receive offered the vaccinated admission to the fact 483.35(i) FOOD PESTORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	enza vaccine annually, will be information about the distribute and March 31st each year, ne shall be offered to residents ion is medically he resident has already been accorded vaccine - Revised dicated residents will be accorded vaccine to aid in accorded infections, that prior to residents will be assessed for it and when indicated will be tion within thirty days of cility. ROCURE, SERVE - SANITARY	F 371		5/3/16
	by: Based on observat review, the facility for dinnerware was cle water to minimize the	NT is not met as evidenced ion, interview and document ailed to assure resident an of food debris and stagnant ne possibility of food borne e potential to affect 288 of 293		F371 Food Procedure/store/prepare/serve Identified serviceware items were w at the time of identification. Current residents who receive meal	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/2	21/2016
_	PROVIDER OR SUPPLIER	REHAB		5	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	of the kitchen. Findings include: During the evening dining observation of dietary aide (DA)-B three staff member orders at the front oplate warmer was a rack sitting on a thr continually took box rack and filled approper the back BWS servening servithree bowls out of the rack, approximately to run out of each of use the bowls, filling and/or mashed pottoresidents seated. During interview on verified the multiple yellow plastic rack where the multiple yellow plastic rack where allowed to dryp.m. DA-A removed bowls and brought. During interview on stated he "tries to le in them." A puddle of inches in diameter area where the yellow the realso put and third shelf of the staff of the	Bridgeway South (BWS) on 3/14/16, at 5:15 p.m. was observed serving food to s who were giving the food of the steam table. Next to the deep sided yellow plastic dishes shelf push cart. DA-B was needed out of the dishoximately 20 food orders for ice. At 6:03 p.m. the front ce started. When DA-B pulled he same yellow plastic dishes and yellow plastic dishes and gravy serving them in the dining room. 3/14/16, at 6:07 p.m. DA-A be blue serving bowls in the were not dry and should have a properly before use. At 6:08 of the yellow plastic dish rack of a new rack of dry bowls. 3/14/16, at 6:35 p.m. DA-B book out for the ones with water of water approximately 8 was observed underneath the ow dish rack had been sitting. ddles of water on the second e three shelf push cart. DA-A on the cart had dripped out of	F3	371	the kitchen have the potential to be affected by this alleged deficiency. Dietary Staff were educated on propractices for mechanical washing and coffee cups. Audits to be completed up to 5 time week by Dietary Manager or design Audits will be brought to QAPI meareview.	per of bowls es per nee.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	2:00 p.m. with the oplastic dish racks we numerous amounts or a mix of blue cerbowls or coffee multinto the racks, with position. In the tennumerous bowls stelleast eight cereal at food debris, some werified the dishes of food debris and it	o kitchen tour on 3/17/16, at director of nutrition (DN), deep were observed to contain of either all blue cereal bowls real bowls and/or smaller fruit real bowls and/or smaller fruit real bowls and real bowls were thrown some stored in an upright dish racks there were ored with water in them and at and fruit bowls contained dried with water in them. The DN should have been stored clean not stored wet with water in re will be changing that	F 37	1			
F 425 SS=D	Revised March 201 "presoak dishes or burnt food, do not or running items throu air-dry." On 3/18/16, at 7:58 expect the dishes to "we need to do it rig 483.60(a),(b) PHAF ACCURATE PROCOURATE PROCOU	ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State ly under the general	F 42	25		5/3/16	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	(X5) COMPLETION DATE
F 425	A facility must prov (including procedur acquiring, receiving administering of all the needs of each The facility must er a licensed pharmace	ide pharmaceutical services es that assure the accurate g, dispensing, and drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation e provision of pharmacy	F 4:	25		
	by: Based on observareview, the facility fordered for 1 of 1 rdiagnosed with bro Findings include: During observation R305 was observe with audible wheez muscles. R305 was interview due to shifting upright in a value of the sitting on the table R305's annual Ministry.	on 3/16/16, at 10:57 a.m. d to be very short of breath ing and usage of accessory s unable to complete initial ortness of breath. R305 was wheelchair with oxygen on via re was a nebulizer machine next to R305. mum Data Set (MDS) dated		F425 R305 has received the antibiotic. Current residents have the po affected by this alleged deficie Emergency drugs and biologic available to residents. Licensed nurses have been eregarding the emergency drug biological. DON/Designee will audit admistat medications weekly Results of audit will be review.	tential to be ency. cal are ducated gs and inistration of	
	2/9/16, indicated R required assistance except for eating w R305 did not have oxygen during the a	305 was cognitively intact, with all activities of daily living hich required supervision. shortness of breath or used assessment reference period annual MDS did indicate				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03.	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	asthma. The care plan initial had shortness of bid diagnoses of chron disease, and R305 comfort and has a large of the physician Tele indicated staff were 20/milligrams(mg.)/needed (PRN) for colliters by nasal cannot be resident was something the evening of 3/16 Keflex (antibiotic) 2 mouth for seven da [immediately, without (breathing treatment days stat every two Prednisone (steroid 10 mg STAT then expended the properties of the expended and dressed cough antibiotic. Lungs with and audible wheezed "bronchitis, not activate and nebulizer treatment of the expended to the expense of the expense	ted on 3/15/16, indicated R305 reath when lying flat due to a ic obstructive pulmonary used supplemental oxygen for history of bronchitis. phone Order dated 3/15/16, edo give Roxanol (milliliter(ml.)) every hour as comfort and start oxygen at two ula continuous for comfort. een by nurse practitioner on /16, and wrote orders for 50 mg three times a day by the story of bronchitis. "Start stat ut delay]!", albuterol neb (althat reduces inflammation) every a.m. for four days. ces of Minnesota Progress (a), indicated (R305) alert, up bothering her, does want the diminished breath sounds es. Assessment was vely dying." The plan was with antibiotics, prednisone, ments. 2016 Medication ord did not indicate Keflex was in 3/16/16. Prednisone 10 mg.	F 4	25		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED
		245183	B. WING			03/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428)E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	
F 425	Northridge 1 SW O medication dispens facility on 3/18/16, a a list of medications emergencies. Ceph on the list. During interview on registered nurse (R short of breath yest yesterday for morph fever, and the oxyg R305 does not norrow on 3/17/16, at 8:30 (TMA)-A asked RN Keflex three times a been given and it is During interview on said, "The order was set up to start at no a.m." RN-G verified given on 3/16/16. During interview on nurse practitioner (I fifteenth and was to dying so I ordered r saw her on the sixte having difficulty bre ordered nebs, pred 'STAT' does not me as soon as possible there was an issue in giving STAT med	mnicell (automated ing system) Inventory faxed to at 10:23 a.m. was provided as a available in the facility for alexin (Keflex) 250 mg was 3/16/16, at 11:00 a.m. N)-F stated R305 was very erday so we obtained orders nine. R305 did not have a en saturations are 92 percent.	F 4	25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY PLETED
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428 SS=D	we start it in the even her doses. There we until the morning. If the pharmacy STAT hours." RN-H was remergency kit. On 3/18/16, at 12:0 said stat means not the medications fro to notify the medication." Administering Medication, "Medicated, "Medicated, "Medicated, "Medicated, "Medicated, "Medicated, "Medicated, "3. Medicated in a seprescribed." "3. Medicated time from 483.60(c) DRUG RIREGULAR, ACT The drug regimen of reviewed at least or pharmacist. The pharmacist muthe attending physicials and service well as the service with the attending physicials and service with the service well as the service with the attending physicials and service with the servic	cheduling the medication. If ening she might not get all of as no supply of the antibiotic we order a medication from they can get it for us in four not sure if Keflex was in the 6 p.m. RN-E nurse manager w. "Sometimes we cannot get m the pharmacy. I expect staff I doctor if they cannot give a cations Policy revised April edications shall be afe and timely manner, and as dications must be ordance with orders, including ne."	F 42			5/3/16
	by:	NT is not met as evidenced ion, interview and document		F428 R422 has been discharged		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	up on recommend reduction for 1 of 5 unnecessary medi Findings include: A Pharmacy Constindicated a recommend (an antimilligrams (mg) at Report was not ad R422's quarterly May 1/8/16, indicated himpairments, requidaily living and discare plan dated 1/psychotropic medianxiety, but did not A review of R422's 3/18/16, indicated mg by mouth at be During an interview R422 stated he preto 3:00 a.m. He sta 6:00 a.m. make a During an observa R422 was lying in eyes closed. He ap During an interview registered nurse (Frecommendations and then get distributed)	ting pharmacist failed to follow ations for a gradual dose for residents (R422) reviewed for cations. Ultation Report dated 10/1/15, mendation to decrease R422's depressant) dose to 7.5 bedtime. The Pharmacy dressed by the facility. Minimum Data Set dated	F 42	Current residents have the po affected by this alleged deficie Consultant pharmacist reports recommendations have been Unit managers have been eduregarding consultant pharmacist recommendations DON/Designee will audit consumentally Results of audit will be reviewed.	ent practice. addressed. ucated ist report ultant dations	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 428	p.m., RN-M stated, recommendation w stated she took car. A facility policy titled Gradual Drug Dose 2012 was reviewed of medications and be completed in co. and consultant pha 483.60(b), (d), (e) LABEL/STORE DR. The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological abeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment.	Int interview on 3/18/16, at 1:13 "the pharmacy as not followed up on." She e of it today. Id. Tapering Medication and Reduction, dated September I. The policy indicated tapering gradual dose reductions will insultation with the physician rmacist. DRUG RECORDS, RUGS & BIOLOGICALS Inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an ation; and determines that drug or and that an account of all maintained and periodically als used in the facility must be new with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in ints under proper temperature t only authorized personnel to	F 4:	28		5/3/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Druction Control Act of 1976 abuse, except when package drug distrit quantity stored is more readily detected. This REQUIREMENT by: Based on observative review, the facility for secured on 1 of 2 under the control of th	ovide separately locked, a compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the tinimal and a missing dose can . NT is not met as evidenced tion, interview, and document ailed to keep medications inits. ervation on 3/14/16, at 12:50 at across from room 607 was tocked. assistant passed medication ember passed the medication	F 43	,	otential to be ency. iits. on securing	
		3/21/16, at 11:09 a.m. the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	self-administration secure them in thei medication cart if the supervise it. The Dodished up on top of adequately secured	unit, unless the resident has a order and then they should r room. Staff should lock the ney are not able to adequately ON said medications that were the medication cart are not I if they are out of reach of the	F 4	31			
F 441 SS=D	,		F 4	41		5/3/16	
	Program under whi (1) Investigates, co in the facility; (2) Decides what proposed to should be applied to (3) Maintains a reco actions related to in	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections.					
	determines that a reprevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus	ion Control Program esident needs isolation to of infection, the facility must					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245183	B. WING		03/2	21/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	professional practic (c) Linens Personnel must hat transport linens so infection.	dicated by accepted	F 441				
	Based on observareview, the facility hygiene, glove usa implemented while residents (R35, R2 personal cares. Findings include: R35 was observed registered nurse (Fright hand without sanitizer. RN-G rearemoved left heel obrown drainage on to visualize the hee RN-G palpated the removed the right gloves. RN-G push and put R35's feet were touching the gloves, washed hare-entered room. Fright heel dressing dressing to right he RN-G applied left if	tion, interview and document failed to ensure proper hand ge and linen handling were providing care for 2 of 3 (82) observed for wound or (882) observed for wound or (883) observed for wound or (883) observed a glove to the washing hands or using ached across R35's legs and dressing. There was yellow and dressing. RN-G moved ankle el. R35's left heel was black. The left wound edges. RN-G then heel dressing without changing ned the right heel skin flap back down so R35's bare heels bed sheets. RN-G removed ands. At 9:23 a.m. RN-G RN-G put gloves on and applied then taped square foam cover seel. Without changing gloves neel dressing then taped of dressing to left heel.		F441 R35 has been discharged. Freceiving care consistent with prophygiene, glove usage, and linen hat Current residents have the potential affected by this alleged deficiency. Residents are receiving care consist with proper hand hygiene, glove us and linen handling. Nursing staff has been educated regarding hand hygiene, glove usage linen handling. DON/designee will audit 2 resident encounters per unit per week to en proper hand hygiene, glove usage linen handling. Results of audit will be reviewed by	er hand ndling. al to be stent age ge, and care sure and		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED			
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	at 11:44 a.m. RN-C change the dressin applied gloves, knowneels up device from the clean dressing chair. Nursing assistoward the wall and dressing change. Notice the clean dressing change. Notice the clean dressing change. Notice the coccyx wound. Cocs shaped with two owner of slough filled with cream cocyx wound. Cocs shaped with two owner of slough filled with cream cocyx wound. So the coccyx wound filled with cream cocyx wound with the cocyx was larger than the dressing to R35's of from R35's bottom gloves with an incontinence brief or removed dressing cleansed wound wound. NA-J did not before applying incomposed gloves, we gloves. RN-G said dressing change, I just remove one later the control of the change of the cha	age 126 Id care observation on 3/17/16, a said to R35 we need to ag on your bottom. RN-G selt on ground and removed the am under R35's legs. RN-G put a still in their package on a stant (NA)-J helped roll R35 d held R35 in place during the NA-J opened the incontinence own stool on the brief. RN-G from coccyx. RN-G applied gauze and cleansed the cocyx wound was irregularly vals connected by a narrow d skin. The two ovals were clored slough and the right oval a left oval. RN-G applied a pink coccyx. NA-J cleaned stool. NA-J then wiped stool off ontinence wipe. A clean was placed under R35. RN-G from left ischial tuberosity and ith wound cleanser. The wound stimately two centimeters in oplied a pink dressing to out wipe the front of peri-area continence product. NA-J ashed hands and applied new to NA-J, "usually when I do a wear two to three gloves so I yer at a time because after you is you cannot put the others	F 44	.1		
	verified saying "usu change, I wear two	n 3/17/16, at 11:55 a.m. RN-G ually when I do a dressing to three gloves so I just at a time because after you				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03.	/21/2016
_	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	on." RN-G said, "W do not wash my har sanitizer. I just was During interview on said I expect them hands after doing p change gloves and different wounds. Wever. During interview on assistant director of expect staff to wash treatment, explain wassesses for pain, expect after they retheir gloves and was contact with anythir on. ADON verified of gloves between wo any cross contamin need to wear multip time while doing cate are to wash their haremove gloves. Staff wash hands after distool. It is not accept off stool from glove R282's Minimum Didentified R282 required with toileting, dress hygiene. During an observation of sanitizers and sanitizers are greatly as a sanitizer.	s you cannot put the others then I do a dressing change I ands between gloves or use the my hands when I am done." 3/18/16, at 1:29 pm RN-E to change gloves and wash their care. I expect them to wash their hands between We should not double glove 3/18/16, at 2:10 p.m. the finursing (ADON) stated would in hands before they start what they are going to do, use the bed side table. I move the dressing to change ish hands if they came in ing before to put new gloves expected staff to change unds because would not want leation. ADON said there is no ble pairs of gloves at the same res. The ADON stated, "Staff ands or use sanitizer after they iff should remove gloves and oing pericare or cleaning up otable to take a wipe and wipe	F 4	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	incontinent of bower provided incontinent turn to the right side bowel movement we personal care with the care was provided applied a clean incompleted a clean incompleted and assisted NA-E then donned care to R282. NA-E movement and the did not wash hands. After providing perigloves and donned proceeded to assist completion of R282 NA-E stated to R282 the room (to put the R282 stated "there NA-E then threw R towel on the floor. NA-E called for add out of bed and into transfer was completed and into tra	rning cares. R282 was el. NA-E donned gloves to nt care. NA-E assisted R282 to e and began to clean R282's with wipes and then provided a washcloth and towel. After ded NA-E removed the gloves, continent product underneath R282 to lay flat on the bed. new gloves and provided peri e cleaned R282's bowel in provided perineal care. NA-E is between cares. neal cares, NA-E removed a new pair of gloves. NA-E it R282 with dressing. After 2's personal care and dressing, 22 that there were no bags in e dirty linen in for laundry) and is nothing unusual about that." 282's gown, washcloth and ditional help to transfer R282 the wheelchair. After the eted, NA-E brushed R282's 282 her toothbrush. NA-E then is and indicated that R282's	F 4-	41		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 465 SS=E	Hygiene dated April employee hands shafter assisting resid indicated handwash using soap and wat 483.70(h) SAFE/FUNCTIONAE ENVIRON The facility must pro	led Handwashing/Hand 2010, indicated that could be washed before and ents with toileting and hing should be completed er. AL/SANITARY/COMFORTABL Divide a safe, functional, ortable environment for	F 44		5/3/16
	by: Based on observat review, the facility for functional and sanit equipment was kep residents (R10, R19 R282, R329, R368) for environmental control facility did not ensu of 5 kitchenettes. T 130 of 293 resident the Bridgeway Sout kitchenettes. Findings include: On 3/18/16, at 8:00 environment tour w maintenance direct (DOH), maintenance the facility's administ	ions, interview, and document ailed to ensure a safe, ary environment, and resident it in good repair for 9 of 10 p, R77, R104, R118, R179, whose rooms were reviewed oncerns. In addition, the re a sanitary environment in 2 his had the potential to affect s who were served food out of h (BWS) and 2 West a.m. to 9:10 a.m. an as conducted with the or, director of housekeeping he staff (MS)-A, at 8:30 a.m. strator joined the tour, during ag environmental concerns		F465 Safe/functional sanitary environment Environmental concerns were addressed for R10, R19, R77, R104, R118, R1 R282, R329, and R368. Current residents who reside in the defined by the deficiency have the potential to be affected by the allege deficiency. Manufacturer guidelines reviewed form grab bar in room 222 R104 s wheelchair was cleaned. Bridgeway South kitchenette backs was repaired. 2 West kitchenette we cleaned. Bridgeway entrance carper replaced. All residents have the potential to be affected, rooms and bathrooms will cleaned daily. Staff will be re-educated on providing safe, functional, sanitary, and comfeenvironment.	79, rooms ed were 1. plash vas t was e be

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/:	21/2016	
	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 465	handle. When asked track and missing to director stated he was being off the track of Maintenance direct teles work order for maintenance electronic responsibility. The second (approximately 8 in on the wall in the rown on the wall in the rown of the was noted with dirt and grab bars on the bear tape on bilate was noted to be filt.	door off track and missing ed how long it has been off he handle, the maintenance was not aware of the closet and missing handle. For stated staff are to put in a rany items needing ronically. bed a large gauge ches by 4 inches) was noted from by the head of the bed. Strong foul/malodorous smell large stains on the carpet on y into room, a large spider web the foot of the bed, fan was dust build up, and bilateral ed were loose. Ir (w/c) was noted to have a ral arm rests and seat cushion hy with food debris. DOH was not a cleanable surface	F 46	Environmental audits and TEL be completed weekly. Audits reviewed by QAPI committee.			
	the bathroom had a garbage can in the filled with used inco-Room 338 the cal with 3 black/brown - Room 346 had a selection - 2 large black/brown	rpet was noted to be dirty/filthy stains on the carpet					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING _		03	3/21/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 465	stains in the hallwashampooed on Mocheck back after the R368's w/c brake noted to be loose, with food debris or cushion. Maintena brakes and arm reneeded to be fixed BWS - 6 dark stains on the BWS unit Room 312 had 2 no soap dispenser - Room 314- brown the head of the bewooden chair, the had black/brown cedges of the bathrokitchenettes During the follow-uz:10 p.m., the folloconfirmed by the desired the counter of the bridgeway Stoot kitchen counter the state of the state of the bridgeway Stoot kitchen counter the state of the state of the bridgeway Stoot kitchen counter the state of the state	It stated she was aware of the ay and the hallway was unday 3/14/16 but she did not be carpet was shampooed. It is and left arm rest on w/c was and w/c was noted to be filthy a both arm rests and on the nee director verified that w/c st were loose and stated they the carpet by the entry way to black stains on the carpet and in the bathroom. In colored stain on the wall by did, a large stain on the seat of bathroom floor was sticky and blored dirt buildup around the	F 40	65		
	was a four inch ballength of the count above the backsplamet the counter. A caulking behind the colored with dirt arbehind the clothing	cksplash behind the entire er which had white caulking ash and where the backsplash pproximately three feet of this e sink was brown/yellow of food buildup. The wall protector receptacle and two was splattered with food debris.				

245183 B. WING 03/2	1/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
- 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 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 wic cleaning and when asked how often wic were cleaned, DOH stated she was not aware how often the w/c were cleaned. DOH turther 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			03/	21/2016	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE	
F 465	Continued From pa	ge 133	F 4	65				
		p.m., the director of nursing er expectation is for resident n.						
F 520 SS=F	Cloth Furnishings F indicated that the fa furnishings shall be to the facility's clear - A routine maintena none provided - A general, residen	ance policy was requested but the equipment, resident room om cleaning policy was provided.	F 5	20			5/3/16	
	assurance committee nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the						
	committee meets a issues with respect and assurance active develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ments appropriate plans of entified quality deficiencies.						
	disclosure of the re- except insofar as su	retary may not require cords of such committee uch disclosure is related to the committee with the s section.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		245183	B. WING		03/2	21/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB			5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520		s by the committee to identify deficiencies will not be used as	F 520			
	by: Based on observareview, the facility of Assessment (QA) of developed action properties in accordance of the control of the	NT is not met as evidenced tion, interview and document ailed to ensure the Quality committee recognized and lans to address potential for ent who was consuming intoxicated, and posed a risk and other residents. In mmittee failed to develop an less an identified lack of essary to provide care and lance with their assessed needs lats (R439, R35, R62, R104, R286, R429, R494, R511, R4, deficient practices had II 294 residents residing in the		The facility has developed action providents consuming alcohol, producers, medication errors, and for providing adequate staffing. Current residents have the potential affected by the alleged deficiency. Facility staff and QAPI committee was re-educated on the QAPI action placorrect deficiencies. The NHA is responsible for compliant NHA will review QAPI reports mont ensure compliance.	essure al to be will be ans to	
	and services to pre ulcers for 1 of 4 res provide care results of pressure ulcers to failed to prevent de for 1 of 4 residents Refer to F323: the adequate supervisi resident (R104) wh	facility failed to provide care vent worsening of pressure sidents (R439). This failure to ed in actual harm, worsening for R439. In addition the facility velopment of pressure ulcers (R62). facility failed to ensure on while intoxicated for 1 of 1 o was known to consume he facility. In addition, the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	interventions to ens 7 of 15 residents (FR494, and R511) we facility. Refer to F333: the resident's (R4, R48 significant medicati transcription. This is and R481. R4 was activity and R481 strated 10/10. During an interview director of nursing ineffective process. She stated during the September of 2015 medication error reprocess improvement changed the procest improvement changed the procest in the nurses can initility errors get recorded was able to track the further stated she thand brings them to the While the process medication errors, transcription errors occurred for R4, and During an interview administrator statementhly to review a including infection of the statement	vide adequate supervision and sure safe smoking practices for R77, R242, R248, R286, R429, who currently smoked in the facility failed to ensure 3 of 3 st, and R57) were free from ion errors related to improper resulted in actual harm for R4 hospitalized related to seizure suffered "almost constant pain" on 3/18/16, at 8:37 a.m., the (DON) stated she identified an for medication error reporting, he months of August and is she did not receive any eports indicating an area for ent. She stated at that time she are from a paper system to a sem. The DON stated, any of ate a medication error and the dimmediately. She stated she he medication errors daily. She racked the errors on a report QA.	F 520			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245183	B. WING			03/2	21/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, 2 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 520	repositioning. The acommittee identified implemented a new program. He further currently working or stated pressure ulcon what comes in fit there was improven building and if they However, he stated particular process of implemented. While the facility ide improvement regard was no evidence of As a result actual hornous about R104's Program. The DON was R104 swinging a knexpect to be inform later stated that she a box cutter, not a knexpect to the informulater stated with identificated with identificated with identificated with identificated was intoxicated.	administrator stated the QA d staffing concerns and reformance based incentive restated the committee was a a pressure ulcer project. He ers are being tracked based rom outside the building, if ment, how many are in the are acquired in the facility. The did not know what changes had been entified a need for process ding pressure ulcers, there any recently revised systems. arm occurred for R439.	F 5	520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245183	B. WING	 	03/	21/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 520	'	age 137 was requested, but none	F 5	20			

DEPARTMENT OF H

19. DETERMINATION OF ELIGIBILITY

	AN SERVICES TARE/MEDICAID CERTIFICATION A - TO BE COMPLETED BY THE STA	AND TRANSMITTAL	ICARE & MEDICAID SERVICES ID: WK73 Facility ID: 00238
MEDICARE/MEDICAID PROVIDER NO.(L1) 245183 STATE VENDOR OR MEDICAID NO. (L2) 531716900	3. NAME AND ADDRESS OF FACILITY (L3) NORTH RIDGE HEALTH AND RE (L4) 5430 BOONE AVENUE NORTH (L5) NEW HOPE, MN	CHAB (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
 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2014 6. DATE OF SURVEY 7/22/2016 (L34) 	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD 02 SNF/NF/Dual 06 PRTF 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	8. Full Survey After Complaint
8. ACCREDITATION STATUS: (L10) 0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 11 ICF/III 04 SNF 08 OPT/SP 12 RHC		FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 320 (L18)	A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC B. Not in Compliance with Program	And/Or Approved Waivers Of 7 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code	_ 6. Scope of Services Limit _ 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF	Requirements and/or Applied Waivers: ICF IID	* Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)
320 (L37) (L38) (L39)	(L42) (L43)	(7) (7) (7) (7)	
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LTC CANCELLATION DATE):	I	
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Lou Anne Page. HFE NE II	8/1/2016 (L19)	Kamala Fiske-Downing, Hea	Ith Program Representative8/3/2016 (L

21. 1. Statement of Financial Solvency (HCFA-2572)

2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)

20. COMPLIANCE WITH CIVIL

RIGHTS ACT:

1. Facility is Eligible to	Participate	3. Both of the Above :			
2. Facility is not Eligib	(L21)				
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY	
05/01/1972			01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTION	NS	03-Risk of Involuntary Termination	OTHER	
	A. Suspension of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change	
(L27)	B. Rescind Suspension Date:	(L44)		00-Active	
		(L45)			
28. TERMINATION DATE:	29. INTERMEDI	IARY/CARRIER NO.	30. REMARKS		
	00270				
	(L28)	(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINA	ATION OF APPROVAL DATE			
	(L32)	(1.33)	DETERMINATION APPROVAL		



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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



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, Program Specialist

Licensing and Certification Program

Kumalu Fishe Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF RE	VISIT
	B. Wing		Y2	7/22/2016	Y3
NAME OF FACILITY NORTH RIDGE HEALTH AND F	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 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	DATE	ITEM	D	ATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix F0241	Correction	ID Prefix	Cor	rection	ID Prefix		Correction
Reg. # 483.15(a)	Completed	Reg. #	Cor	mpleted	Reg. #		Completed
LSC	06/20/2016	LSC			LSC		-
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix		Correction
Reg. #	Completed	Reg. #	Cor	mpleted	Reg. #		Completed
LSC		LSC			LSC		-
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix		Correction
Reg. #	Completed	Reg. #	Cor	mpleted	Reg. #		Completed
LSC		LSC			LSC		-
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix		Correction
Reg. #	Completed	Reg. #	Cor	mpleted	Reg. #		Completed
LSC		LSC			LSC		-
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix		Correction
Reg. #	Completed	Reg. #	Cor	mpleted	Reg. #		Completed
LSC		LSC			LSC		-
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURV	VEYOR		DATE	20/0040
	GD/kfd	8/1/2016	T.T. E	18	622		22/2016
CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY 3/21/2016	COMPLETED ON		R ANY UNCORRECTED CTED DEFICIENCIES (C			- A OU IT) (O	s 🗆 no

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	W K/3
Faci	lity ID: 00238

							•	
MEDICARE/MEDICAID PROVII NO.(L1) 245183	DER	3. NAME AND AL (L3) NORTH RII			4. TYPE OF ACT	<u></u>		
2. STATE VENDOR OR MEDICAII	O NO.	(L4) 5430 BOON	E AVENUE N	1. Initial 3. Termination	 Recertification CHOW 			
(L2) 531716900	(L5) NEW HOPE, MN			(L6) 55428	5. Validation 7. On-Site Visit	6. Complaint9. Other		
5. EFFECTIVE DATE CHANGE OF (L9) 01/01/2014	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Af		
6. DATE OF SURVEY 06 /28. ACCREDITATION STATUS:	14/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF D 15 ASC	FISCAL YEAR ENI	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATIO)N	10.THE FACILITY	' IS CERTIFIED	AS:				
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Require	ments:	
To (b):		_	equirements e Based On:		2. Technical Personne 3. 24 Hour RN	6. Scope of 7. Medical l		
12.Total Facility Beds	320 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI			
13.Total Certified Beds	320 (E16)	X B. Not in Con	npliance with Prog	gram	5. Life Safety Code	9. Beds/Roo	om	
		Requirements	and/or Applied V	Waivers:	* Code: B*	(L12)		
14. LTC CERTIFIED BED BREAKDO					15. FACILITY MEETS	(7.15)		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16 OTATE OLIDVEY A GENOV DEN	AADIZG ZE ADDI IGA	DIE GHOWLEG CA	NOTE LATION	DATE)				
10. STATE SURVET AGENCT REM	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Rebecca Wong. HFE N	EII	0	7/21/2016	(L19)	Kamala Fiske-Downing, He	alth Program Repre	sentative07/22/2016 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBI		20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 			
1. Facility is Eligible to	-				3. Both of the Abov	e:		
2. Facility is not Eligibl	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	B DATE	ENDING DA	TE	VOLUNTARY 0		UNTARY	
05/01/1972					01-Merger, Closure		o Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination		o Meet Agreement	
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	OTHER	ider Status Change	
(1.25)			(L44)			00-Activ	_	
(L27)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	D. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00270						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



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

North Ridge Health And Rehab June 29, 2016 Page 2

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 2702 Fax: (655)

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

North Ridge Health And Rehab June 29, 2016 Page 4

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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



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.

North Ridge Health And Rehab June 1, 2016 Page 2

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, Program Specialist Licensing and Certification Program

Kamala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 07/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED	
	245183		B. WING _	06	R 5/ 14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	714/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ΓS	{F 000)}	
	of this department of determine compliar issued during a reco 3/21/16. During th corrected that can be	was conducted by surveyors on June 13 - 14, 2016 to note with Federal deficiencies ertification survey exited on its visit, certification tags were be found on the CMS2567B. A g was issued that can be \$2567.			
	signature is not req				
F 241 SS=E	on-site revisit of you validate that substa regulations has bee your verification. 483.15(a) DIGNITY	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with	F 24	1	6/20/16
	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observat review, the facility fa dining experience fo R517, R425, R409) were dependent on	NT is not met as evidenced ion, interview and document ailed to provide a dignified or 4 of 4 residents (R150, who were tablemate's and staff assistance for eating.		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	

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

Electronically Signed

7/20/2016

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.

Facility ID: 00238

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			06/1	R I 4/2016
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	14/2010
					5430 BOONE AVENUE NORTH		
NORTH	RIDGE HEALTH AND	REHAB			NEW HOPE, MN 55428		
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES				N	2.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From page	age 1	F 2	41			
	Findings include:	ago :			executed as a means to continuous	cly	
	i indings include.				improve the quality of care, to com		
	R150 was observe	ed slapping her left leg			all applicable state and federal regi		
		ner left hand while sitting in her			requirements and constitutes the fa		
		lining room table on 6/13/16,			allegation of compliance.		
		until 8:46 a.m. Three other					
		1409, R425) and a family			R150's foot was removed from the	table.	
		ted at the table with R150.			Skin assessment was completed 6		
		pright in the wheelchair with			source of behavior. Communication		
		n front of her. R150			provided to the provider, pain asse		
		ed her left leg with both hands			was completed and the plan of care reviewed. Resident 150 also had h		
		apping both legs with both placed her foot on the table as			wheelchair tilted in a more upright		
		eg on the table. R517 was			when sitting by the table to ensure		
		eat by a family member at the			comfortable eating position and mo		
		led to slap at her legs and			appropriate positioning of her LE.		
		the table, placed her leg over			was also seated by the Aviary until		
		She then rubbed and hit her			prior to serving the meal. Resident		
	legs with both hand	ds and then continued to hit at			has since then expired. R425, R5		
	her right leg with h	er hand while pounding her			R409 are receiving a dignified dinir	ıg	
		family member (F-A) who was			experience.		
		table from R150 shook her					
		a nurse was administering			Residents in the front of Bridgeway		
		25, who was seated at the			dining room have the potential to b		
		50, however, the nurse did not			impacted. Ongoing audits to identi		
	communicate with	R150 or intervene in any way.			additional similar non-dignified dini	_	
	On 6/13/16 at 8:4'	3 a.m. F-A stated she came			behaviors have not revealed additional concerns with foot placement. Sho		
		orning meal and reported			other dining dignity concerns arise		
		unds her foot on the table			have been educated to appropriate		
		legs everyday, and nobody			intervene and manage potential be		
		ut it. She also takes other			to preserve a dignified dining exper		
	peoples food."				Residents experiencing behaviors	-	
					impacting the dignity of other will be	е	
On 6/13/16, at 8:45 a.m. an anonymous family member (F-B) stopped the surveyor and stated					reviewed in our weekly PAR meetir		
					ensure that appropriate intervention		
		nt on the unit daily for the			in place. The dining process has be		
		F-B reported R150, "She hits			altered to include a change in dinin		
	Llike that everyday	They never do nothing about			and a change in the way we provid	a maal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	СОМ	(X3) DATE SURVEY COMPLETED R		
		245183	B. WING			∺ 14/2016	
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 241	dated 11/12/15, ide severely impaired. assessment dated history of being occ wheelchair. R150's identified weight los loss due to cognitic increased needs. It assist with meals a sitting at the meal that drink to keep reside R517's facesheet in Alzheimer's diseas 3/7/16, and carepla physical assistance R425's facesheet in Alzheimer's diseas 6/1/15, indicated that assistance to eat. R409's facesheet in Alzheimer's diseas assessment dated 2/16/15, identified if with eating. On 6/15/16, at 11:4 nursing (ADON) verbeen a dignified dir would have expected she was making control of the resident's foot for confidential for the resident's foot for	ata Set (MDS) assessment entified R150's cognition was R150'S MDS care area 11/12/15 identified R150 had a casionally restless in her careplan dated 9/16/14 as with potential further weight on, and the possibility of interventions included "staff is needed; while resident is able, staff to offer food and ent occupied while waiting." Identified diagnoses including it. R517's the MDS dated in indicated that R517 required it with eating. Identified diagnoses of it. R425's careplan dated it eresident required staff it. R409's MDS care area 1/22/16, and careplan dated R409 required staff assistance. 8 a.m. the assistant director of rified the breakfast had not ning experience. The ADON it is a staff to reposition R150 if instant movement and remove	F 24	Staff have been re-educated of Quality of Life-Dignity policy wincludes possible sources of the Dementia and appropriate into manage those behaviors in a way. Audits were completed of and no other similar behaviors observed. DON/Designee will audit 2 me week in the front of Bridgeway dining room to ensure a dignific experience. Results of the audits will be regardled to the committee.	which pehaviors in perventions to dignified on the unit is have been eals per y South fied dining		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING			R / 14/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 241	policy or procedure "not my roleI don' The facility's 10/09, directed "Each resimanner that promo life, dignity, respect	s directed to intervene by the CRN responded, it was t direct them to do anything." Quality of LifeDignity policy dent shall be cared for in a tes and enhances quality of and individuality" The policy moting dignity at mealtime.	F 2	41			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245183 _{Y1}	B. Wing	Υ	′2	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).

ITE	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	F0157	Correction	ID Prefix	F0225	Correction	ID Prefix	F0226	Correction
Reg. #	483.10(b)(11)	Completed		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	-	483.25(h)	Completed	Reg. #	483.25(I)	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	-	483.25(n)	Completed	Reg. #	483.30(a)	Completed
LSC		05/03/2016	LSC		05/03/2016	LSC		05/03/2016
REVIEWS		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF			DATI	
REVIEWS	ED BY	GD/kfd REVIEWED BY (INITIALS)	7/22/2016 DATE	TITLE	;	30951	DATI	6/14/2016 =

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER A. Building B. Wing											Y2	DATE C		ISIT Y3
NAME OF NORTH			H AND F	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428								
program	, to show d and the numbe	v those e date r and t	e deficien such cor he identif	cies previously rective action v	reported ovas accom	on the (plished	CMS-256 . Each d	7, State eficienc	ment of Defici y should be fu	encies and Illy identifie	ry Improvement Plan of Correc d using either t In to the left of t	tion, that he regula	have bation or	LSC
ITEI	М			DATE	ITEM				DATE	ITEM			DATE	<u> </u>
Y4				Y5	Y4				Y5	Y4			Y5	
ID Prefix	F0371			Correction	ID Prefix	F0425			Correction	ID Prefix	F0428		Corre	ction
Reg. #	483.35(i)		Completed	Reg. #	483.60((a),(b)		Completed	Reg. #	483.60(c)		Comp	leted
LSC				05/03/2016	LSC				05/03/2016	LSC			05/03/2	
ID Prefix	F0431			Correction	ID Prefix	F0441			Correction	ID Prefix	F0465		Corre	ction
Reg. #	483.60(k	o), (d), ((e)	Completed	Reg. #	483.65			Completed	Reg. #	483.70(h)		Comp	leted
LSC				05/03/2016	LSC				05/03/2016	LSC			05/03/2	2016
ID Prefix	F0520			Correction										
Reg. #	483.75()(1)		Completed										
LSC				05/03/2016										
REVIEWE STATE AC			REVIEW (INITIAL		DATE		SIGNATU	IRE OF	SURVEYOR			DATE		
REVIEWE CMS RO	D BY		REVIEW (INITIAL		DATE		TITLE					DATE		
FOLLOW 3/21/201		SURVE	Y COMPL	ETED ON					CTED DEFICIEN ES (CMS-2567)		A SUMMARY OF HE FACILITY?	YE	s □	NO

POST-CERTIFICATION REVISIT REPORT

				_	
	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REVIS	SIT
	B. Wing	,	Y2	5/10/2016	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 q	ualified State surveyor for the Medicare,	Medicaid and/or Clinical Laboratory Improveme	ent /	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 NFPA 101	Correction	ID Prefix	NFPA 101	Correction	ID Prefix	 NFPA 101	Correction
Reg. # K0021	Completed 05/03/2016	Reg. # LSC K	(0066	Completed 05/03/2016	Reg. # LSC	K0146	Completed
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. # LSC		Completed	Reg. # LSC		Completed
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	_	Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC _			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC _			LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE		E OF SURVEYOR	7000	DATE	
REVIEWED BY CMS RO	TI /kfd REVIEWED BY (INITIALS)	6/29/2016 DATE	TITLE	·	37009	DATE	<u>10/2016</u>
FOLLOWUP TO SURVEY 3/16/2016			DRRECTED DEFICIENT IENCIES (CMS-2567)		UE EA OU IT\/O	res 🗆 no	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	WK/3
Faci	lity ID: 00238

MEDICARE/MEDICAID PROVID NO.(L1) 245183 STATE VENDOR OR MEDICAID (L2) 531716900		3. NAME AND AE (L3) NORTH RII (L4) 5430 BOON! (L5) NEW HOPE	OGE HEALTH E AVENUE NO	I AND RE	HAB (L6) 55428	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 01/01/2014 6. DATE OF SURVEY 03/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	1/2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATEGO 15 HHA 166 PRTF 17 X-Ray 18 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	320 (L18) 320 (L17)	X B. Not in Com	equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B *	6. Scope of Services Limit7. Medical Director
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 320 (L37) (L38) 16. STATE SURVEY AGENCY REM	19 SNF (L39)	ICF (L42) BLE SHOW LTC CA	IID (L43)	DATE):	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
05/02/2014					18. STATE SURVEY AGENCY Kamala Fiske-Downing, Hea	APPROVAL Date: alth Program Representative05/06/2016 (L20)
PAI 19. DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 2. Facility is not Eligible	ITY articipate	20. COM	BY HCFA RE IPLIANCE WITH ITS ACT:			ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 05/01/1972 (L24) 25. LTC EXTENSION DATE: (L27)	-	S DATE	4. LTC AGREEM ENDING DATE (L25) (L44) (L45)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety mement 06-Fail to Meet Agreement
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/		(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION	OF APPROVAL	LDATE (L33)	DETERMINATION APP	ROVAL



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:

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

North Ridge Health And Rehab April 7, 2016 Page 2

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

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

DEPARTMENT 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

North Ridge Health And Rehab April 7, 2016 Page 4

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

North Ridge Health And Rehab April 7, 2016 Page 5

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

Kumala Fiske Downing

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

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 000	INITIAL COMMENT	rs .	F 00	0		
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the form. Your electronic be used as verificated Upon receipt of an accommodate that substates accept the substate of your end of the substate of the s	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the				
	your verification. "A recertification su	rvey was conducted and tion(s) were also completed at dard survey."				
	completed. The cor	complaint, H5183122 was nplaint was substantiated. ed at F353, F282, F312 and				
	completed. The cor	complaint, H5183121 was nplaint was substanitated. ed at F353, and F312.				
		complaint, H5183110 was mplaint was not substantiated.				
F 157 SS=D	completed. The cor 483.10(b)(11) NOTI		F 15	7		5/3/16
	•	ediately inform the resident;				(/0) 2:==
-ABORATOR'	T DIRECTOR S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATUKE	TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245183	B. WING		03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	00.200
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F 157	known, notify the re or an interested far accident involving to injury and has the properties injury and has the properties injury and has the properties in	ident's physician; and if esident's legal representative mily member when there is an he resident which results in potential for requiring physician ificant change in the resident's resident's respectosocial status (i.e., a alth, mental, or psychosocial threatening conditions or each of the properties of the facility as specified in paragraph (b)(1) of the facility interview, and document the facility of the facility interview, and document the facility interview, and document the facility interview, and document do notify family of the facility interview, and document do notify family of the facility interview, and document do notify family of the facility interview, and document do notify family of the facility interview, and document do notify family of the facility interview, and document do notify family of the facility interview. The facility interview is an action, the facility interview interview, and document do notify family of the facility interview. The facility interview is an action, the facility interview interview interview.	F 157	Preparation, submission and implementation of thie plan of corredoes not constitute an admission of agreement with the facts and concluser forth in the statement of deficient of the facility has appealed the deficient of the statement of the deficient of the statement of the statement of deficient of the statement of the statem	f or usions ncies.

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F 157	7:05 a.m. until 9:55 observed: - 7:05 a.m. R35 was on back with mouth was elevated 45 deplace via nasal cares. 8:51 a.m. nursing room and spoke w R35 breakfast and cannula only in one get up today. This NA-J did not ask R repositioning befor tray. R35 remained at 7:05 a.m 9:08 a.m. registernebulizer machine nebulization chamber RN-G completed the land left without 9:23 a.m. RN-G of the other heel and repositioning R35. During interview or member (F)-A said she [R35] had gott she knew everythir sore on her bottom about blisters on hor controlled the facility provide F-A which indicated	continuously on 3/17/16, from 5 a.m. and the following was as observed sleeping lying flat in open. The head of the bed egrees. R35 had oxygen in innula. I assistant (NA)-J entered the ith R35. NA-J offered to get orange juice. R35's nasal enostril. R35 said "I hope I can thing behind my ear hurts." i35 about turning or eleaving room to get breakfast in same position as observed and applied mask with per attached to resident's face. The wound care to R35's left at repositioning R35 off bottom. It is a the room without and a the last three weeks en so bad. "Three weeks ago ng. They told me she had a bed not." F-A said, "No one told me er heels." I did a letter dated 3/22/16, from did "I was also aware of the her heels as the staff updated	F 1	and licensing violations stat This plan of correction is pre executed as a means to cor improve the quality of care, all applicable state and federequirements and constitute allegation of compliance. F 157 R35 family has been MD has been notified. Each resident who has a acresulting in injury with poten requiring physician intervent significant change in status, alter treatment significantly, to transfer or discharge, will and MD notification and is prelated to this alleged deficit Licensed staff have been re regarding notification of chat Don/designee will audit 2 re unit per week to ensure that has occurred. Results of audit will be revie	epared and/or ntinuously to comply with eral regulatory as the facilities notified. R305 ccident stial for tion, a a need to or a decision have family obtential at risk ency. Seeducated anges. Esidents per tinotification	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X A. BUILDING	X3) DATE SURVEY COMPLETED
245183 B. WING	03/21/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY	
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	

AND DUAN OF CODDECTION INDESTRUCTION NUMBER.		` ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03	/21/2016	
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F 157	On 3/17/16, at 8:30 aide (TMA)-A aske Keflex three times been given and it is During interview or said, "The order was the up to start at not a.m." RN-G verified given on 3/16/16. During interview or practitioner (NP) safifteenth and was the dying so I ordered saw her on the sixthaving difficulty broordered nebs, preceding in giving stat medically on 3/18/16, a list of medication dispensifacility on 3/18/16, a list of medication emergencies. Cepton the list. During interview or said, STAT meant was an issue with save start it in the event of the morning. If the morning. If the morning. If the morning. If the morning interview or said, STAT meant was an issue with save start it in the event of the morning. If the morning interview or said, STAT meant was an issue with save start it in the event of the morning. If the morning. If the morning interview or said, STAT meant was an issue with save start it in the event of the morning. If the morning interview or said, STAT meant was an issue with save start it in the event of the morning. If the morning interview or said, STAT meant was an issue with save start it in the event of the morning. If the morning interview or said, STAT meant was an issue with save start it in the event of the morning interview or said.	stat was given at 6:06 p.m. Dia.m. the trained medication of RN-G about R305's order for a day. TMA-A said "None has sont due until noon." Dia. 3/17/16, at 2:12 p.m. RN-G as inputted incorrectly. It was bon, so I corrected it to 9:00 of that Keflex had not been as Morphine (a narcotic). When I deenth she was up in her chair eathing but not dying, so I drisone and an antibiotic. The eath of the antibiotic and the eath of the antibiotic. Delays cations are not acceptable." Dia. 3/18/16, at 10:55 a.m. RN-H as soon as possible. "There is scheduling the medication. If ening she might not get all of was no supply of the antibiotic fer we order a medication from they can get it for us in four they can get it for us in four the state of the condensation of they can get it for us in four they can get it for us in four they can get it for us in four the state of the condensation o	F 15				

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245183	B. WING _		03/	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 157	emergency kit. On 3/18/16, at 12:0 said STAT meant no get the medications staff to notify the medications.	6 p.m. RN-E nurse manager ow. "Sometimes we cannot from the pharmacy. I expect edical doctor if they cannot	F 18	57			
F 225 SS=D	indicated, "Medicati safe and timely mar	cations Policy revised 2010, ions shall be administered in a nner, and as prescribed." (c)(2) - (4) PORT	F 22	25		5/3/16	
	been found guilty of mistreating resident had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry ties.					
	involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce	· ,					
	The facility must ha	ve evidence that all alleged					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 225	The results of all into the administrator representative and with State law (includentification agency incident, and if the appropriate correction. This REQUIREMENT by: Based on observative review, the facility for investigate an incidintoxicated resident threatening others with the state of the state	ughly investigated, and must ential abuse while the rogress. vestigations must be reported or his designated to other officials in accordance uding to the State survey and within 5 working days of the alleged violation is verified ve action must be taken. AT is not met as evidenced ion, interview and document alled to report and thoroughly ent involving 1 of 1 (R104) documented to be with a knife. Date dated 3/8/16, at 5:49 p.m. ported resident appeared ed a bottle of Volka [sic] mixed ing. Incidence reported	F 2	F225 R104 Behavioral episoreported and thoroughly invecurrent resident have the positive affected by this alleged deficing Alleged violations are thorough investigated and measures purevent potential abuse during investigation. Results of investigations are the administrator or his designed State agency within 5 working incident. Staff have been reeducated reporting and investigating. DON/designee will audit up to allegations per week. Results of audit will be review	stigated. tential to be iency. ghly out in place to ng the reported to gnee and the g days of the regarding o 2		

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
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F 225	min [minute] check (nursing assistant) found no liquorOh hour for the next 2 24 hours. Monitor for alcohol intoxicatinarcotics as neederesident about the Resident refused to re-approach and conterventions which checks hourly and room and room cheprohibited substant orders to hold narcand "Update MD Ploare plan did not id when R104's was atto do if R104 was for room or on him, if housume alcohol, ademonstrated while on how to handle a symptoms for R104 others were kept saconsumption. R104's care plan furthers were kept saconsumption.	/S [vital signs] and place on 15 for safety. Writer and NAR searched resident's room and to monitor VS q [every] 1 hours then check VS q shift x or s/sx [signs and symptoms] ons every shift and hold d. Education provided to consequences of drinking.	F 22	5				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING		· · · · · · · · · · · · · · · · · · ·	03/2	21/2016
	PROVIDER OR SUPPLIER			543	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428		
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F 225	should do if sharp R104's possessior of other residents. R104's significant indicated R104 dia failure, cirrhosis, a impairment. On 3/18/16 at 10:2 the 3/8/16 Progres alcohol use and systated she was nowould not be inforbeen drinking. RN-was identified as a immediate report y supervisor, assistand DON, and state the resident. RN-K from 3/8/16 was a reported, a full inversident in the ADON had been DON further stated any time of R104 sand would have exhad happened. The incident report con 3/8/16, and no rep DON also verified objects was a "hab identified on R104".	e plan did not identify what staff objects were observed in n, or how to ensure the safety change MDS dated 2/1/16, agnoses included hepatic (liver) and severe cognitive as Note regarding the resident's winging of a knife, and RN-K to aware of the incident, and amed every time R104 had and every time R104 had and the danger to self or others, an would be made to the ant director of nursing (ADON), as stated that the progress note "unique situation" but if it was estigation should be completed. As a.m., the DON was asked as Note dated 3/8/16, regarding a sumption and knife. The DON recall the incident, but stated en on-call that evening. The dishe'd never been informed at swinging a knife at other people appeted to be informed if that the DON confirmed there was no appleted for the incident of ort was made to the SA. The that having knifes or sharp bit" of R104 that had been	F 2	225			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X	,	SURVEY
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F 225	requested to discust documentation from surveyor. The DON inaccurate information because what RN-I The DON stated RI with a knife but chaby another staff me charted what the AI was asked to come to R104's intoxication a different floor and assist with R104's to R104 was intoxicated witness R104 threat stated that was who on the way down to denied that, and staff RN-H "got this infor LSW-B stated they R104 when he was the box cutter to the ADON and LSW-B residents were presidented ever seeing stated she locked to ADON and LSW-B the hospital after cophysician. The DON 3/8/16, at 17:49 p.m. "Hearsay" was chanot informed of the RN-H was re-educated and her expectation accurate informatic confirmed that had would have expected.	ker (LSW)-B and RN-H ss the Progress Note in 3/8/16, at 5:49 p.m. with the N stated RN-H had charted ition in R104's medical record H had been charted "hearsay." N-H never witnessed R104 inted what she had been told imber. RN-H then stated she'd DON had told her when she is to R104's floor to assist due on. RN-H had been working on it was asked to come and iransfer to the hospital as ed. RN-H stated she did not iten anyone with a knife and at she was told by the ADON in R104's floor. The ADON then inted she did not know where irmation." The ADON and obtained a box cutter from in his room and R104 handed in his room and R104 handed in without incident. The denied that any other staff or is ent at the time. LSW-B R104 threaten anyone and in the box cutter. RN-H, the stated R104 was not sent to ontacting hospice and the N again stated the charting on in. by RN-H was not accurate. In the DON stated ated about inaccurate charting in was staff was to chart in. The DON additionally this incident occurred she and the information to be ininistrator, law enforcement	F 2	225			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE		
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F 225	a.m. and stated she another floor and w come to R104's floor the emergency room RN-H stated on the ADON told her the into R104's progres had made an inacc chart on 3/8/16, at 8 ADON was now repconfirmed she wrot swinging at other potold her that informatentry was made. RI that she would have since her the ADON been the one to repnot follow up. RN-H R104's unit, R104 with they did not send RI An interview with they did not send RI An interview with they did not send RI The administrator since R104 was upset, had but denied R104 was asked about the 3/8 medical record, the charted in the progress told that evening. Hinaccurately and the type of behavior fro stated he expected	-	F 2	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING	····	03/2	21/2016	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB			5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225 F 226 SS=D	given direction from been a good idea for was written. When was not followed up provided further in administrator stated and erase what ware about making a conjudicated that policing R104 had a weapo and reports would be appropriate agency. A facility policy titled Agencies and Other 3/16 indicated: All swill be immediately Additionally, the portion of "verbal written or gestured disparaging and detention of the state	inistrator stated RN-H was a the ADON, and it would have or the ADON to review what asked why the progress note of and no information was the medical record, the did the facility "Can't go back is written" and was unsure rection. The administrator also is would have been called if in and was threatening people have been filed to the did Reporting Abuse to State in Entities/Individuals, dated suspected incidents of abuse reported to the stated agency. It is a sany use of oral, language that willfully includes rogatory terms to residents or in P/IMPLMENT, ETC POLICIES	F 225			5/3/16	
	review, the facility f	tion, interview and document ailed to ensure 1 of 1 t (R104) reported to be		F226 R104 Behavioral episode wareported to the state agency and administrator.	S		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING		 	03/2	21/2016
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 226	reported to the adragency (SA). Findings include: A facility policy titled dated 3/16, and incright to be free from policy titled Report management- Review report any suspect. The policy indicate "neglect" the failure services necessary Additionally, the podefinition of "verbawritten or gestured disparaging and detheir families. A fact Abuse to State Agentities/Individuals suspected incident reported to the SA R104's Progress Nidentified, "Staff redrunk and consum with Coke this eve around 5 pm. Hx [I abuseResident vother people. Knife was immediately president's speech leaning on the righ but was able to proindicated R104's highly sician were not serviced.	with a knife was immediately ministrator and the State d Abuse Prevention Program, dicated, residents have the mabuse and neglect. A facility ing Abuse to Facility ised 9/12, directed staff to ed abuse to the administrator. d the following definition: e to provide the goods and y to avoid physical harm. Dicy indicated under the I abuse" as any use of oral, I language that willfully includes erogatory terms to residents or cility policy titled Reporting encies and Other made and Other in dated 3/16, indicated: All its of abuse will be immediately included a bottle of Volka [sic] mixed ning. Incidence reported	F 2	226	Current residents have the potential affected by this alleged deficiency. Allegations of mistreatment, negled abuse of residents and misapproprio for resident is property will be immereported to the administrator and Stagency. Staff have been reeducated regard implementation of the abuse and repolicy and procedure. DON/designee will audit up to 2 allegations per week. Results of audit will be reviewed by	et, iation ediately tate ing eglect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03.	/21/2016	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	remove any alcohomonitor residents' vimin [minute] check (nursing assistant) found no liquorOhnour for the next 2 24 hours. Monitor for alcohol intoxicatinarcotics as neederesident about the Resident refused to re-approach and consuming alcohol, any behavious and room and room cheprohibited substant natively drinking was found to have if he was assessed alcohol, any behavious and room to ensure he and R104's care plan fur pressure ulcers and R104 was found to R104's care plan fur pressure ulcers and R104 has a pressure wheelchair. R104" w/c [wheelchair] culike scissors," R104 benefits," and R104	I found and continue to /S [vital signs] and place on 15 for safety. Writer and NAR searched resident's room and to monitor VS q [every] 1 hours then check VS q shift x or s/sx [signs and symptoms] ons every shift and hold d. Education provided to consequences of drinking. o cooperate at this time. Will	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03	/21/2016	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,,_	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	not identify R104's knives, what staff sobserved in R104's he and others were possession of share R104's significant of indicated R104 dia failure, cirrhosis, an impairment. On 3/18/16, at 10:2 (RN)-K was asked Note in R104's mewas not aware of the need to be informed been drinking. RN-was a danger to see report would be mand DON and staff resident. RN-K staff 3/8/16 referred to a reported a full investigation of R104 was a diameter of R104 see happened. The DON was asked at 3/8/16, at 5:4 she did not recall the on-call that evening at any time of R104 people but would ehappened. The DON was asked the incide knife. The DON ve sharp blade end, he aware of R104 swii one was threatener not verify who the unaware if any other was threatener of R104 swii one w	possession of sharp objects or should do if these items are s possession or how to ensure e kept safe if R104 had	F 22	26			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DENTIFICATION NUMBER: (X DILDING		(X3) DATE SURVEY COMPLETED				
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZII 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 226	incident of 3/8/16 a state agency (SA). having knifes or sha R104 and that was At 12:51 p.m. on 3/ licensed social worl requested to discus 3/8/16, at 5:49 p.m. The DON began to inaccurate informat for the Progress No The DON stated R1 with a knife but chaby another staff me charted what the AI was asked to come R104 was intoxicate on a different floor a assist with R104's t R104 was intoxicate witness R104 threa stated that was who on the way down to denied that, and star RN-H "got this infor LSW-B stated they R104 when he was the box cutter to the ADON and LSW-B residents were presidents were presidents were presidents were presidents after cophysician. The DON 3/8/16, at 17:49 p.m.	nt report completed for the nd no report was made to the The DON also stated that arp objects was a "habit" of identified on R104's care plan. 18/16, the DON, ADON, ker (LSW)-B and RN-H as the progress note written on	F 2	26			

			TE SURVEY MPLETED			
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH APPOSES REFERENCED TO THE APPOSES DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	RN-H was re-educe and her expectation accurate informatic confirmed that had would have expective reported to the admand the state agence. RN-H was interview a.m. and stated she another floor and woome to R104's floothe emergency rook RN-H stated on the ADON told her the into R104's progress had made an inaccuration 3/8/16, at ADON was now repositioned she wroth swinging at other propositioned she would have since her the ADON been the one to report follow up. RN-HR104's unit, R104 with the influence with the result of the influence and in the administrator is R104 was upset, he but denied R104 with the influence and in the influence R104 was upset, he but denied R104 with the influence R104 was upset, he but denied R104 with the influence R104 was upset, he but denied R104 with the influence R104 was upset, he but denied R104 with the influence R104 was upset, he but denied R104 with the influence R104 was upset, he but denied R104 with the influence R104 with the influence R104 was upset, he but denied R104 with the influence R104 with the infl	incident. The DON stated ated about inaccurate charting in was staff was to chart in. The DON additionally this incident occurred she add the information to be ininistrator, law enforcement	F 22	6		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	medical record, the charted in the progression told that evening. Hinaccurately and the type of behavior from stated he expected that was what occur informed. The admigiven direction from been a good idea for was written. When was not followed up provided further in the administrator stated and erase what was about making a cor indicated that police R104 had a weapon	administrator stated what was ress note was not what he was e stated the note was charted e nurse did not observe that m R104. The administrator staff to chart accurately and if rred that he should have been inistrator stated RN-H was a the ADON, and it would have or the ADON to review what asked why the progress note of and no information was the medical record, the did the facility "Can't go back is written" and was unsure rection. The administrator also be would have been called if and was threatening people have been filed to the	F 22	26		
F 250 SS=D	Agencies and Othe 3/16 indicated: All s will be immediately Additionally, the pol definition of "verbal written or gestured disparaging and de their families. 483.15(g)(1) PROV RELATED SOCIAL The facility must preservices to attain or	ovide medically-related social maintain the highest I, mental, and psychosocial	F 25	50		5/3/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, 5430 BOONE AVENUE NOW HOPE, MN 5542	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTIOI TIVE ACTION SHOULD CED TO THE APPROPI EFICIENCY)	BE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 18	F 2	50			
	by: Based on interview facility failed to iden appropriate interver utilization of interna of 1 resident (R104 related to alcohol in Findings include: R104's significant c dated 2/1/16, indica hepatic (liver) failure severe cognitive im R104's Progress Neidentified, "Staff repdrunk and consume with Coke this even around 5 pm. Hx [habuseResident wother people. Knife was immediately planesident's speech ileaning on the right but was able to projindicated R104's hophysician were noting. "Received order to remove any alcoholmonitor residents' Namin [minute] check (nursing assistant) if found no liquorOkhour for the next 2 limitation.	hations including the potential I and external resources for 1 with an identified concern toxication and aggression. hange Minimum Data Set ated R104 diagnoses included be, cirrhosis, and R104 had pairment. hated dated 3/8/16, at 5:49 p.m. corted resident appeared a bottle of Volka [sic] mixed ing. Incidence reported		F250 R104 is red social services indinternal and external appropriate. Current resident vabuse have the pothis alleged deficient ETOH use/abuse related social service internal and external and external esocial services including and external resocial worket to 2 residents per Results of audits value.	with a history of E otential to be afferency. Residents are receiving me vices including utiliternal resources are reeducated regically related socially utilization of interfurces. er/designee will a trunit, per week.	TOH cted by with dically lization as arding al rnal	

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 250	narcotics as neederesident about the Resident refused to re-approach and control R104's care plan do had a history of alcointerventions which checks hourly and room and room cheprohibited substant orders to hold narcand "Update MD Placare plan did not id when R104's was at to do if R104 was for room or on him, if had consume alcohol, ademonstrated while on how to handle a symptoms for R104 others were kept saconsuming alcohol. R104's care plan fur pressure ulcers and R104 has a pressure wheelchair. R104 "w/c [wheelchair] culike scissors," R104 benefits," and R104's knives, what staff sobserved in R104's sorved	ons every shift and hold d. Education provided to consequences of drinking. It cooperate at this time. Will ontinue to monitor." ated 10/2/15, identified R104 ohol use, and provided included, "Frequent safety PRN [as needed] of resident ecks hourly and PRN for ces," "MD [medical doctor] otic medications for lethargy," RN for substance abuse." The entify interventions to assist actively drinking alcohol, what bund to have alcohol in his ne was assessed to be safe to any behaviors R104 econsuming alcohol, direction my potential withdrawal afe if R104 was found to be arrived and identified an intervention that are reducing cushion in his prefers to hoard objects under shion including sharp objects at "is aware of the risks and a was "offered alternative and declined."The care plan did possession of sharp objects or hould do if these items are a possession or how to ensure the kept safe if R104 had	F 24	50		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 250	under the "Safety" scushion for liquor be and "frequent safet that R104 was "awafurther identified "Medications for lett for substance abus received." Additiona "monitor for use of registered] to report to have signs of imorders." The "Behat identified R104 "water increased anger, lathreatened by other someone, possess could be used as wwere not document record. A vulnerability asser R104. On 3/21/16, nursing (DON) statt do a specific VA [vulnerability VA]	rdex Report directed staff section to "check under w/c ottles with every pad change" y checks hourly and PRN" and are of the risks." The Kardex ID orders to hold narcotic hargy and updated MD PRN e. Psych [psychiatrist] orders ally, the Kardex included ETOH, NAR [nursing assistant to nurse. Nurse if observed pairment to ETOH, call MD for vior" section of the Kardex is at risk for harming others: bile mood or agitation, feels are or thoughts of harming ion of weapons or objects that reapons." The hourly checks ed anywhere in the medical ssment was requested for at 10:32 a.m. the director of ed "Our social workers don't illnerable adults] assessment	F2	50			
	VA." The DON furth	nts when they are admitted are ner stated the "asterisks rability on the care plan."					
	assistant (NA)-E re "had a big problem "behaviors when dr think, he thinks he and he gets an attit getting alcohol, I ha leave sometimes w the liquor store dow	7/16, at 7:45 a.m. with nursing vealed that "a while ago" R104 with drinking" and had inking, he likes to swear. I needs more help than he does ude. I'm not sure how he is even't heard lately. He used to when he had a power chair to wn the road. " At 11:25 a.m. iN)-I stated that she was					

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		245183	B. WING		0	3/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 250	time R104 had use weeks ago." R104 drunk." R104's phy order was obtained times and to monitor about R104 leaving signs out up front at to do that and he gracility." RN-I also so Mobility for transporand went to the bara.m. NA-F revealed he had been using "drank liquor last wis very aggressive NA-F was unable to R104's alcohol condicensed practical in "drinks all the time" revealed the physical as a pain reliever) obeen drinking. LPN seven months and LPN-B stated R104 her shift "for a coup be using alcohol "mulph-B further revesurprised" if R104 wover and sleeps on asked about the spender was directed to using alcohol, LPN-monitor-15 min chemicals.	age 21 cohol use and stated the last d alcohol was "maybe two had "gone out and come back sician was updated and an to hold medications at those or for intoxication. When asked the facility, RN-I stated "He at the desk sign out, he is able oes and sits out front of the stated R104 used Metro rtation, arranged his own rides and went shopping. At 9:34 d R104 refused help a lot when alcohol and noted R104 eek" and he "curses a lot and when he's been drinking." o provide a date and time to sumption. At 2:22 p.m. jurse (LPN)-B revealed R104 and "gets drunk." LPN-B stan ordered methadone (used cannot be given if R104 has and "been here this is an ongoing issue." I had been using alcohol on the months" and noted R104 to multiple times per week." aled that she "wouldn't be was "drunk" and he "just leans the armrest" of his w/c. When ecific interventions for R104 and how/where to document ed "I don't know, I would hope a treatment record] and to tion." When asked what else to do when R104 has been as replied "nothing, just ecks, he will usually pass out in N-B went on to say that if	F 2	250			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	or swearing" she we supervisor. LPN-B scall the hospital due asked where R104 stated "There's a lostore delivers close supervisor happenerand confiscated it be seen a visitor outsich him leave the facilit. On 3/18/16, at 8:37 aware of R104's drisince I have seen hwas done when R1 replied "usually" a rno pain medications or hospice was notiroom searches werdon't know of a rood drinking, that's just NA-G revealed R10 time" and would condrunk." NA-G would would take R104 bashe has not witness been a month now" and then managem 8:54 a.m. NA-H rev by staff in the dining drinking and smells last time that occurring and sago." NA-H st. R104 smelling of al him back to his roos sure where R104 grank it. NA-H states	ent, pushing, slapping, yelling buld call the charge nurse or stated she had never had to e to R104's alcohol use. When obtained alcohol LPN-B t of suspicions that one liquor by the front door and that one ed to be in the front area once efore it was open. I've never de of facility and never seen	F 2	50		

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F 250	went when he was a.m. licensed social she "sometimes che staff thinks he is into random checks if wonever found alcoholochecks are compledepends, nurses do "depends" on she sit depends on." LSV thought R104 left the Metro Mobility- not the Health Unit Coosigns out. He tells to long as he is signed asked if there was a resident could lead LSW-A responded assessment, and the assessment or requested assessment or requested and the room searches, social services" was the facility staff four facility in planters a R104's bottles. RN-to identify where or but he was "friends and the connected services" was the facility where or but he was "friends and the connected services" was the facility where or but he was "friends and the connected services" was the facility where or but he was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility staff four facility in planters a R104's bottles. RN-to identify where or but he was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends and the connected services" was the facility of the was "friends" of t	ge 23 and was unsure of where he off of the nursing unit. At 10:13 I worker (LSW)-A indicated ecks his room for alcohol if oxicated. We complete the suspect intoxication; I have I. "When asked how often the LSW stated it "just to it too" when asked what it tated she was "not sure what IV-A went on to say she he building and "goes out with with any supervision, he tells ordinator [HUC] and he usually the HUC or charge nurse, as dout he can leave." When an assessment to determine if the the facility unsupervised, that it was based off a nursing that she was not aware of any unirement for anyone to leave. The man asked about the facility's had "not received an answer and asked about the facility's had "not received an answer and R104's alcohol use, RN-K was interviewed and R104's alcohol use, RN-K was directed to complete these for alcohol, hold narcotics sident if he appeared asked who was responsible for RN-K replied that "typically is responsible. RN-K indicated the outside of the not indicated these were the stated staff was unable how R104 obtained alcohol with everyone" at the facility assisted living facility. When any interventions in place to	F2	250			

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	was encouraged to on the unit and that had been discussed was aware R104 of possession and preas steak knives, the R104's possession office. RN-K stated R104's care plan at multiple times abourisk for skin breakd his wheelchair cush. On 3/18/16 at 11:50 was aware of R104 where R104 obtains the facility staff was obtained his alcohol unsupervised and a transportation. The the alcohol himself store that delivered stated R104 had be discontinue drinking however that was mecord. The DON a sharp objects was a indicated on R104's asked about R104's asked about R104's at 5:49 p.m. and the recall the incident. nursing (ADON) was DON was not inform swinging a knife at to be informed if the	phol use, RN-K stated R104 participate in more activities a Alcoholics Anonymous (AA) do but declined by R104. RN-K sten had knives in his esented two knives described at she had removed from that she kept locked up in her the knives were identified on and R104 had been talked to but it. In addition, R104 was at own because R104 punctured anion with the sharp objects. Do a.m. the DON confirmed she is alcohol use. When asked ed alcohol, the DON indicated is unaware of where R104 old and R104 left the building	F 25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03.	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 25	f 2	250		
	At 12:51 p.m. on 3/licensed social wor	18/16, the DON, ADON, ker (LSW)-B and RN-H ss the progress note written on				
	inaccurate informate for the Progress No. The DON stated RI with a knife but chated by another staff metharted what the AI was asked to come R104 was intoxicated assist with R104's tangled R104 was intoxicated witness R104 threat stated that was who on the way down to	discuss RN-H charted ion in R104's medical record of as RN-H charted "hearsay." N-H never witnessed R104 red what she had been told omber. RN-H stated she DON had told her when she to R104's floor to assist, as ed. RN-H had been working and was asked to come and ransfer to the hospital as ed. RN-H stated she did not ten anyone with a knife and at she was told by the ADON R104's floor. The ADON then ated she did not know where				
	RN-H "got this infor LSW-B stated they R104 when he was the box cutter to the ADON and LSW-B residents were presidented ever seeing stated she locked and ADON and LSW-B the hospital after cophysician. The DON 3/8/16, at 17:49 p.m "Hearsay" was channot informed of the RN-H was re-educa and her expectation accurate information.	ated sne did not know where mation." The ADON and obtained a box cutter from in his room and R104 handed em without incident. The denied that any other staff or sent at the time. LSW-B R104 threaten anyone and up the box cutter. RN-H, the stated R104 was not sent to ontacting hospice and the N again stated the charting on in. by RN-H was not accurate. Ited and that was why she was incident. The DON stated ated about inaccurate charting in was staff was to chart in. The DON additionally this incident occurred she				

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 250	RN-H was interview a.m. and stated she another floor and w come to R104's floot the emergency roor RN-H stated on the ADON told her the into R104's progres had made an inaccochart on 3/8/16, at SADON was now repconfirmed she wrots swinging at other petold her that informatentry was made. RI that she would have since her the ADON been the one to repnot follow up. RN-H R104's unit, R104 w they did not send R There was no docu interaction with R104 had a signific consumption, aggres intoxicated, and createned in the removal of the known and consumption, aggres intoxicated, and createned in the safety on the safety was no indivito ensure the safety	ed the information to be inistrator, law enforcement	F 2	50		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	`	3) DATE SURVEY COMPLETED
	245183	B. WING		03/21/2016
	REHAB		430 BOONE AVENUE NORTH	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
A facility must use to develop, review comprehensive plate. The facility must deplan for each residobjectives and time medical, nursing, a needs that are idented assessment. The care plan must to be furnished to a highest practicable psychosocial well-by \$483.25; and any side required under a due to the resident \$483.10, including under \$483.10(b)(a). This REQUIREME by: Based on observative review, the facility of comprehensive plate residents (R511, R smokers. Findings include: R511 was observed outside smoking a	the results of the assessment and revise the resident's in of care. Evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive It describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided by exercise of rights under the right to refuse treatment and to develop a an of care (POC) for 2 of 7 429) who were identified as	F 279	F279 R511 and R429 have comprehensive care plans that includ 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 plant that include smoking. Licensed staff have been educated	d ns
A Progress Note da	ated 1/5/16, indicated R511		include smoking. Lead Social worker/designee will aud	it up
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE 483.20(d), 483.20(l COMPREHENSIVIA A facility must use to develop, review comprehensive plants objectives and times medical, nursing, an eeds that are idental assessment. The care plan must to be furnished to a highest practicable psychosocial well-by \$483.25; and any significant of the second of th	PROVIDER OR SUPPLIER RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	ROVIDER OR SUPPLIER 245183 245183 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, IM 55428 SUMMARY STATEMENT OF DEFICIENCIES (EACH OEDERICIENCY MUST DE PRECEDED BY PILL (REGULATORY OR LSC IDENTIFYING INFORMATION) 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 but are not provided due to the resident's exercise of rights 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: 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 until include smoking. Licensed staff have been educated regarding comprehensive care plans includes smoking.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		E SURVEY PLETED
		245183	B. WING		03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	and smoke." R511's significant or (MDS) dated 1/15/1 cognitively intact ar all activities of daily 2/5/16, did not addrown administrator stated agreement on administrator stated agreement on administrator stated agreement on smoke thable to smoke thable to smoke independent of nursing (have a smoking asstated he had not by who smoked. She sign a smoking agradmission. A Smoking assess 3/14/16, after the amotified of R511 sm. The assessment in reminders not to smoke significant in the smokes of the significant in the significant of the significant in the signi	hange Minimum Data Set 6, indicated he was de required staff assistance for living. R511's care plan dated less smoking. on 3/14/16, at 8:13 a.m., the diall residents sign an dission that they acknowledge a free. He stated if residents go ney have been identified as	F 279	to 2 smoking residents per unit p for comprehensive smoking care Results of audit will be reviewed	plans.	
	R511 stated he had prior to the previous did not know where	on 3/15/16, at 10:37 a.m., I not been outside to smoke is night. He further stated he he got the cigarette. R511 on admission if he wanted to eve to go outside.				

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		245183	B. WING		00	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	nursing assistant (NR511 smoked. She outside but did not phe was smoking. During an interview licensed practical nasked about smokindid not smoke. She him smoke but statin the common area During an interview AA-O stated R511 toutside and smoke. The remember if she him smoke if she him smoke if she him smoke but statin the common area During a subsequent p.m., the administratidentified smoking a student administration and determining whoutside to smoke. It on enjoy the weather the stated, "This is a While R511 was obwith his oxygen rundesire to smoke, the reminders regarding there was no evided updated to include a R429 was admitted diagnoses of repearmismanagement, tracities. R429 significant in the sizures.	on 3/15/16, at 2:03 p.m., IA)-T stated she was unsure if stated she knew he went pay attention to whether or not on 3/15/16, at 2:06 p.m., urse (LPN)-C stated R511 was ng on admission and stated he stated she had never seen ed he does spend his time out a by the front door. on 3/15/16, at 2:16 p.m., old her he wanted to go . She stated she "did not ad told anyone. Int interview on 3/15/16, at 3:23 ator stated the facility had as a concern. He stated the or had been completing audits hen residents are going the stated residents will outside a major concern for us." served smoking a cigarette ning, and had expressed a refacility assessed a need for g smoking with oxygen but noe R511's care plan was	F 2	79		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016	
-	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COL 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,,_	
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F 279	2/19/16, the assessivisual deficit, dexters smoking, can their and is any adaptive lacked any assessives, put out the the resident was sates, put out the the resident was sate and indicating facility was unable rules description. On 3/14/16, a smoth (after surveyor interesident chooses to smoking policy. The comply with no smown would be encouraged interventions were chooses and the set in the smoking in the median and the smoking in the median and the set in the set	sment asked cognitive loss, brity problem, frequency of esident light their own cigarette equipment needed. The form ment of the ability to handle cigarette, and did not state if afe to smoke or had limitations. Sing rules applied statement on of what that meant, the to provide community smoking king care plan was initiated rvention) and indicated or smoke despite facility no egoal will be encouraged to oking policy. The resident led to decrease smoking. To offer nicotine patch if R429 moking assessments quarterly, an identified care plan for dical record. I stated she had cigarettes and cket (jacket draped over w/c, ns), smokes down the road. Of a.m. observation of the TCU of than 75 cigarette butts on the There was a garbage with a did but with open sides, and a	F 2'	79			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 280 SS=D	and then go out to a assessments were themselves as smo assessment, nurses smoking. A new tas developed. We are and care planning." smoking at the mail entrance, but lacked receptacles to put to butts safely into. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive assessment as deter and, to the extent put the resident, the resident, the resident participate in plannic disciplines as deter and, to the extent put the resident, the resident and revised by a teach assessment.	intract agreeing not to smoke smoke anyway. The done on people who identify kers on admission is do assessment on safe sk force on smoking was still in the process of planning. The facility had residents in entrance and at the TCU down any safe smoking out cigarettes and put cigarette. O(k)(2) RIGHT TO NNING CARE-REVISE CP is right, unless adjudged erwise found to be in the laws of the State, to any care and treatment or down treatment. Are plan must be developed the completion of the diessment; prepared by an immore, that includes the attending red nurse with responsibility down the resident's needs, racticable, the participation of sident's family or the resident's expandically reviewed arm of qualified persons after	F 2			5/3/16
	This REQUIREMEN	NT is not met as evidenced				

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F 280	review, facility failed of 2 residents (R35 care required with ulcers and decline facility failed to rev of 5 residents (R10 currently using alcothe wheelchair (w/d). Findings include: R35 was observed 7:05 a.m. until 9:55 observed: - 7:05 a.m. R35 was on back with mouth was elevated 45 deplace via nasal cares:51 a.m. nursing room and spoke we R35 breakfast and cannula only in one get up today. This NA-J did not ask Frepositioning befor tray. R35 remained at 7:05 a.m 9:08 a.m. registernebulizer machine nebulization chamled RN-G completed the other heel and repositioning R35. mattress after the	ation, interview and document d to revise the care plans for 2 5, R62) to reflect changes in development of pressure in condition. In addition, the ise the plan of care (POC) for 1 04) who were identified to be chol and carried a knife under c) cushion. continuously on 3/17/16, from 5 a.m. and the following was as observed sleeping lying flat in open. The head of the bed egrees. R35 had oxygen in	F 280	F280 R35 is discharged. R62 ar have had their care plans revised reflect current status. Current resident with skin breakd who have a history of etoh abuse potential to be affected by this alledeficiency. Residents who have sulcerations or consume alcohol h reviewed and care plans revised appropriate. Licensed staff have been educate regarding care plan revisions for with skin alterations and residents consume alcohol. DON/designee will audit up to 2 reper unit per week to ensure approve revisions of care plan. Results of audit will be reviewed to a sulfative statement of the sulfa	own or have the eged skin ave been as ed residents s who esidents opriate	

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		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	not one offered to real The annual Minimu 2/5/16, indicated R3 Independence with required occasional maneuvering in bed bed to chair or walk assistance with dre R35 was incontiner had a history of falls identified as at risk pressure ulcers. R3 diagnosis of heart for vascular disease, and dysphagia (difficulty R35's Pressure Ulce (CAA) dated 2/12/1 pressure ulcers relableder, below nor with bed mobility. C	s being fed breakfast and still eposition her. m Data Set (MDS) dated 35 was modified decision making. R35 I assistance of one person in d and while transferring from sing with walker. R35 required ssing, toileting and hygiene. In of bowel and bladder. R35 is in the last 90 days and was for the development of 85's MDS indicated R35 had ailure, anemia, peripheral rthritis, dementia, and of swallowing). er Care Area Assessment 6, indicated R35 had risk for ated to being incontinent of mal weight, and needing assist AA also indicated skin was	F 2	280			
	had a ROHO cushion pressure on bottom	reakdown. CAA indicated R35 on (air filled cushion to reduce while sitting) in chair and erventions to minimize risk akdown,					
	was frequently inco assist with toileting, and incontinent pac would care plan into incontinence when for complications re	dated 2/12/16, indicated R35 ntinent of bladder and needed managing clothing, peri care I. R35's CAA indicated facility erventions to manage it occurs and reduce potential elated to incontinence.					
	Pressure ulcer care	plan dated 3/3/16, identified					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		E SURVEY IPLETED
		245183	B. WING		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 280	incontinence, Preduse-has chronic semuscle wasting. The diagnosis of periphright great toe beingedema, and history skin breakdown on reposition, end of listaff: "Creams/ointordered, encourage resident reluctant be with legs elevated a ROHO cushion in Mattress on bed. Concerns to license weekly on bath day per MD/NP orders. R35 as having skindid not address her The care plan did ristages of ulcers. The care plan did ristages of ulcers. The care plan difference on heels. On 2/29/16, the tree heels dry and offloaintact. The care plan on how to relieve pubed. The Visual Bedside 3/17/16, (after survistaff to encourage positioning, R35 "cabilateral grab bars."	_	F 28			

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		5430	ET ADDRESS, CITY, STATE, ZIP CODE BOONE AVENUE NORTH / HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	Continued From pa	age 35	F 2	80			
	and benefits was p In addition, staff we every two hours an and off load pressu However the sheet	o turn and reposition. The risks rovided to resident and family." ere to check and change R35 d as needed, Keep heels dry are while blisters are intact. lacked direction for the staff ressure on the heels while in					
	please don't move legs are hurting bar The note indicated encourage turning/ as resident allowed buttocks. The medi	ated 3/5/16, at 1:00 p.m. "Oh me. I'm hurting so much. My d. Don't make me turn please." staff were to continue to repositioning every two hours I to reduce pressure on ical record lacked any ving pressure on the heels.					
	RN-E and RN-J, RI Monday and today [R35] had three pre coccyx and two on [R35] had a new st posterior upper this new wound is found use risk assessme RN-E verified the contact the care plan until a	n 3/17/16, at 12:46 p.m. with N-E said "When I spoke to you to the best of my knowledge essure ulcers; one on her her heels. [RN-G] told me age three wound on left lateral ghs." RN-E said that when a d it is our facility protocol is to nt to document the wound. are plan did not indicate R35 re ulcers nor was hospice on after survey had started. RN-J cant change in condition in.					
	assistant director o nurses look at the s the process is the r documentation reg	n 3/18/16, at 2:10 p.m. the f nursing (ADON) said the skin weekly. The ADON said nurse manager enters arding wounds on the pressure r report. ADON stated, "I would					

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F 280	wound and alert nu supervisor, notify h and put it on the 24 pass it on in report R62's Weekly Skin indicated he had a buttock that was re interventions at tha complete weekly sk to avoid positioning further indicated R6 himself in bed, how assessment dated required extensive There was no evide assessments betweet which time, a facilit Report indicated a right buttock. R62's care plan data trisk for pressure with a pressure ulchistory of re-opening R62's care plan wano new interventior though R62 had de The care plan contencourage R62 to a even though his MI	rse manager and nursing ospice physician and family hour report. The nurse should including new open areas." Report dated 12/31/15, pressure ulcer on his right solved. The care planned t time directed staff to kin checks and encourage R62 on coccyx. The care plan 62 was able to reposition rever, his quarterly 11/27/15, indicated he assistance from two staff. Pence of weekly skin een 12/31/16 and 1/27/16, at y Weekly Skin Condition new pressure ulcer to R62's ted 1/14/16, indicated he was ulcers, admitted to the facility er on his coccyx and had a	F 28	30		
	had no cognitive im assist of two staff for	S dated 2/26/16, indicated he pairment, required extensive or bed mobility and transfers, pressure ulcer (Full thickness				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG			E SURVEY IPLETED
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CIT 5430 BOONE AVENUE NEW HOPE, MN 55	E NORTH	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	S PLAN OF CORRECTIO ECTIVE ACTION SHOULE ENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	skin loss with externecrosis, or damag supporting structure. Undermining and sassociated with State During an observat R62 was lying in betelevision. During of 7:22 a.m., 7:50 amin his room lying in During an interview nursing assistant (Nof R62's skin condition is an open area on stated, R62 had not he needed anything. During an interview licensed practical macouple of open are daily dressing changes high grab bar, she further go in and offer report However, there was interventions direct stated RN-M was resulted to the wound hopened up again or During an interview director of nursing of damages in the wound hopened up again or During an interview director of nursing of damages in the wound hopened up again or During an interview director of nursing of the wound in the woun	resive destruction, tissue be to muscle, bone, or es (e.g., tendon, joint capsule). Inus tracts also may be use 4 pressure ulcers). Sion on 3/16/16, at 3:06 p.m., ed on his back watching bservations on 3/17/16, at and 8:44 a.m., R62 remained bed. From 3/17/16, at 11:08 a.m., NA)-K stated she was unaware tion. She stated, "I think there his bottom." She further scheduled cares and stated if g he would put his light on. From 3/17/16, at 11:11 a.m., urse (LPN)-C stated, R62 has eas to his bottom and has ges. She stated during his he is able to hold on to the er stated staff are supposed to be sitioning every two hours. In some care planned ing staff to do that. LPN-C esponsible for the care plan. From 3/17/16, at 11:17 a.m., and then he moved to the unit. She and healed on 12/31/16, and		80			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	changed position in was able to offload. risk for pressure uld assistance for repoimplement interven pressure from R62' previous pressure ure-opened, the care new interventions to pressure ulcers or pulcers. R104's significant of dated 2/1/16, indicaincluded hepatic fair also revealed R104 impaired. R104's progress not identified, "Staff report of the drunk and consume with Coke this ever around 5pm. Hx [hi Resident was seen people. Knife was the consume with coke this was the consume people. Knife was the consume people. Knife was the consume with coke this ever around 5pm. Hx [hi Resident was seen people. Knife was the consume with coke this ever around 5pm. Hx [hi Resident was seen people. Knife was the consume with coke this ever around 5pm. Hx [hi Resident was seen people. Knife was the consume with coke this ever around 5pm. Hx [hi Resident was seen people. Knife was the complex com	ge 38 bed but was not sure if he While R62 was at increased cers and required staff sitioning, the facility did not tions to ensure offloading of s bottom. Further, while ulcers had healed and e plan was not revised with prevent worsening of existing prevention of new pressure change MDS assessment ated R104 had diagnoses that lure and cirrhosis. The MDS is cognition was severely the dated 3/8/16, at 5:49 p.m. ported resident appeared a bottle of Volka [sic] mixed and ing. Incidence reported story] of alcohol abuse swinging a knife at other aken away and resident was on 1:1 [one to one] for safety.	F 2		CY)	
	Resident's speech leaning on the right but was able to pro identified R104's ho doctor (MD) were n was obtained to see but none was found would, "Monitor for alcohol intoxication as needed." Further "Education provided consequences of d	is non-coherent. Resident was side of his W/C [wheelchair] pel himself." The note ospice agency and medical otified of the incident, an order arch R104's room for liquor, d, and staff identified they s/sx [signs and symptoms] of every shift and hold narcotics er, the note identified, d to resident about the rinking. Resident refused to me. Will re-approach and				

NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 39 F 280	TATEMENT OF D ND PLAN OF CC	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 39 F 280		03/21/2016
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 39 F 280		, , , , , , , , , , , , , , , , , , , ,
	PRÉFIX	ILD BE COMPLÉTION
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's possession or low to ensure he and others were kept safe if should of it 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.	R1 live cook hx of the above safe respective substants and vise the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		MPLETED
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	liquor bottles with e "frequent safety chi included "frequent of for prohibited subst "aware of the risks' " MD orders to hold lethargy and update abuse. Psych order Kardex included "m to report to nurse. I signs of impairmen " The "Behavior" so that R104 "was at m increased anger, la threatened by othe someone, possess could be used as w Information identifie the "Safety" section care plan. A vulnerability asse R104. On 03/21/20 stated that " Our so specific VA assessi when they are adm and stated that "assi vulnerability on the An interview with R revealed that RN-K progress note in R that she was not av she did not need to R104 had been drin that R104 often has then presented to t described as steak from R104's posse	"check under w/c cushion for very pad change" and ecks hourly and PRN" also room checks hourly and PRN ances" and that R104 was ". The Kardex further identified narcotic medications for ed MD PRN for substance is received. "Additionally, the nonitor for use of ETOH, NAR Nurse if observed to have to ETOH, call MD for orders. ection of the Kardex identified isk for harming others: bile mood or agitation, feels is or thoughts of harming ion of weapons or objects that reapons". ed on the Kardex Report under a was not identified on R104's sesment was requested for 16 at 10:32 a.m. the DON ocial workers don't do a ment because all residents itted are vulnerable adults" terisks denote some		30		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	3/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	on R104's care planknives) and R104 h times about it and is because R104 pund with the sharp edge. The DON confirmed R104's alcohol use obtains alcohol, the staff is unaware of alcohol and that R1 unsupervised and a transportation. The purchases alcohol of a liquor store that stated that having k "habit" of R104 and R104's care plan. An interview with the on 3/18/16 at 11:30 no assessment comwas able to leave the facility (on the seconable to leave the facility (on the seconable to leave the facility (on the seconable to leave the facility (on his care the nurses know whis safely. The DON stidentified on his care this was on R104's the care plan and p stage liver disease, impairment, hx of c ETOH. Often refuse the risks and benefiabnormal labs". Intersafety checks hourly substances. Reside orders to hold narce	n (regarding R104 having as been talked to multiple is at risk for skin breakdown ctures his wheelchair cushion is. If that she was aware of it when asked where R104 DON indicated that the facility where R104 obtains his 04 leaves the building	F 2	80			

		245183	B. WING _		03	/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CORRECTION (X5) ON SHOULD BE COMPLET HE APPROPRIATE DATE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	that may interest, 1 PRN". The DON i listed as interventic prudent nurse" wor using alcohol and v intoxicated at the fa that R104 has beed discontinue drinkin however this was r record. The DON fr checks should be o on R104's care pla (NA's) but that nurs well. The DON con be aware and follor confirmed that the policy. POLICY A policy entitled Ca dated November 2 comprehensive car assessment that in the MDS and physi residents are ongo as information abo condition change." that "each resident's co designed to: a. Incorporate iden b. Incorporate risk identified problems c. Build on the resid d. Reflect the resid regarding care and e. Reflect treatmen objectives in meas	evisit and remind of activities :1 visits and chaplain support indicated that with what was ons that "any reasonable and ald know that he is currently what to do if R104 was acility. The DON further stated in offered support to g such as AA meetings, not identified in R104's medical aurther indicated that room completed hourly (as identified in) by the nursing assistants ses could complete this as firmed that she expects staff to w R104's care plan. The DON facility did not have an alcohol are Plans-Comprehensive o12 indicated that "the re plan is based on a thorough cludes, but is not limited to, icians orders. Assessments of ing and care plans are revised aut the resident and resident's The policy further indicates imprehensive care plan is tified problem areas; factors associated with stified strengths; ent's expressed wishes I treatment goals if applicable; at goals, timetables and	F 28				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	21/2016	
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 282 SS=D	levels; g. Enhance the optiresident". A facility policy labe Comprehensive, da The Care Panning/responsible for the care plnas: when the change in the resid desired outcome is 483.20(k)(3)(ii) SEP PERSONS/PER CATTHE services provided by the serv	I status and/or functional mal functioning of the led Care Plans- ated November 2012, indicated interdisciplinary team is priodic review and updating of aere has bee a significant ents condition, and when the not met. RVICES BY QUALIFIED	F 2			5/3/16	
	This REQUIREMENT by: Based on observative review, the facility for (R439, R35) was recare plan; the facility hygiene care for 1 or (R35) who was deported according to facility failed to provimprove or maintain 1 resident (R179) at Findings include: Repositioning:	NT is not met as evidenced ion, interview and document ailed to ensure 2 of 3 residents epositioned as directed by the y failed to provide personal of 1 resident in the sample endent upon staff for personal the plan of care; and the vide ambulation assistance to a each resident's ability for 1 of ccording to the plan of care.		F282 R439 and R179 are receiv services by qualified persons per plan. R35 has been discharged. Current resident have the potenti affected by this alleged deficiency Residents are receiving services qualified persons per care plan in personal hygiene, turning and repositioning and ambulation ass Nursing staff have been educated regarding the provision of person hygiene, turning and repositioning ambulation assistance. DON/designee will audit will audit residents per unit per week to en	care al to be // by ncluding istance. d al g and		

-	OF DEFICIENCIES OF CORRECTION			` /	(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	extensive hospitalizand long term acute admission diagnosi included paraplegia sacral region Stage extensive destruction to muscle, bone, or tendon, joint capsultracts also may be a pressure ulcers), ty obesity, and major. The initial care plan R439 had pressure pressure ulcers deverocess, prolonged discussion on the culcers were or any dated 9/28/15, indicated will show signs of hinfection. The initial indicated, "Assess healing. Measure lepossible. Assess ar perimeter, wound b Report improvement of skin brelieving/reducing as per orders prior ensure comfort. Ed as to causes of skir transfer/positioning taking care during a nutrition and frequence. On 3/17/16, continua.m. until 8:00 a.m.	ations in acute care hospitals acare hospitals. 439's so from the Face Sheet a [functional], pressure ulcer of 4 (full thickness skin loss with on, tissue necrosis, or damage supporting structures (e.g., e). Undermining and sinus associated with Stage 4 pe II diabetes and morbid depression. In dated 9/28/15, indicated ulcers and potential for relopment related to disease immobility. There was no are plan of where the pressure stages listed. The initial goal cated R439's pressure ulcer ealing and remain free from interventions dated 9/28/15, strecord/monitor wound ength, width and depth where and document status of wound ed and healing progress. Its and declines to the MD. and family/caregivers of any eakdown. Pressure evice in bed/chair. Treat pain to treatments/turning etc. to ucate R439/family/caregivers of ambulating/mobility, good	F 2	282	appropriate provision of care by quersons. Results of audit will be reviewed by		

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	ΣE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD E	3E	(X5) COMPLETION DATE
F 282	and entered room fa.m. RN-B entered called R439 by name seconds of entering treatment cart garb stated she had entered get his blood sugar insulin. At 8:03 a.m. interviewed and state he night shift. At 8: that the resident had time of continuous resident had stated night. RN-N stated two hours. " On 3/18/16, at 9:08 and stated he had refrom North Memoria had been assessed department. When turned, R439 responsible 19:52 a.m. notified Rurned since 830 p. nurse had shown hinursing assistant can R439 refused to turcharting and stated There was no docu RN-N stated the aid when R439 refused document more that the resident should benefits of refusal cand benefits and reeach time he refuse notes lacked document more that the resident should benefits and reeach time he refuse notes lacked document.	red nurse (RN)-P, knocked or blood glucose test. At 7:08 room without knocking, then ie, she left the room within 15 and placed something in the age. At 11:16 a.m. RN-B ered his room the first time to and the second time to give resident R439 was ted he had not been turned on 05 a.m. RN-N was notified d not been turned during the observation, and that the he had not been turned all "He should be turned every" a.m. R439 was interviewed eturned to facility last night al Medical Center where he	F 2	282			

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	the orders for NA to care plan, I told nur " At 11:04 a.m. RN R439 who told him him at night." The facility was abl of NA charting for brepositioning which opportunities per shat total of 360 opportunities per	continue repositioning on the ses to document if he refused. I-N, stated he had interviewed "They [staff] do not reposition to to print out the last 30 days ed mobility, turning and revealed that out of four nift (12 opportunities per day), tunities there were 84 actual ollows: 6, 3/5/16, 3/8/16, 3/11/16, and hift NA did not document or turning and repositioning. 16, 3/4/16, 3/9/16, 3/10/16, A documented "NO" once, ositioning. 16, 3/9/16, 3/14/16, and arting indicated the resident eper shift, however there was enal benefits of refusal to turn ress Notes. 4 p.m. the director of nursing poke to the evening of frequently refused to be	F 2	82		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	· · ·		E SURVEY PLETED
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CIT 5430 BOONE AVENUE NEW HOPE, MN 55	E NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	was elevated 45 de place via nasal can - 8:51 a.m. nursing room and spoke wit R35 breakfast and cannula only in one get up today. This t NA-J did not ask R3 remained in same pa.m 9:08 a.m. register nebulizer machine anebulization chamb RN-G completed th not offer to check a - 9:23 a.m. RN-G cathe other heel and I repositioning R359:32 a.m. R35 was not one offered to recheck and change The annual Minimu 2/5/16, indicated R3 independence with required occasional maneuvering in bed bed to chair or walk assistance with dre R35 was incontiner had a history of falls identified as at risk pressure ulcers. R3 diagnosis of heart for vascular disease, a dysphagia (difficulty R35's Urinary CAA	grees. R35 had oxygen in nula. assistant (NA)-J entered the th R35. NA-J offered to get orange juice. R35's nasal nostril. R35 said "I hope I can hing behind my ear hurts." 35 about toileting needs. R35 osition as observed at 7:05 ed nurse (RN)-G started and applied mask with er attached to resident's face. e wound care to R35's and did nd change R35. ame to finish wound care on eft the room without a being fed breakfast and still eposition her nor did the staff her. Im Data Set (MDS) dated as was modified decision making. R35 I assistance of one person in and while transferring from thing with walker. R35 required ssing, toileting and hygiene. In the last 90 days and was for the development of 15's MDS indicated R35 had ailure, anemia, peripheral rthritis, dementia, and	F 2	82			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	assist with toileting and incontinent par would care plan intincontinence when for complications recomplications recomplicatio	I, managing clothing, peri care d. R35's CAA indicated facility reventions to manage it occurs and reduce potential elated to incontinence. 2/15/16, indicated R35 had a rance Deficit related to pain, congestive heart failure, pulmonary disease. Care plan 5/16, after the survey started to is currently enrolled on North Decline expected." The care written 3/15/16, instructed staff: d changed by staff every two 3/17/16, instructed staff to R35 every two hours and as als dry and off load pressure intact. 1 3/17/16, at 9:50 a.m. NA-J in [R35] after every two hours. I intence in the morning at the infit and then at the end of the faround 6:00 a.m. when I got had not offer to reposition or do R35 since 6:00 a.m. 1 3/17/16, at 9:52 a.m. RN-G rosed to be turned every two to tis the same for checking her	F 28	32		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	dressing change. I hours since he las During interview of said, "I expect there a resident in accordance to the accordance to the accordance to the During interview of assistant director of expect them to foll toileting care plan. Ambulation: R179's physical the note dated 7/31/15 therapy goals and with instructions for unit to ambulate R R179's care plan, R179 was to amburate walker and R179's Kardex (nusheet) dated 3/10/15 to meals with a frowalking device) and During observation R179 was observed At 11:07 a.m. staff into the dining room to ambulate R179 On 3/17/16, at 7:53 was observed to a NA-A applied a training room to a staff into the dining room to a staff into the dining room to ambulate R179	verified it had been over three to changed her." In 3/18/16, at 1:29 p.m. RN-E in to at least offer to reposition dance to her care plan. I check and change or toilet and he care plan." In 3/18/16, at 2:10 p.m. the of nursing (ADON) said "I would ow the check change or " It is a service to the property of the prop		32		

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 282	shower chair. At 9:00 the dining room for offers by staff to an room. When interviewed overified R179 was refurther stated it had R179 had walked to On 3/17/16, at 11:3 (RN)-A stated she was a walking program Kardex. After check verified R179 was the stated she had wor and had never seer further stated that Noresponsible for amb During interview on nurse manager RN R179 was responsi RN-E further stated to follow resident's refusals and report During interview on facility's director of expected staff to for resident refuses can urse and nurse to medical record. The facility's Rehabilitative nursing rehabilitative nursing record.	elf from the bed and onto a 20 a.m. R179 wheeled self to breakfast. There were no abulate R179 to the dining on 3/17/16, at 11:21 a.m. NA-A not walked to meals. NA-A been several weeks since to the dining room. 5 a.m. registered nurse was not aware if R179 was on and needed to check the king R179's Kardex, RN-A to be walked to meals. RN-A was evaluated to meals. RN-A was assigned to R179 was oulating R179. 3/18/16, at 11:13 a.m. unit -E stated NA assigned to ble for ambulating R179. I the expectation was for staff care plan, document any	F 2	82			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
	245183	B. WING		03/2	21/2016
	REHAB		5430 BOONE AVENUE NORTH		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
optimal level of self policy directed reha performed daily for services. 483.25(a)(2) TREA IMPROVE/MAINTA A resident is given to services to maintain specified in paragra. This REQUIREMENTA Based on observative, the facility for serview, the facility for serview, the facility for serview, the facility for serview, the facility for serview in the facility for serview. This physical the service in the facility for serview in the facility for serview in the facility for serview. Findings include: R179's physical the note dated 7/31/15, therapy goals and for with instructions for unit to ambulate R1. R179's care plan, la R179's care plan, la R179's care plan, la R179's care mount in the facility of the facil	care and independence. The bilitative nursing care to be residents who require such TMENT/SERVICES TO IN ADLS the appropriate treatment and nor improve his or her abilities uph (a)(1) of this section. In a not met as evidenced ion, interview and document ailed to provide ambulation we or maintain each resident's ident (R179) reviewed for ivities of daily living (ADL's). Tapy (PT) discharge therapy indicated R179 had met his per services were discontinued nursing rehabilitation on the resident at the total meals with a front dassist of one staff. The mum Data Set (MDS) dated R179 was diagnosed with cognitive impairment and		F311 R179 is has been reevaluated physical therapy and is receiving ambulation services per recommen Current resident receiving restorative ambulation programs have the potential be affected by this alleged deficient Appropriate residents are ambulated Nursing staff have been educated regarding ambulating residents. DON/designee will audit 2 residents unit per week to ensure appropriate residents ambulate.	dation. ve ential to by. ed.	5/3/16
	CONTINUED FOR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa optimal level of self policy directed reha performed daily for services. 483.25(a)(2) TREA' IMPROVE/MAINTA A resident is given the services to maintain specified in paragra This REQUIREMEN by: Based on observate review, the facility for assistance to improve ability for 1 of 1 resi ambulation with act Findings include: R179's physical the note dated 7/31/15, therapy goals and Fe with instructions for unit to ambulate R1 R179's care plan, la R179 was to ambul wheeled walker and R179's current Mini 1/29/16, indicated Fe dementia, had mild required one staff a transfers, dressing,	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 with activities of daily living (ADL's).	A. BUILDING 245183 B. WING ROVIDER OR SUPPLIER IDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	A BUILDING 245183 ROVIDER OR SUPPLIER 1DGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQULATION ON LISC IDENTIFYING INFORMATION) Continued From page 51 F 282 Continued From page 51 A BUILDING PREFIX PROVIDERS PLAN OF CORRECTION OF PROPERTIES OF PROPER	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOOME AVENUE NORTH NEW HOPE, MN 55428 SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 as a 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 oas 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, tolleting and ambulation.

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 311	one staff with ambu- R179's Kardex (nur- sheet) dated 3/10/1 to meals with a fror walking device) and During observations R179 was observed At 11:07 a.m. staff into the dining room to ambulate R179 t On 3/17/16, at 7:53 was observed to as NA-A applied a tran- and assisted R179 walker to transfer s shower chair. At 9:0 the dining room for offers by staff to an room. When interviewed overified R179 was r further stated it had R179 had walked to On 3/17/16, at 11:3 (RN)-A stated she wa a walking program Kardex. After check verified R179 was t stated she had wor and had never seen	R179 required assistance of ulation. rsing assistant assignment 6, indicated R179 was to walk at wheeled walker (an assistive d wheelchair to follow. s on 3/16/16, at 11:04 a.m. d to wheel self in the hallway. were observed to wheel R179 a. There were no offers by staff o the dining room. a.m. nursing assistant (NA)-A sist R179 with morning cares. asfer belt around R179's waist as he utilized a front wheeled elf from the bed and onto a 00 a.m. R179 wheeled self to breakfast. There were no abulate R179 to the dining and 3/17/16, at 11:21 a.m. NA-A been several weeks since of the dining room. 5 a.m. registered nurse was not aware if R179 was on and needed to check the king R179's Kardex, RN-A o be walked to meals. RN-A ked on the unit for six months an R179 walked to meals. RN-A lA assigned to R179 was	F 31				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING	 	03/2	1/2016
	PROVIDER OR SUPPLIER	REHAB	5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 311 F 312 SS=D	nurse manager RN R179 was respons RN-E further stated to follow resident's refusals and report During interview or facility's director of expected staff to for resident refuses canurse and nurse to medical record. The facility's Rehal revised 4/2007, increhabilitative nursin assist each resider optimal level of sel policy directed rehaperformed daily for services. 483.25(a)(3) ADL ODEPENDENT RESIDENT RE	in 3/18/16, at 11:13 a.m. the unit II-E stated the NA assigned to ible for ambulating R179. It the expectation was for staff care plan, document any it to the nurse. In 3/18/16, at 11:30 a.m. the nursing (DON) stated she ollow resident's care plan, if ares NA are to report to the indocument in the resident's care plan, if ares not are to report to the indocument in the resident's care plan, if are and in the resident's care plan, if are and in the resident's care point in the resident's care point in the resident in the facility's and care program is designed to not to achieve and maintain an and independence. The abilitative nursing care to be a residents who require such care provided in the provided in th	F 311			5/3/16
	by: Based on observa interview, the facili- hygiene care for 1	NT is not met as evidenced tion, interview and document ty failed to provide personal of 1 resident in the sample pendent upon staff for personal		F312 R35 has been discharged. Current residents who are incontine bowel and bladder have the potenti be affected by this alleged deficience.	al to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB	;	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 312	7:05 a.m. until 9:55 observed: - 7:05 a.m. R35 wa on back with mouth was elevated 45 deplace via nasal can - 8:51 a.m. nursing room and spoke wi R35 breakfast and cannula only in one get up today. This t NA-J did not ask R remained in same pa.m. - 9:08 a.m. register nebulizer machine nebulization chamb RN-G completed the not offer to check and repositioning R35. -9:23 a.m. RN-G completed the other heel and repositioning R35. -9:32 a.m. R35 was not one offered to recheck and change. The annual Minimum 2/5/16, indicated R3 independence with required occasional maneuvering in bed bed to chair or walk assistance with dread of the single part of the s	continuously on 3/17/16, from a.m. and the following was sobserved sleeping lying flat open. The head of the bed egrees. R35 had oxygen in nula. assistant (NA)-J entered the th R35. NA-J offered to get orange juice. R35's nasal nostril. R35 said "I hope I can thing behind my ear hurts." 35 about toileting needs. R35 position as observed at 7:05 and applied mask with per attached to resident's face. The wound care to R35's and did and change R35. The wound care on left the room without the being fed breakfast and still eposition her nor did the staff her.	F 312	Dependent residents who are in are receiving care. Nursing staff have been educat regarding the provision of inconfor dependent residents. DON or designee will audit 2 de residents per unit per week for provision of incontinent care. Results of audit will be reviewed.	ed itinent care ependent the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03	/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 312	identified as at risk pressure ulcers. R3 diagnosis of heart for vascular disease, at dysphagia (difficulty). R35's Urinary CAA was frequently incomposite assist with toileting and incontinent pact would care plan into incontinence when for complications recomplications	s in the last 90 days and was for the development of 85's MDS indicated R35 had ailure, anemia, peripheral rthritis, dementia, and v swallowing). dated 2/12/16, indicated R35 ntinent of bladder and needed managing clothing, peri care d. R35's CAA indicated facility erventions to manage it occurs and reduce potential elated to incontinence. 2/15/16, indicated R35 had a conce Deficit related to pain, congestive heart failure, pulmonary disease. Care plan 5/16, after the survey started is currently enrolled on North Decline expected." The care written 3/15/16, instructed staff: d changed by staff every two	F 31:	2			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 314 SS=G	During interview on stated "She is supphours. I think that it for incontinence even buring interview on said, "After you left and he went in and but did not have an dressing change. I hours since he last buring interview on said, "I expect them a resident in accordance to the buring interview on assistant director of expect them to do a cin accordance to the buring care plan." Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores.	3/17/16, at 9:52 a.m. RN-G osed to be turned every two is the same for checking her ery two hours." 3/17/16, at 11:55 a.m. RN-G the floor [NA-J] and I spoke changed her. She was wet y stool until we did the verified it had been over three changed her." 3/18/16, at 1:29 p.m. RN-E to at least offer to reposition dance to her care plan. I check and change or toilet and e care plan." 3/18/16, at 2:10 p.m. the foursing (ADON) said "I would ow the check change or toilet and the care plan." SYCS TO RESSURE SORES Archensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that lible; and a resident having gives necessary treatment and the healing, prevent infection and	F 3			5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	Based on observareview, the facility is monitoring and assisted deterioration of presidents (R439) resulted in actual hulcers. The failure resulted in actual hulcers deteriorated prevent developmeresidents (R35, R6) Findings include: R439 was interview and stated "The nig R439 stated he had nurse, and several to care for him. R439 was admitted extensive hospitalizand long term acut admission diagnos included paraplegia sacral region, Stag with extensive desidamage to muscle (e.g., tendon, joint sinus tracts also m pressure ulcers), ty obesity, and major. The admission Cardated 9/27/15, indistage IV pressure with exposed bone eschar may be preundermining and to	tion, interview and document failed to provide care including sessment, to prevent essure ulcers for 1 of 4 eviewed who had pressure to provide adequate care for R439 whose pressure. In addition the facility failed to ent of pressure ulcers for 2 of 4 2). In addition the facility failed to ent of pressure ulcers for 2 of 4 2). In addition the facility failed to ent of pressure ulcers for 2 of 4 2). In addition the facility failed to ent of pressure ulcers for 2 of 4 2). In addition the facility failed to ent of pressure ulcers for 2 of 4 2). In addition the facility failed to ent of pressure no longer allowed aides were no longer allowed at to the facility on 9/15/15, after exations in acute care hospitals e care hospitals. R439's is from the Face Sheet a [functional], pressure ulcer of e IV (full thickness skin loss truction, tissue necrosis, or bone, or supporting structures capsule). Undermining and ay be associated with Stage IV to the facility of the supporting and and the supporting and the sup	F 31	F314 R35 has been discharged. and R439 are receiving treatment services to prevent/heal pressure. Current residents with pressure urisk risk of pressure ulcers have a potential to be affected by this all deficiency. Residents are receiving treatment of pressure ulcers and prevention of pressure ulcers. Nursing staff have been educated regarding the prevention and treat pressure ulcers. DON/designee will audit 2 reside unit per week to ensure that care provided to treat pressure ulcers. Results of audit will be reviewed.	t and e sores. elcers or eleged eged eged ettment of ents per is or	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED					
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F 314	tissue loss. Subcuta bone, tendon or mumay be present but tissue loss. May incomply the present the present in the present the prese	aneous fat may be visible but uscle are not exposed. Slough does not obscure the depth of clude undermining and dright buttocks. The areas ng prolonged hospitalization all complications. A colostomy and Foley catheter (urine the bladder) was initiated exation as well as wound vactor management) to sure areas. A plastics [plastic b) was following R439 and was closure of the pressure ulcer of pressure ulcer to promote llow-up scheduled for 10/1/15. Collowing R439 while here and the Physician Progress ments and debridement since was and debridement since was and triggered as R439 had the past six months, which inificant, increased metabolic or pressure areas.	F3	314			
	pressure ulcer developrocess and prolon discussion on the culcers were or any dated 9/28/15, indicated show signs confection. The initial indicated staff were	ulcers and potential for elopment related to disease ged immobility. There was no are plan of where the pressure stages listed. The initial goal cated R439's pressure ulcer of healing and remain free from interventions dated 9/28/15, to assess/record/monitor by were to measure length,					
	width and depth wh document status of and healing progres	ere possible. assess and wound perimeter, wound bed ss. Staff were directed report declines to the MD. "Inform					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	area of skin breakd relieving/reducing of as per orders prior ensure comfort." Reprotein, amino acid ordered to promote educate R439/fami skin breakdown what transfer/positioning taking care during a nutrition and frequent the Physician Proggoing forward were followed: On 9/16/15, initial admission to facility management of Sapressure ulcer with (infection in the bor requiring tracheoste Chronic pain due to Fentanyl patch (extwith Dilaudid (oral pain. A colostomy a started to promote reports patient has since admission. Pastage IV which was and complicated he by a wound vac and Air mattress to assicontinue physical the therapy [OT]." On 9/17/15, VOHI specializes in wound note: "Consult requires."	mily/caregivers of any new own. Pressure levice in bed/chair. Treat pain to treatments/turning etc. to 439 required supplemental s, vitamins, minerals as wound healing. Staff were to ly/caregivers as to causes of ich included requirements; importance of ambulating /mobility, good		4		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 314	cm [centimeters] x serous exudate, 10 dressing negative p (wound vac). Stage ischium 4 cm x 4 cm serous exudate, thi necrotic tissue 90% Wound debrided visubcutaneous tissue tissue. Post debride Foam once daily, Sonce daily. Stage II ischium 4 cm x 5.5 serous exudate. The necrotic tissue 90% Wounds debrided visubcutaneous tissue. Post debride foam once daily, Sa Alginate (provide an infection, absorb exenvironment to prorous environment to prorous environment to prorous plastics tea appointment) sugge "Patient requested meals and mental higil.' Requested shodays, charge nurse around when more help. Sacrococcyge vac, left and right is major bones that mounds covered with assess. [R439] had	pressure ulcer of the sacrum 7 11.5 cm x 0.5 cm moderate 0% granulation tissue, pressure three times per week all pressure ulcer of the right m x 1.5 cm with moderate ck adherent devitalized as urgical excision and the removed along with necrotic ement depth 1.6 cm. Dressing antyl (helps clean wound) I pressure ulcer of the left cm x 2 cm with moderate tick adherent devitalized to, granulation tissue 10%. The pressure ulcer of the left cm x 2 cm with moderate tick adherent devitalized to, granulation tissue 10%. The pressing antyl once daily, Calcium the properties and maintain a moist mote rapid healing) once daily. The progress note: and on 9/17/15, (transported to the promised they will work staff would be available to the promised they will wor	F3	314			

- On 9/24/15, Wound specialist progress note:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 314	"Stage IV pressure x 1.5 cm moderate granulation tissue, of three times per wee generalized decline. Stage III pressure ux 5 cm x 0.5 cm with thick adherent devit granulation tissue 1 pressure ulcer of the with moderate sero devitalized necrotic 10%. Improved, decomplete of the with moderate sero devitalized necrotic 10%. Improved, decomplete of the with moderate sero devitalized necrotic 10%. Improved, decomplete of the with moderate sero devitalized necrotic 10%. Improved, decomplete of the sero devitalized necrotic 10% granulation tipressure three times change. Stage III prischium 5.0 cm x 4. decreased depth. Stage III prischium 4 x 6 x granulation." On 10/1/15, Plasti "[R439], last seen 1 was never made, uproviders at facility, substantially improve with no debris and uproviders at facility in the significant progress is chial tuberosity promment of the lac contributed to wors "When I saw him lace contributed to wors "When I saw him lace and his left si wound." "Now both both have necrotic stage."	ulcer of the sacrum 10 x 11.5 serous exudate, 100% dressing negative pressure ek (wound vac) deteriorated to of patient. Optimize nutrition. elcer of the right ischium 5 cm h moderate serous exudate, ralized necrotic tissue 90%, 0%. No change. Stage III e left ischium 4 x 6 x 0.6 cm us exudate. Thick adherent tissue 90%, granulation tissue	F3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB			ESS, CITY, STATE, ZIP CODE AVENUE NORTH MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULE -REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	is under the care of a wound-care nursifeel like the cares at to me." Lastly, "[Dr - On 10/1/15, Wound Surgery Clinic, Dr If the 4 page report with impression and - On 10/6/15, NH pwound/burn special appointment) for cowound dressing dirvisit. "Sacral wound wound vac. Nurse wounds were puttirit has some odor, indressing change to Sacrococcygeal wounds covered with assess. [R439] had and behavior was inchronic and nonher ischial stage 2 ulce involving epidermis superficial and presiblister, or shallow dexcessive purulent grade temperature weekend. Obtain winfection] prior to no culture next lab day - On 10/7/15, VOH off on R439.	ate manner to my opinion." "He f a wound care nurse, but how e can look at his wounds and are appropriate is not adequate F.] will see him today." Ind Clinic Initial Note of Plastic F: Requested, but page 3 of vas missing, which included I plan of care. Irogress note: seen by the list (transported to oncern for patient wound, ections were given during that did dressing continues with reported bilateral ischialing out excessive drainage and hurse had already completed day. Poor wound healing. Found connected to wound vac, I (the lowest of the three major of each half of the pelvis) ith dressings, unable to the anormal mood and affect, normal. Sacral ulcer stage IV, aling. Patient also had bilateral or [partial thickness skin loss of dermis, or both. The ulcer is seents clinically as an abrasion, erater] which is now draining malodorous drainage. Low and nausea over the round cultures [to look for ext dressing change and blood	F3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03	/21/2016
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F 314	unstageable ischia draining copious, n drainage few days which came back with klebsiella pneumor growth of enteroba bacteria] and heav Beta hemolytic (S. bacteria]. Poor woo house psych [psyc antidepressants ar with mixed growth, [antibiotic]. Continudaily per wound spon 10/15/15, NH the bilateral unstage draining copious modial draining co	d: progress note: "Bilateral I wound which was noted to be nalodorous greenish yellow ago. Wound culture collected with moderate growth of niae [bacteria], moderate cter aerogenes [gram negative y growth of streptococcus B Agalactiae) [gram positive und healing. Agrees to see in hologist] and increase nd pain control. Wound culture sensitive to tetracycline ue to change wound dressing	F 31	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP OF 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE
F 314	reposition. The quarterly Minim 12/15/15, indicated intact and had major due to pressure ulcombinate two with turning and resist cares. On 2/9/16, the care pressure ulcers we which directly confliperogress Notes and The care plan ident noncompliant with crecord lacked evided documentation for the care plan lacked direfuse cares, espect of his wounds. In active in the care plan lacked direfuse cares, espect of his wounds. In active in the care plan lacked direfuse cares, espect of his wounds. In active in the care plan lacked direfuse cares, espect of his wounds. In active in the care plan lacked direfuse cares, espect of his wounds. In active in the care plan lacked direfuse cares, espect of his wounds. In active in the care plan lacked directly i	num Data Set (MDS) dated R439 was fully cognitively or depression, was on bedrest ers, required assistance of direpositioning and did not plan was updated to state the re all stage IV on admission, acted with the Physician diadmission assessments. If ified R439 had been cares, however the medical	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 314	glucose test. At 7:0 without knocking, continuous the room within 15 a.m. R439 was intered all notified the resident the time of continuous resident stated he resident the time of continuous resident stated he resident stated "He shours." At 10:55 a.m. observation was not a.m. the assistant of stated the wounds resident the wounds resident the wounds resident the assistant of stated the wounds resident the wounds resident the stated the wounds resident the stated the wounds resident the stated she first saw wounds have decreased she first saw wounds have decreased she first saw wounds have decreased and continue to have magnetic resonance 3/14/16, to rule out tuberosities) and whe sent him to the resident the nurses of what on the nursing staff happening. The aid the nurses. At 11:30 change in ownership coming back, "You	ge 65 I and entered room for blood 8 RN-P entered the room alled R439's name, and left seconds of entering. At 8:03 rviewed and stated he "had night." At 8:05 a.m. RN-N was thad not been turned during bus observation, and the nad not been turned all night. Hould be turned every two may a pressure ulcer table to be obtained. At 11:00 director of nursing (ADON) have not changed in staging, rence between wound clinics. How had D-D and so maybe the difference, but RN-N assurements. RN-N stated they stages since he started in When interviewed at 11:16 she had entered R439's room for an and the second time to give may an anothe second time to give may anothe the second time to give may anothe the second time to give may anothe the second time to give may be the deep tunneling. An elemating (MRI) was done on osteomyelisitis (in the ischialmen the results arrived today hospital to receive intravenous atted the aides need to inform they see, because NP-B relied to inform her of what's es don't take direction from the p quality declined, but was have to have enough staff, re what they are doing." D-C	F3				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	ulcer care in the fac stated the wound h time she saw it, as "charge nurse", stadaily, and the facilit doctor measures astated there had be providers for the fac with a new wound of the MRI exam combilateral deep ulcer inferomeidal buttoo anteriorly along the tuberosities, conce (infection in the bor North Memorial Me (NMMC) emergence indicated the reside the evening of 3/17 indicated the osteonew concern as stated of 12.5 hours assistant (NA)-Q states this unit and didn't locare card on the doreposition every two repositioned 15-20 9:30 a.m. RN-N was he had not been turif he had reported to him yes	system breakdown in pressure cility. At 12:00 p.m. RN-N ad changed a lot since the last it was oozing a lot more. RN-P ted nursing does wound care y did wound rounds as the nd RN-P wrote it down. RN-P ten three different wound acility, they had just started doctor during the current week. In pleted 3/14/16, identified ative changes at the k soft tissue with extension medial aspect of both ischial rning for osteomyletitis ne) and he was admitted to dical Center for IV antibiotics. It was sent back to the facility 1/16, on oral antibiotics, and myelitis was chronic and not a	F 3	14		

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F 314	resident after the a reported. RN-N state had not asked about night shift. At 10:2 spoke to the even frequently refused to the night supervistated R439 "told night." At 2:04 p.m two hour turn and room, because he informed this morn had not been turned the nurse at home requested not to b p.m. R439 stated disturbed at night. refused to turn, be been sore. R439 coccurred on, but c times. R439 stated better."	f he had interviewed the allegation of neglect was ated he had talked to R439, but but being repositioned on the 4 a.m. the DON stated she ng supervisor and R439 to be turned at night, according risor. At 11:04 a.m. RN-N, me he was not being turned at . RN-N stated he put an every reposition sheet up in R439"s took it very seriously when ning, that R439 again stated he ed again last night. RN-N called , who told him R439 had e disturbed at night. At 2:10 ne had never asked to not be he may have occasionally cause his shoulders may have ould not say what shift that larified it was not very many directions.	F 31	4		
	R439's unit, until F announcement to to the facility. At 5: refused the midnig a.m. turn and got p 4:00 a.m. turn but at 6:00 a.m. LPN-I meds whenever he she would turn R4 who was working whallway (one of for now. At 5:30 a.m. and asked if the air	O a.m. no staff was observed in RN-T made a facility wide welcome the health department 11 a.m. LPN-H, stated R439 th turn, and accepted the 2:00 pain medicine, accepted the requested not to be awakened 1 stated R439 was offered pain 12's awakened. LPN-H, stated 139 again now, but stated aide with her was helping in the 800 ar hallways on the unit) right LPN-H called two other wings de was there with them, both 1:35 a.m. the director of nursing				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 314	LPN-H. At 5:42 a.m. turn R439, LPN-I s removed, he didn't and it's whatever n 6:53. a.m. LPN-I a you, we were looki was taking my breasked how many tinight, and she stat acknowledged she hallway to know whopportunity or not. there must be a lar R439's room right the DON was infor repositioning concressioning concressioning concressioning concressioning concressioning concression making, rof one person in matransferring from b walker. R35 require toileting and hygier bowel and bladder for the development R35's Pressure Ulc (CAA) dated 2/12/pressure ulcers relibladder, below nor with bed mobility. The R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a ROHO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO reduce pressure of turns and free R35 had a R0HO red	a39's unit and spoke with m. LPN-H and LPN-I offered to stated "he just wanted the pillow want to turn to the other side, nakes him comfortable". At sked NA-S "Hey where were ng for you". NA-S stated, "I ak." At 6:54 a.m. NA-Q was imes R439 was turned last led "hmm 3 or 4," however, had not been down the nether R439 turned the forth At 6:00 a.m. the DON stated nguage barrier, as RN-N was in away at 8:00 a.m. At that time med RN-N did not discuss the	F3	114		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 314	minimize risk factor The care plan revis a Self Care Perform weakness. The car one day after surve "resident is current! Hospice. Decline exinstructed staff to a two hours and as n and reposition using were to assist every preference. Family to turn and reposition provided to the resident of the resi	ed 2/15/16, indicated R35 had nance Deficit r/t pain and e plan was revised on 3/15/16, y entrance. It included y enrolled on North Memorial xpected." The care plan heck and change R35 every eeded (PRN). R35 could turn g bilateral grab bars. Two staff y two hours and PRN, per was aware of resident refused on. The risks and benefits was	F 31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 314	pressure. At 9:32 a breakfast and not be 11:44 a.m. RN-G in change the dressin R35 toward the wal the dressing chang incontinence brief. brief. RN-G remove (tailbone). RN-G apgauze and cleanse wound was irregula connected by a nar filled skin. The two colored slough and the left oval. RN-G R35's coccyx. NA-bottom. NA-J then incontinence wipe. placed under R35. from left ischial tub wound with wound circular and approx diameter. RN-G ap wound. NA-J did no before applying incremoved gloves, wigloves. RN-G said dressing change, I just remove one lay remove your gloves on."	m. R35 was being fed been offered repositioning. observation on 3/17/16, at formed R35 it was time to g on her bottom. NA-J rolled I and held her in place during e. NA-J opened the There was brown stool on the ed dressing from coccyx oplied wound cleanser to d the wound. The coccyx orly shaped with two ovals row strip of slough (unhealthy) ovals were filled with cream the right oval was larger than applied a pink dressing to I cleaned stool off gloves with an A clean incontinence brief was RN-G removed the dressing erosity (hip) and cleansed cleanser. The wound was imately two centimeters in plied a pink dressing to obt wipe the front of peri-area continence product. NA-J ashed hands and applied new to NA-J, "usually when I do a wear two to three gloves so I wer at a time because after you sayou cannot put the others." It 2/25/16, instructed staff to	F3	.14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		430 BOONE AVENUE NORTH		
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F 314	Only ." The NWSC heel blister measur and the blister was loss. Subcutaneous tendon or muscle a be present but doet tissue loss. May incurrent tunneling). However Advisory Panel (NF that "purple or mare discolored intact sk damage of underly and/or shear " shout tissue injury. The N blister was first obsindividualized intermattress/bed, were section of report insured the section of report insured the section of the section of the section of the staged as a stage I was first observed 2/25/16. A specialty were indicated as in section of report insured the section of the se	ds, Stage Pressure Wounds R indicated R35 had a Left ing 4 centimeter (cm) x 4 cm Stage III (Full thickness tissue is fat may be visible but bone, are not exposed. Slough may is not obscure the depth of clude undermining and interpretation of the National Pressure Ulcer PUAP) directs professionals con localized area of the nor blood-filled blister due to any soft tissue from pressure and be considered a deep and be considered a deep and with the normal such as specialty indicated the date the served was 2/25/16. No wentions such as specialty indentified. The comment is structed staff to "Keep heels sure while blisters intact in its interpretation on the report as we bed and wheelchair cushion interventions. The comment is structed staff to "Keep heels in the comment in the structed staff to "Keep heels in the comment in the structed staff to "Keep heels in the comment in the comment in the structed staff to "Keep heels in the comment in	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428		
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F 314	intact. The care plate on how to relieve plate on how the nurse yesterday R35 had morphine. The Prophad "new o/a [open stage 2 dark terminulcers that develop dying)" and blisters The NP note indicte R35 wanted comform on 2/10/16. The NWSCR dated left heel blister that and was still a stag wound bed was desyellow or gray necroindicated that the bountinue same treat now measured 4 crass a stage II pressure with a dark pink/redincluded a third worstage I pressure ulcorintact skin, the houlceration) on R35's cm that was first obbed was described reddened surround have pain from all to the pressure ulcer identified that "R35"	and heels while blisters were in lacked direction for the staff ressure on the heels while in gress Notes dated 3/1/16, and a practitioner (NP), indicated requested an increase in gress Note also indicated R35 area] bil [bilateral] Buttocks all Kennedy ulcers (pressure when a person is actively both heels has heels floated. And declining terminal condition, art care and declined hospice. If 3/3/16, indicated R35 had a now measured 5 cm x 6.4 cm are III pressure ulcer. The scribed as "slough -moist otic tissue." The report lister had deteriorated and to the timent. The right heel blister m x 4 cm and was described are ulcer that was unchanged a wound bed. The report and that was described as a cer (nonblanchable erythema eralding lesion of skin s coccyx measuring 5 cm x 4.8 pserved on 3/1/16. The wound as pink, pale tissue with ing skin. R35 was noted to	F3	3114			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	use- has chronic se spots on the skin commuscle wasting. The diagnosis of periphoright great toe being edema, and history skin breakdown on reposition, end of listaff: "Creams/ointrordered, encourage resident reluctant be with legs elevated a ROHO cushion in wattress on bed. Community [every] shift, observed to include the concerns to license weekly on bath day per MD/NP orders identified R35 as he buttocks, it did not Kennedy Ulcer. The location or stages on the concerns to include the concerns of the normal stages of the not revised to include the normal stages of the	nisone [a steroid medication] enile purpura [a rash of purple aused by internal bleeding essels] of both limbs and he resident also had a eral vascular disease with the g ischemic, lower extremity of ulceration .Resident with buttock r/t refusal to turn and fe ." The care plan instructed ments/tx [treatments] as eside to side positioning out encourage, encourage to sit as she allows, [R35] has a NC pressure reduction theck cushion inflation que skin daily with cares reported nurse, and skin check of by licensed nurse, treatments aving skin breakdown on the address the heel ulcers or encourage to reduce the licers. The care plan was de interventions to reduce heels.	Fí	314			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	Resident has been turned/ repositioned is currently being to barrier cream. Upd diagnosis of PVD a Resident is decline of time. Resident is Hospice. She refus asked staff to leave Kennedy ulcer Plar MD/NP. Care plan healing Notes: Resident in the move me. I'm hurting bad. Don't routinue to encour hours as resident a buttocks. Pre-mediturning. Updated not resident's new skin order to clean wour over o/a, change QCalazime treatmen areas." The medicinformation for relied the left heel blister that was now an unstage [full-tissue thicknessulcer is covered by therefore, the true of be estimated until the diagram was described Slough-moist yellow eschar-thick hard lesurrounding skin with comment sections.	declining and refusing to be d. Resident's skin on buttocks eated with topical Calazime ate /Progress: Resident has a nd abnormal posture. recently and stay in bed most recently admitted to North ed turn and reposition and her alone. NP diagnosis New orders received from updated. Will monitor for ident description: 'Oh please hurting so much. My legs are make me turn please.' age turning/ repositioning q2 llows to reduce pressure on cate 20-30 minutes before ursing supervisors and NP on condition. Received new nd and apply Allevyn dressing D [every day]. Continue t. Updated son about open al record lacked any eving pressure on the heels. I 3/10/16, indicated R35 had a measured 5 cm. x 5.3 cm and eable pressure ulcer s loss in which the base of the slough or an eschar and, depth of the damage cannot hese are removed]. Wound as pink, pale tissue, we or grey necrotic tissue and	F 31	4		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 314	mattress, positioning for repositioning. Of this time." The right x 4.5 cm and was a pressure ulcer. The both pink, pale tiss or grey necrotic tis reddened. A nutritical intervention. The now described as of 6.8 cm x 5.5 cm described as both slough-moist yellow the surrounding sk section indicated, repositioned q [evenoted to have pain A NWSE dated 3/1 intact with no open right heal as healing R35. The left heel keep repositioning described as healing had refused to cool during the day shift. The Visual Bedsid 3/17/16, 2 days fol investigation, instruallow side to side preposition using bil two every 2 hours. Family is aware of reposition. The risk resident and family check and change	geable. Resident has an air ng device and is on a schedule continue with current orders at the heel blister measured 5.3 cm described as a stage III e wound bed was described as use and as slough-moist yellow sue with the surrounding skin onal supplement was added as the coccyx pressure ulcer was a stage II with measurements a x 0.3 cm. The wound bed was pink, pale tissue and as a or grey necrotic tissue with in reddened. The comment 'Resident is comfortable, ery] 2 hrs [hours]." R35 was with all three wounds. 1/16, indicated R35's skin was a areas. It went on to describe and to keep repositioning with healing area noted and to R35, and the coccyx was ng. R35 was repositioned but aperate with repositioning	F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	while blisters are in lacked direction for pressure on the he During interview or stated, "I am to turn check her for incombeginning of the sh shift. I turned her a here ." NA-J verifie reposition or incomburing interview or stated, "I don't have residents unless ar During interview or stated "She is supphours. The orders expect them to offer hours. I think that it for incontinence evenumember (F)-A said she had significant had a bed sore on one told me about During interview or said, "I brought two not know how big it two wounds. I was wounds. The new wounds. The new wounds. The new wounds as tage III based or covered with yellow you left the floor [N	attact. However the sheet the staff on how to relieve els while in bed. 1 3/17/16, at 9:50 a.m. NA-J in [R35] after every two hours. I attinence in the morning at the lift and then at the end of the around 6:00 a.m. when I got d R35 had not been offered to tinence care since 6:00 a.m. 1 3/17/16, at 9:51 a.m. NA-A is her. I only take care of my nother aide asks me for help." 1 3/17/16, at 9:52 a.m. RN-G posed to be turned every two say as resident allows. I would it is the same for checking her	F 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428		
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F 314	verified it had been changed her ." During interview or RN-E and RN-J, Ri Monday and today [R35] had three precoccyx and two on [R35] had a new st posterior upper this wound was found if the risk assessmer RN-J stated the on weekly unless they nurses noticed the wound which started sometimes R35 we because of pain and was at a higher risk repositioning her. If started as a clear fifthe 2/26/16, there were redness on R35's worder for Calazime staff first noted the verified the note did staff measured it at the care plan did noulcers nor was hos survey entrance and RN-J stated R35's happened 3/16. During interview or director of nurses (condition started or comfort care and or care and	I we did the dressing change. I over three hours since he last a 3/17/16, at 12:46 p.m. with N-E said "When I spoke to you to the best of my knowledge essure ulcers; one on her her heels. [RN-G] told me age three wound on left lateral ghs." RN-E stated when a new to was facility protocol to use into document the wound. It charting on wounds was had a specific order. The heels first then the coccyx and as a blister. RN- J said ould refuse to be repositioned and with appetite changing, R35	F3	114			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		5430	EET ADDRESS, CITY, STATE, ZIP CODE O BOONE AVENUE NORTH W HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	refused but on 3/2/s be re-approached as During interview on said the heels had a components. The N wound is a Kenned expected to heal. Treposition her at least changing her every orders to allow premarks and in accordance to the During interview on asid, "I expect them a resident in accordance to the During interview on assistant director of nurses looked at the process was for documentation regapressure/non press stated, "I would expfinding a new woun and nursing supervand family and put in nurse should pass if open areas." R62's quarterly MD required extensive acares. R62's Weekly Skin	3/18/16, at 10:04 a.m. the NP vascular and pressure IP stated, "[R35's] coccyx y terminal ulcer and is not hey should be offering to ast every two hours and two hours. They do have medication before turning." 3/18/16 at 1:29 p.m. RN-E to at least offer to reposition lance to her care plan. I check and change or toilet and e care plan." 3/18/16, at 2:10 p.m. the finursing (ADON) said the e skin weekly. The ADON said the nurse manager to enter arding wounds on the ure ulcer report. The ADON sect to a nurse to document d and alert the nurse manager isor, notify hospice physician it on the 24 hour report. The ton in report including new S dated 11/27/15, indicated he assistance from two staff for Report dated 12/31/15, pressure ulcer on his right	F 3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	at risk for pressure with a pressure ulchistory of re-opening planned intervention complete weekly slate avoid positioning further indicated Richimself in bed. How what the MDS date. There was no evide assessments betweet which time, a facilit Report indicated a right buttock. The plant as unstageable, may pressure ulcer was 2/4/16, A Weekly Sa pressure ulcer toom x 4.7 cm x 0.8 cm was assessed by wound physicians. Evaluation on that pressure ulcer to the cm x 3.0 cm x 1.4 cm indicated a healed or pressure exerted layers of the skin) opering present for greater wound was not not assessments. R62 2/9/16, however, no implemented even new pressure ulcer direct staff to encounting the pressure ulcer direct staff to encounting coccyx even the	ted 1/14/16, indicated he was ulcers, admitted to the facility er on his coccyx and had a ng pressure ulcers. The care ins at that time directed staff to kin checks and encourage R62 g on coccyx. The care plan 62 was able to reposition vever, that contraindicated	F 31	4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COMPLETED	
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 80	F 31	4		
	R62 was cognitivel	S dated 2/26/16, indicated y intact, required extensive or bed mobility and transfers, pressure ulcer.				
	lying in bed on his l During observation	6/16, at 3:06 p.m., R62 was back watching television. s on 3/17/16, at 7:22 a.m., a.m., R62 remained in his				
	NA-K stated she was condition. She state area on his bottom	on 3/17/16, at 11:08 a.m., as unaware of R62's skin ed, "I think there is an open ." She further stated, R62 had as and stated if he needs this light on.				
	licensed practical r a couple of open and daily dressing char dressing changes h grab bar. LPN-C fu	on 3/17/16, at 11:11 a.m., nurse (LPN)-C stated, R62 had reas to his bottom and has ages. She stated during his ne was able to hold on to the orther stated staff was and offer repositioning every				
	RN-M stated, R62 when he moved to	on 3/17/16, at 11:17 a.m., had a stage IV pressure ulcer the unit. She stated the wound 31/15, and opened up again on				
	DON stated, R62 "himself." She state	on 3/17/16, at 3:07 p.m., the is pretty good at repositioning d he changed position in bed he was able to offload (relieve				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/:	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 314	ulcers and required repositioning, the far interventions to ensigned from R62's bottom. pressure ulcers had new individualized in implemented to pre	ncreased risk for pressure staff assistance for cility did not implement ure offloading of pressure Further, while previous I healed and re-opened, no	F 3 ⁻	4			
F 323 SS=E	A facility policy titled Guidelines dated 5/purpose was to pro care of existing pre prevention of additional policy directed staff resident and the preloads, education and 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remain as is possible; and		F 32	23		5/3/16	
	by: Based on observat review, the facility for supervision while in	NT is not met as evidenced ion, interview, and document ailed to ensure adequate toxicated for 1 of 1 resident own to consume alcohol		F323 R104 is receiving adequate supervision related to ETOH consumption. R 77, R 286 and R41 have been discharged. R242, R24			

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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, Z 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•		
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F 323	to provide adequate to ensure safe smore residents (R77, R2 R511) who current! Findings include: Substance abuse: R104's care plan do had a history of alcointerventions which checks hourly and room and room cheprohibited substance and "Update MD P care plan did not iccusing alcohol, what attempt if R104 was room or on him, if I consume alcohol, ademonstrated while on how to handle asymptoms for R10 others were kept sconsuming alcohol R104's significant of (MDS) dated 2/1/16 included hepatic facirrhosis, and R104 impairment. A Wandering and E 2/4/16, indicated un R104 was not alert place, time, situation	ity. In addition, the facility failed e supervision and interventions being practices for 7 of 15 42, R248, R286, R429, R494, ly smoked in the facility. atted 10/2/15, identified R104 tohol use, and provided in included, "Frequent safety PRN [as needed] of resident ecks hourly and PRN for ces," "MD [medical doctor] totic medications for lethargy," RN for substance abuse." The lentify if R104's was currently to interventions staff should as found to have alcohol in his ne was assessed to be safe to any behaviors R104 econsuming alcohol, direction any potential withdrawal 4, or how to ensure he and afe if R104 was found to be	F3	R429, R104, and R511 a supervision per smoking recommendations. Current residents with a abuse and/or smoking w the community have the affected by this alleged of Residents requiring super ETOH or smoking are reappropriate supervision. Staff have been educate supervision of residents was ETOH. DON/designee will audit unit per week to ensure the provided. Results of audit will be residents and the provided of th	history of etoh hile residing in potential to be leficiency. ervision related to ceiving d regarding who smoke or 2 residents per hat supervision is		

-	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	A. BUILDING			TE SURVEY MPLETED
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F 323	and procedure was indicated the reside shortened attention mobile. The section using the Brief Invescore section was r Wandering/Exit Secchecked "History of setting, including context doors." The subsection of the evaluation did not indicate any care plan. The evaluation of the evaluation of the evaluation of Farange March 7, 2 documentation of Farange March 8, 104's Progress Notice of the incidentified for the incidentified of	left blank. The assessment ent exhibited forgetfulness or span and was independently to determine cognitive status ntory for Mental Status (BIMS) not completed. Under the exing Patterns two boxes were exit seeking at home or other arrent setting" and "Stays near mary and interventions ation was not completed and initiation or review of R104's uation was signed 2/6/16. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use. Progress Notes from February 016, did not reveal 104's alcohol use.	F3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING		· · · · · · · · · · · · · · · · · · ·	03/:	21/2016
	PROVIDER OR SUPPLIER			5430	EET ADDRESS, CITY, STATE, ZIP CODE D BOONE AVENUE NORTH W HOPE, MN 55428	,	
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F 323	MD/NP [nurse praneeded for new or alcohol abuse." R104's undated Kaunder the "Safety" cushion for liquor had "frequent safe that R104 was "aw further identified "Imedications for let for substance abusteceived." Addition "monitor for use of registered] to report to have signs of imorders." The hourbanywhere in the manywhere in	cting drunkenness. Contact ctitioner] and hospice as ders every shift for hx of ardex Report directed staff section to "check under w/c cottles with every pad change" ty checks hourly and PRN" and vare of the risks." The Kardex MD orders to hold narcotic chargy and updated MD PRN se. Psych [psychiatrist] orders hally, the Kardex included ETOH, NAR [nursing assistant rt to nurse. Nurse if observed apairment to ETOH, call MD for y checks were not documented edical record. 17/16, at 7:45 a.m. with nursing evealed that "a while ago" R104 in with drinking" and he had with drinking" and he had with he had a power chair to when he had used alcohol was a ago. "R104 had used alcohol was a ago." R104 had "gone out and and R104's physician was der was obtained to hold se times and to monitor for a asked about R104 leaving the	F3	23			
	the liquor store do - At 11:25 a.m. with that RN-I was awa stated the last time "maybe two weeks come back drunk" updated and an or medications at tho intoxication. When facility, RN-I stated	wn the road. " h registered nurse (RN)-I stated re of R104's alcohol use and e R104 had used alcohol was ago."R104 had "gone out and and R104's physician was der was obtained to hold se times and to monitor for					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 323	R104 used Metro Narranged his own riwent shopping. - At 9:34 a.m. with Nelp a lot when he Inoted R104 "drank" curses a lot and is been drinking." NAdate and time to R1-At 2:22 p.m. licens revealed R104 "drindrunk." LPN-B revemethadone (used a given if R104 has beshe had "been here ongoing issue" (R10 stated R104 had befor a couple months alcohol "multiple tim revealed that she "was "drunk" and he on the armrest" (of she has been direct using alcohol or direct using alcohol or direct using alcohol, LPN-monitor-15 min che his wheelchair." LP R104 was "belligered or swearing" she we supervisor. LPN-B call the hospital duasked where R104 "There's a lot of sus	the facility." RN-I also stated lobility for transportation, des and went to the bank and NA-F revealed R104 refused had been using alcohol and liquor last week" and he very aggressive when he's F was unable to provide a 04's alcohol consumption. Sed practical nurse (LPN)-B has all the time" and "gets aled the physician ordered is a pain reliever) cannot be een drinking. LPN-B stated is seven months and this is an 04's alcohol use). LPN-B een using alcohol on her "shift is" and noted R104 to be using the ser week." LPN-B further wouldn't be surprised" if R104 "just leans over and sleeps his w/c). When asked what the to do when R104 has been exted where to document the replied "I don't know, I would by TAR [treatment record] and cation." When asked what led to do when R104 has been B replied "nothing, just cks, he will usually pass out in N-B went on to say that if ent, pushing, slapping, yelling ould call the charge nurse or stated she had never had to be to R104's alcohol use. When obtains alcohol LPN-B stated spicions that one liquor store effont door and that one	F3	23			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION NG		E SURVEY MPLETED
		245183	B. WING _		03	/21/2016
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F 323	supervisor happener and confiscated it be seen a visitor outsich him leave the facilit. An interview on 3/1 revealed she was a "it's been awhile sin When asked what so R104 has been usin "usually" a room seemedications are giver or hospice. When a searches are compounded in the com	ed to be in the front area once before it was open. I've never de of facility and never seen y." 8/16, at 8:37 a.m. with RN-J ware of R104's drinking and ace I have seen him do it." she was directed to do when any alcohol, RN-J replied arch was completed, no pain en and we notify the physician sked how often room leted RN-J replied "I don't arch, usually if suspected"	F 3:	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	suspect intoxication When asked how o LSW stated it "just when asked what it was "not sure what on to say she thoug "goes out with Metr supervision, he tells [HUC] and he usua or charge nurse, as can leave." When a assessment to dete the facility unsupervit was based off an she was not aware requirement for any stated she had asked policy and had "not - At 10:29 a.m. RN-asked about R104's that it was a "typica facility did not have it was something the indicated some resion order to receive so benefit to R104. RN directed to complete alcohol, hold narcothe appeared intoxic responsible for the that "typically social However, she had present the searches with a section of alcohol she do found alcohol "lately aware of R104's driver."	ge 87 Inplete random checks if we at the checks are completed depends, nurses do it too" "depends" on she stated she it depends on." LSW-A went the R104 left the building and to Mobility- not with any at the Health Unit Coordinator lay signs out. He tells the HUC long as he is signed out he asked if there was an armine if a resident could leave vised, the LSW responded that the ursing assessment, and that of any assessment or one to leave. The LSW also also ded about the facility's alcohol received an answer on one." K was interviewed and when a policy for drinking, however at was discouraged. RN-K dents have a Physician's me alcohol but that was not of I-K went on to say staff was a random room searches for ics and monitor the resident if ated. When asked who was room searches, RN-K replied services" was responsible. Deriodically completed room cond nurse and when she ocumented how much was RN-K indicated she had not y." RN-K indicated staff was nking and when R104 lent pad change staff were to	F3	323			

NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES NEW HOPE, MN 55428	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NORTH RIDGE HEALTH AND REHAB X41 ID PREFIX TAG TAG PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 88 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 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			245183	B. WING			03/	21/2016
F 323 Continued From page 88 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			REHAB		5430 BOONE AVENUE NORTH	P CODE		
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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	F 323	look under his cush of liquor and carried staff are supposed the facility staff had of the facility in plar R104's bottles. RN-staff were not able obtained alcohol but everyone" at the facility undersone often before had 1/23/16. RN-K were any nursing assess leave the facility undergone "cognitive call a cab however idea" for R104. RN-Metro Mobility for the When asked if the place to prohibit R1 R104 was encourage activities on the unity Anonymous (AA) had a fall on 11/5/1 to be intoxicated and a transfer. RN-K inclinity from the fall. 3/8/16, Progress Notand stated she was that she did not need that R104 had been sharp Object safety R104's care plan fur pressure ulcers and	nion as he stored mini-bottles d'suspicious coke bottles" that to dispose of. RN-K indicated I found vodka bottles outside nters and indicated these were -K also stated she or facility to identify where or how R104 at he was "friends with cility and the connected ity. RN-K indicated R104 did supervised and used to leave his enrollment in Hospice on ton to say she could not recall sment to determine if he could supervised but that R104 had we testing" and he was safe to indicated that was "not a good -K also indicated R104 used ransportation that he set up social worker's assistance. e was any interventions in 04's alcohol use, RN-K stated ged to participate in more t and that Alcoholics ad been discussed and RN-K also confirmed R104 5, while R104 was suspected and did not use assistance with dicated R104 did not have RN-K was asked about the ote in R104's medical record is not aware of the incident and end to be informed of every time in drinking.	F3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	wheelchair. R104 " w/c [wheelchair] cu like scissors," R10- benefits," and R10- storage of items ar not identify R104's knives, what staff s observed in R104's he and others were possession of shar Review of R104's F through March 7, 2 documentation of F knife(s) under the v R104's Progress N identified, "Resider other people. Knife was immediately p safety." The note ic agency and MD we Progress Note lack interventions being from "swinging a ki R104's undated Ka under the "Safety" cushion for liquor b and "frequent safet included "frequent for prohibited subs- "aware of the risks Kardex identified F others: increased a feels threatened by someone, possess could be used as w	prefers to hoard objects under shion including sharp objects 4 "is aware of the risks and 4 was "offered alternative and declined." The care plan did possession of sharp objects or should do if these items are a possession or how to ensure a kept safe if R104 had p objects. Progress Notes from February 016 did not reveal R104's threatened staff with the		23		

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F 323	R104. On 3/21/16, nursing (DON) stard do a specific VA [vibecause all resider VA" and stated that vulnerability on the An interview on 3/1 revealed R104 refubeen using alcoholast week" and he aggressive when hunable to provide a alcohol consumption. An interviewed and i	essment was requested for at 10:32 a.m. the director of ted "Our social workers don't ulnerable adults] assessment into when they are admitted are to the "asterisks denote some care plan." 17/16, at 9:34 a.m. with NA-Fused help a lot when he had and noted R104 "drank liquor "curses a lot and is very le's been drinking." NA-F was a date and time to R104's	F 32	23		

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F 323	punctures his whee edges. The DON was interal. The DON indicated sheethe assistant direct on-call that evening at any time of R104 people but would ehappened. The DON believed the incide knife. The DON vesharp blade end, haware of R104 swi one was threatenenot verify who the unaware if any othe involved with the sithere was no incide 3/8/16, occurrence not expect an incide every time R104 wfurther stated that manager to be infointoxicated and sho occurred on 3/8/16 confirmed she was When asked where DON indicated the where R104 obtain the building unsuper transportation. The the alcohol himself store that delivered.	age 91 elchair cushion with the sharp rviewed on 3/18/16, at 11:50 D4's alcohol use and sharp ON was asked about R104's ed 3/8/16, at 5:49 p.m. and the edid not recall the incident and or of nursing (ADON) was g. The DON was not informed 4 swinging a knife at other expect to be informed if that DN later stated that she ent involved a box cutter, not a rified the box cutter did have a owever stated that she was not enging it at others and that no ed or harmed. The DON could cother people" were and was er staff or residents were etuation. The DON confirmed ent report made about the eand further indicated she did ent report made about the and further indicated she did ent report to be completed as intoxicated. The DON eshe would expect R104's nurse rmed of any time that R104 is build be informed of what at 17:49 with R104. The DON exaware of R104's alcohol use. ER104 obtained alcohol, the facility staff was unaware of ed his alcohol and R104 left ervised and arranged his own eDON stated R104 purchased and she was aware of a liquor et to the home. The DON also knifes or sharp objects was a	F 3.	23		

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F 323	assessment compleable to leave the buthe DON indicated (on the second flooto leave the facility know who was able The DON stated Ridentified on his car that was on R104's the care plan and p stage liver disease, impairment, hx of cETOH. Often refuse the risks and benef abnormal labs." Intesafety checks hourly substances. Reside orders to hold narcoupdate MD PRN foorders received. Rethat may interest, 1 PRN." The DON incinterventions that "a nurse" would know alcohol and what to the facility. The DO been offered suppoas AA meetings, ho in R104's medical rindicated room chehourly (as identified nursing assistants (complete that as we expected staff to be	N revealed there was no eted to determine if R104 was aliding unsupervised. However, his placement in the facility r) indicated that he was able unsupervised and the nurses to leave the facility safely. IO4's alcohol use was to plan. When asked where care plan the DON displayed ointed to the focus of "end hx of ETOH, r/t cognitive offee ground emesis, hx of es lactulose and is aware of its. R104 "has a history of erventions included, "frequent y and PRN of resident and and PRN for prohibited ent is aware of the risks. MD office medications for lethargy. It is aware of the risks. MD office medications for lethargy. It is aware abuse. Psychevisit and remind of activities are trivial to discontinue drinking such wever that was intoxicated at N further stated R104 had out to discontinue drinking such wever that was not identified ecord. The DON further cks should be completed on R104's care plan) by the NA's) but that nurses could ell. The DON confirmed she aware and follow R104's Na confirmed the facility did not	F3	23			

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
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F 323	At 12:51 p.m. on 3/approached by the LSW-B and RN-H written on 3/8/16, at The DON began to inaccurate information for the Progress Now "hearsay." The DO witnessed R104 with had been told by at The surveyor then correct, and RN-H what the ADON had to come down to R was intoxicated. RI different floor and with R104's transferint intoxicated. RN-H sR104 threaten anywas told to her by tR104's floor. The ADON then denot know where RN The ADON and LS a box cutter from F and R104 handed incident. The ADON and the physician.	/18/16, the surveyor was DON, along with the ADON, regarding the progress note	F 32	23		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 323	that "hearsay" was was not informed of RN-H was re-educe and expected staff RN-H was interviewa.m. and stated shorogress note in R was the charge nu contacted by the A to assist with a traduce to his intoxicated down to R104's floinformation that RI progress note. RN inaccurate progres 3/8/16, at 5:49 p.m wrote R104 had a other people becaus information. RN-H she would have infisince her supervisinformation she did the time she got do not a threat to any R104 to the emerging of 3/8/16, the influence" and The administrator R104 was upset, hout denied R104 wasked about the 3/medical record, the charted in the progressions.	m. by RN-H was not accurate, charted and that was why she of the incident. The DON stated ated about inaccurate charting to chart accurate information. wed again on 3/21/16, at 7:42 to had entered the 3/8/16, 104's chart. RN-H stated she rise on another floor and was DON to come to R104's floor insfer to the emergency room ition. RN-H stated on the way or, the ADON told her the N-H entered into R104's confirmed she had made an its note in R104's chart on it. and again confirmed she knife and was swinging at use the ADON had told her that stated in any situation like that formed her supervisor, but or (ADON) had told her the dinot follow up. RN-H stated by own to R104's floor, R104 was one and they did not send	F 32	3		

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F 323	type of benavior frostated that he experience and if that was what been informed. The was given direction have been a good in what was written. We note was not follow was provided further administrator stated and erase what was about making a confinicated the police R104 had a weapo. When asked about administrator stated had not been a threat any manner. He were to monitor his behat use was suspected unaware of how or alcohol however stagoes on outings out administrator confinion of a liquor store that administrator stated contacted about not of the facility. Addit stated the facility. Addit stated the facility diand if residents had allowed a specific and it would be kept only released per we physician. However 3/8/16, did not incluse specific amount of	lege 95 le nurse did not observe that om R104. The administrator octed staff to chart accurately of occurred that he should have eladministrator stated RN-H from the ADON, and it would dea for the ADON to review When asked why the progress red up on and no information for in the medical record, the did the facility "Can't go back is written" and was unsure rection. The administrator also would have been called if in and was threatening people. R104's alcohol use, the did R104 was non-compliant and feat towards resident or staff in ent on to say staff are directed evior and lethargy when alcohol in the administrator was where R104 was obtaining fated R104 had visitors and tiside of the facility. The standard he had heard suspicions at delivered to the resident. The did the liquor store was at delivering to private property ionally, the administrator did not have an alcohol policy, did alcohol, they would be amount per Physician Orders of in the medication room and what was ordered by the receive a falcohol. In addition, the dence of any staff member	F3	23		

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F 323	asking R104 if R10 the physician and i locked up in the m On 3/21/16, at 7:4 were reviewed and Note from 3/8/16, a edited or followed record.	04 wanted alcohol ordered by f R104 would keep the alcohol	F 32	23		
	R77 had diagnose: anxiety and difficul MDS dated 12/18/ moderate cognitive indicated R77 need	s which included, restlessness, t walking. R77 most current 15, indicated R77 had impairment. The MDS also ded staff supervision with independent with transfers and				
	"Smoking Evaluation that R242 did not have deficit or a dexterit	w identified a facility form titled on" dated 12/18/15, indicated have any cognitive loss, visual y problem and could light own ired staff supervision while				
	required staff supe However, the care	tted 3/15/16, indicated R77 ervision while smoking. plan was developed 88 days taff assessed R77 requiring hile smoking.				
	10:26 a.m. with RN packs of cigarettes R242 was asked if that were located in	om observation on 3/15/16, at N-C, observed two opened in R77's night stand drawer. she smoked the cigarettes in her night stand R77 stated noke by herself and when her sit.				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION DATE
F 323	NA-C, stated he wagroup. NA-C stated needed staff supers. On 3/17/16, at 2:16 R77 was a smoker. aware R77 needed smoking. On 3/17/16, at 2:22 works evening shift R77. NA-D continue goes outside to smoth further stated she wastaff supervision who buring interview on acknowledged that unsafe to smoke in supervised while some verified that a care smoking was not do safe smoking intervities and staff supersmoking intervities. On 3/18/16, at 1:39 and stated R77 was supervision while some expectation is for poonce it has been denot safe to smoke in R242's Admission R	on 3/15/16, at 1:06 p.m., as usually assigned to R77's I he was not aware R77 vision while smoking. In p.m. RN-A acknowledged that RN-A stated that she was not staff supervision while In p.m. NA- D stated she usually and assigned to take care of ed to state sometimes R77 oke independently and NA-D vas not aware R77 needed nile smoking. In a 10:33 a.m. RN-E the facility assessed R77 as dependently and needed to be moking on 12/18/15. RN-E plan to address R77's unsafe eveloped until 3/15/16 and the ventions were not included in E further stated residents vision should not have on their possession. In p.m., DON was interviewed as assessed to need staff moking. DON stated the lan of care to be developed etermined that a resident was independently. Record dated 3/21/16,	F3	23			
		l diagnoses which included					

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F 323	sclerosis. R242's s 3/4/16, indicated R3 impairment. The M needed staff assist hygiene, dressing, wheelchair for mob Review of R242's pto 3/21/16, revealed 1/13/16, written by indicated SW obsefloor in R242's roor with R242 regarding progress note furth that he will be taking progress note date noticed burn holes family was updated staff that R242 had outside and poking progress note date nursing and SW dis R242. The progres R242 needed staff R242's record revietitled "Smoking Evaindicated that R242 loss, visual deficit of light own cigarette equipment required dated on 2/27/16, a indicated that R242 loss, visual deficit own cigarette, requineeded staff superfiled staff staff superfiled staff staf	tobacco use and multiple ignificant change MDS dated 242 had severe cognitive DS also indicated R242 with transfers, personal toileting and that he used a	F 32	23		

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F 323	required a smoking with smoking. How developed 61 days became aware of F practices. During resident roo 9:55 a.m. with RN-on R242's clothing - 1st pair- Red jack holes on the front of approximately 1/4" - 2nd pair- Gray partices on the front of the back of right partices on the front of 3rd pair- Checker holes on the front of 3rd pair- Checker holes on the front of 4th pair- Light teacigarette burn hole jacket. When interviewed RN-C stated R242 schedule.	g apron and staff supervision ever the care plan was later after facility staff first R242 unsafe smoking om observation on 3/15/16, at C the following were observed to the following were observed to 1/2" in size. In the had nine cigarette burn and 2 cigarette burn holes on ant leg and three cigarette burn of left leg. If green jacket had nine son the front chest area of the son 3/15/16, at 10:18 a.m. did not have a smoking at the staff supervision with the know where the smoking who stairs. On 3/15/16, at 1:06 p.m., NA-B, igarette burn holes on R242's tarted working at the facility who are the smoking at the facility who are the same t	F3	323			

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F 323	completed a smok assessed R242 to independently. RN smoking apron and smoking. RN-D fur clothing the reside remembers checking red jacket did not have a sinterviewed via aware of the numbers an assisted living fourn holes on his of facility staff. F-A furn a smoking apron a while smoking, but depending which shaware where the shaware where the shaware where the shaware smoking properties of the safe smoking properties. During interview or acknowledged the unsafe smoking properties and the safe smoking wand the safe smoking applan of care to be of determined that a standard want was smoking applant of care to be of determined that a standard want was smoking applant of care to be of determined that a standard want was smoking applant was smoking applant of care to be of determined that a standard want was smoking applant was smoking ap	5 p.m., RN-D stated she ing assessment on 3/7/16, and be unsafe to smoke -D stated R242 needed a d staff supervision with ther stated looked at the nt had on at the time, she ng R242's red jacket and the nave any burn holes in it. 2 p.m., a family member (F)-A a phone and stated she was ser of cigarette burn holes in A stated R242 used to live at acility, they found cigarette clothing too and she informed or ther stated R242 was to have nd needs to be supervised it was "hit and miss" taff was working and if they are moking apron was kept. 1 3/18/16, at 10:52 a.m. RN-E facility became aware of actices by R242 on 1/13/16. a care plan to address R242's as not developed until 3/15/16 ing interventions were not Kardex (nursing assistant	F 32	3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	expectation that a	age 101 resident assessed to need a ould be readily available to	F 32	23		
	indicated R248 had chronic obstructive generalized weakn and difficult walking dated 1/12/16, indic intact. The MDS als	Record dated 3/21/16, d diagnoses which included, pulmonary disease, ess, restless leg syndrome g. R248 most current MDS cated R248 was cognitively so indicated R248 needed staff ersonal hygiene, dressing, lity.				
	titled "Smoking Eva indicated that R248 loss, could light ow deficit and a dexter	ew identified a facility form aluation" dated 1/22/16, 8 did not have any cognitive n cigarette but had a visual rity problem. The smoking licated R248 did not require tions.				
	was a smoker. How address R248's vis problem that were assessment and th	ated 3/14/16, indicated R248 vever, the care plan did not ual deficit and dexterity identified in the smoking e care plan was developed 52 lity staff assessed R248's				
	smoking a cigarette facility. The DON wand was heard to to allowed near the buout her cigarette. Refer cigarette on the	a.m. R248 was observed by the entry way to the vas observed to walk to R248 cell R248 that smoking was not uilding and asked R248 to put 1248 was observed to put out wall. The DON did not correct but out her cigarette on the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY MPLETED
		245183	B. WING _		03/	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	stated she smokes main entrance. Wh off cigarette butts, on the ground or in state "there is no a 3/18/16, at 10:07 a cigarettes but disposentrance that was purveyor had intervidisposals. When interviewed nursing assistant (I assigned to R77's phe was not aware while smoking. During interview or acknowledged R24 visual deficit and a further acknowledged R24 visual deficit and a further acknowledged address R248's visproblem. On 3/18/16, at 1:17 safe to dispose cig garbage. DON stat care plan to be devare completed to a with an assessment R286 was admitted diagnoses of pneuropulmonary disease deficit, and anxiety	outside of the building by the en asked how she disposes R248 stated she throws them the garbage and continued to sh tray down there." On .m. R248 stated the facility has beal receptacles by the main placed by the entrance after riewed her about cigarette. on 3/15/16, at 1:06 p.m., NA)-C, stated he was usually group and continued to state R77 needed staff supervision a 3/18/16, at 10:20 a.m. RN-E-8 was assessed to have a dexterity problem. RN-E-19 ded R248's care plan did not unal deficit and dexterity. or p.m. DON stated it was not arettes on the ground or in the ed her expectation was for the reloped once the assessments ddress all concerns identified it.	F 32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(3) DATE SURVEY COMPLETED	
		245183	B. WING		03	3/21/2016	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	visual deficit, dext smoking, can the and is any adaptive lacked any assess ashes, put out the the resident was so A community smolacked any indicate facility was unable rules description. On 2/16/16 a care resident goes outset the resident will for stated the facility wintervention was to on facility grounds was added to state inicotine patch if real the facility of the nursing assist but not provided. On 3/15/16, at 10: down the street, at TCU entrance, for last night, it's shouterrible. TCU entracting is a garbage with and street and street is a garbage with and street is made and street is a community of the street is a street in the street in the street in the street is a street in the stre	ssment asked cognitive loss, erity problem, frequency of resident light their own cigarette e equipment needed. The form sment of the ability to handle cigarette, and did not state if afe to smoke or had limitations. king rules applied statement ion of what that meant, the to provide community smoking plan was initiated that stated side to smoke, with a goal that llow smoking contract (which was nonsmoking). The premind resident to not smoke to on 3/14/16 a new intervention the the resident will be offered equests to discontinue smoking. I ant care card was requested that stated side to smoke the resident will be offered equests to discontinue smoking. I are card was requested that care card was requested that stated side to smoke and has been cleaning up the days, I even was picking it upuld be cleaned up it looks ance, had more than 75 the ground on 3/15/16. There that a plastic liner covered but and a large green bin of	F3	223			
	diagnoses of repe mismanagement,	d 2/17/16, with admission ated falls, medication traumatic brain injury (TBI) with gned smoking contract 2/17/15.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED
		245183	B. WING			03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428)E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	
F 323	2/19/16, The asses visual deficit, dexter smoking, can the read and is any adaptive lacked any assessmashes, put out the cesident was sat a community smokil lacked any indication facility was unable to the resident was unable to the resident was unable to the resident was unable to the rules description. On 3/14/16 a smok (after a list of smok (after a list of smok by survey) and indication smoke despite facility be encouraged to conceive the resident will	nent was completed on sment asked cognitive loss, rity problem, frequency of esident light their own cigarette equipment needed. The formment of the ability to handle sigarette, and did not state if fe to smoke or had limitations. ing rules applied statement on of what that meant, the coprovide community smoking ing care plan was initiated that ing residents was requested eated resident chooses to ity no smoking policy. Goal will omply with no smoking policy, couraged to decrease ons: offer nicotine patch if smoking assessments stated she had cigarettes and ket (jacket draped over w/c, ns), smokes down the road of a.m. the DON stated the a smoking focus group and and they noted that we did not The facility was revamping oking, people know it's a no do sign contract agreeing not to out to smoke anyway, done on people who identify	F3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	developed. We are and care planning. The facility had resentrance and at the any safe smoking regarettes and put of the same	sk force on smoking was still in the process of planning ident smoking at the main a TCU entrance, but lacked eceptacles to put out cigarette butts safely into. Id on 3/15/16, at 10:49 a.m. a ng apron was on the table in a.m. R494 was observed aff members asking staff and we a cigarette to lend. R494	F 32	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		` '	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE		
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F 323	went out side with F smoke. The Progre able to light cigarett indicated R494 struput out the cigarette documented on sm plan. A smoking assessn 3/14/16, The asses visual deficit, dexte smoking, can the reand is any adaptive lacked any assess ashes, put out the commodities application of what the unable to provide on the assessment incognitive loss or visual descriptions or visual deficit. The smoking rules application of what the unable to provide on the assessment incognitive loss or visual descriptions. From the smoke was indicated indicated representations and the smoking apron and the could safely list smoking apron and the care plan were nicotine patches if From the care plan were nicotine patches if From the smoking, R494 wou assessments by nu smoking assessme supervision to smoke the care plan were nicotine patches if From the care plan were nicotine patches in the care plan were nicotine patches in the care plan were nicotine patches in the care plan were nicotine pa	atted 3/7/16, indicated RN-M R494 to assess ability to safely as Note indicated R494 was to and smoke it safely. It also aggled with figuring out how to example the information was not oking assessment or care the ment was completed on a sment asked cognitive loss, rity problem, frequency of a sident light their own cigarette equipment needed. The forminent of the ability to handle sigarette. A community and the action of the action	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	plan instructed staf and should have st see R494 propel do outside to ensure s informed staff that aggressive with yel when R494 wanted plan did not instruct smoking apron in a assessment. During observation Visual/Bedside Kar posted inside R494 Kardex Report date no instructions regard the Visual/Bedside Kar which instructed states assessment deemed supervision to smooth During interview on said, "Now we need week they started supervision." During interview on stated "I go outside apron to wear last we to watch us so I put someone to go out evening up till about 6:30 a.m. I smoke sthere. I have been sis all I want to do."	f that R494 chose to smoke aff supervision. When staff own the hall they need to assist moking safety. Care plan also R494 would get very verbally ling and swearing at staff to go outside to smoke. Care t staff to have R494 wear a ccordance with smoking on 3/15/16, at 10:49 a.m. the dex Report dated 1/14/16, was closet. The Visual/Bedside ed 1/14/16, provided staff with arding R494's smoking. A copy de Kardex Report dated sted but facility provided dex Report dated 3/21/16, aff that resident smoking ed that R494 required	F 3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		245183	B. WING			03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
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F 323	indicated he was constaff assistance for R511's care plan do smoking. A North R Note dated 1/5/16, aide (AA)-O, "I just smoke." During an observati R511 was outside susing oxygen via natitiers. During an interview administrator stated agreement on admit the facility is smoke outside to smoke the able to smoke independent of the stated, all reagreement as part of A Smoking assessment in agreement in a specified of R511 sm. A Smoking assess 3/14/16, after the admotified of R511 sm. The assessment in a smoking safety was plan. During an interview.	hange MDS dated 1/15/16, orgnitively intact and required all activities of daily living. ated 2/5/16, did not address idge Skilled, LLC progress indicated R511 told activity want to go outside and from on 3/14/16, at 8:10 p.m., amoking a cigarette. He was asal cannula, running at four on 3/14/16, at 8:13 a.m., the diall residents sign an assion that they acknowledge afree. He stated if residents go be have been identified as been dently. on 3/14/16 at 8:26 p.m., the lid not have a smoking ated. She stated he had not sident who smoked. She sidents sign a smoking	F 3.	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 323	prior to the previous did not know where stated he was told smoke he would have the would have the work of the wor	s night. He further stated he he he got the cigarette. He on admission if he wanted to ave to go outside. y on 3/15/16, at 2:03 p.m., as unsure if R511 smoked. We went outside but did not ether or not he was smoking. y on 3/15/16, at 2:06 p.m., as asked about smoking on the did not smoke. She wer seen him smoke but stated time out in the common area. y on 3/15/16, at 2:16 p.m., told her he wanted to go e. She stated she "did not	F 3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	` '	E SURVEY MPLETED
		245183	B. WING		03/	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	smoking restrictions a resident's care pla supervision with sm supervision at all tir	ated for "safe smoking", any s/concerns shall be included in an and all residents requiring toking shall have direct	F 3			5/3/16
SS=D	Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequents should be reduced combinations of the Based on a compressident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and resident drugs receive gradubehavioral intervent contraindicated, in a drugs.	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of idea which indicate the dose or discontinued; or any ereasons above. Thensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition documented in the clinical that who use antipsychotic is all dose reductions, and it is incompleted in the serior of the serior				3/3/10
	by: Based on observat	NT is not met as evidenced ion, interview and document ailed to ensure a gradual dose		F329 R422 has been discharge Facility has reviewed all outstand		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	R422) reviewed for Findings include: A Pharmacy Consume indicated a recommendations of the prefers to a.m. He stated the make a lot of noise. During an interview stated he appropriate the prefers to a.m. He stated the make a lot of noise. During an interview stated he appropriate the prefers to a.m. He stated the make a lot of noise. During an interview stated he prefers to a.m. He stated the make a lot of noise. During an interview stated he prefers to a.m. He stated the make a lot of noise. During an interview stated he prefers to a.m. He stated the make a lot of noise. During an interview registered nurse (Recommendations of and then get distributed).	Itation Report dated 10/1/15, nendation to decrease R422's pressant) dose to 7.5 milligram ne Pharmacy Report was not acility. Inimum Data Set dated 1/8/16, o cognitive impairments, with activities of daily living ehaviors. R422's care plan cated use of psychotropic pression and anxiety, but did nia. Physician's Orders dated ne was receiving Remeron 15 d time for insomnia. I on 3/14/16, at 6:33 p.m. R422 o stay up until 2:00 a.m. to 3:00 night staff coming at 6:00 a.m.	F 329	gradual dose reduction requests a resolved as appropriate. All current residents using psychomedications have the potential to affected by this alleged deficiency Licensed staff have been educate regarding gradual dose reduction. The DON/designee will audit 2 reper unit, per month to ensure that dose reduction recommendations been addressed by the provider a processed appropriately. Results of audit will be reviewed to the sure that dose reduction recommendations are the sure that dose reduction recommendations been addressed by the provider at processed appropriately.	pactive be v. ed process. sidents gradual have	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329 F 333 SS=G	p.m. RN-M stated, recommendation w stated she took car. A facility policy titled Gradual Drug Dose 2012 was reviewed of medications and be completed in column and consultant pha 483.25(m)(2) RESII SIGNIFICANT MEDICAL SIGNIFICANT MEDICAL SIGNIFICANT MEDICAL SIGNIFICANT MEDICAL SIGNIFICANT MEDICAL PROPERTY AND STATEMENT SIGNIFICANT MEDICAL PROPERTY SIGNIFICANT SI	nt interview on 3/18/16, at 1:13 "the pharmacy as not followed up on." She e of it today. d, Tapering Medication and Reduction, dated September . The policy indicated tapering gradual dose reductions will nsultation with the physician rmacist. DENTS FREE OF DERRORS sure that residents are free of	F 32			5/3/16
	by: Based on observat review, the facility foresident's (R4, R48 significant medicati transcription. This r and R481. R4 who seizure activity and constant pain" rated Findings include: R4's quarterly Minim 1/8/16, indicated sh impairment, require with all activities of diagnosis which inc	NT is not met as evidenced ion, interview and document ailed to ensure 3 of 3 1, R57) were free from on errors related to improper esulted in actual harm for R4 was hospitalized related to R481 who suffered "almost d 10/10. The properties of the proper is a suffered to the had some cognitive and extensive to total assistance daily living, and had an active sluded seizure disorder. Sign of 3/16/16, at 2:40 p.m.,		F333 R4 has been discharged. Rand R57 medications have been transcribed appropriately. Current residents have the potenti affected by this alleged deficiency. Residents are receiving medicatio transcribed appropriately as ordere the health care provider. Licensed staff and health unit coordinators have been educated regarding appropriate transcription medication orders. DON/designee will review all medierrors. Results of audit will be reviewed by	al to be ns ed by n of cation	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	R4 was sitting up in alert and able to co During an interview family member (F)- and depressed." F- appointment with the to the hospital. She it was discovered the Lamotrigine." F-B is receiving 200 milling an additional 50 mg. A review of facility in the Record (MAR) date was receiving Lamotriconvulsant druseizure disorders) in the following four times daily. A review of a facility in the review of a facility dated 1/5/16, indica include the time/time. The order was transcoordinator (HUC) in the order was transcoordi	her wheel chair. She was nverse briefly with surveyor. on 3/16/16, at 2:40 p.m., B stated R4 was more "down B stated she brought R4 to an he physician who admitted R4 stated during the hospital stay hat R4 was getting "too little tated R4 should have been rams (mg) four times daily and g as needed. Medication Administration and January 2016 indicated R4 brigine (Lamotrigine is an g used in the treatment of 200 mg four times daily until the dose was decreased to 50		33			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		245183	B. WING		0	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 333	P) dated 2/7/16, inchospitalized 2/1/16, behavior, decrease stiffness." The over altered mental statu "multifactoral secon infection, mild hypo seizures." The H&P an electroencephalitest that measures activity of the brain seizure activity) and EEG monitoring as intermittent seizure increased and two a medications were a During an interview RN-K stated she was R4's Lamotrigine er sure of the details." During an interview director of nursing (the seizures during DON further stated chart review when F During a subsequent 12:51 p.m., RN-K sexpected RN-L to q Lamotrigine dose a clarification.	ital history and physical (H & licated R4 had been due to atypical "withdrawn d interaction, and new left leg all etiology of the patient's as was thought to be ndary to probable urinary tract natremia and/or subclinical indicated R4 had undergone ogram (EEG). (an EEG is a and records the electrical and is often used to detect a was placed on continuous she was found to have so the Lamotrigine dose was additional anti-epileptic added. on 3/18/16 at 8:06 a.m. as aware of a discrepancy with the ror, but stated she was "not"	F 3:	33		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 333	moderate/severe dassistance with all eating. In addition, almost constant paractivities, with the rat 10/10 (on a scale painful). The Physician dated 2/2/16, indicated 2/2/16, indicated 2/2/16, indicated areceive the physician dated R481 remained A Care Area Asses 2/11/16, was comp MDS. The CAA for to R481's response indicating she had was almost constaindicated R481 had adenocarcimoma warthritis/ DJD (degapain with chronic propioid dependence Allina Hospice was with their consulting closely to manage than) 5. The care plan initiated to lymph system that interventions instruan analgesia [sic] [pair orders."	ely intact, suffered from epression, and required activities of daily living except R481 was identified as having in that limited her day to day most severe pain being rated e where 10 is the most cian's Admission Orders/note ated R481 was admitted to the for gastric (stomach) cancer. It harm as R481 did not an ordered pain medication	F 33:	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP (5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 333	times daily for nerve pain medication) 5 severe pain, Morph concentrate 20 mg/every four hours as shortness of breath analgesic) 1000 mg. The Hospice Certifit dated 2/2/16, also it gabapentin 800 mg planed for treatmer. A review of R481's had not been identified MAR. The Allina Hospice Visit Record dated 2 pain at 10/10. The ACare Facility Visit Reindicated pain impreseven doses of Mon New orders written mg three times a da 20 mg every hour Facility Allina Hospice and Record dated 2/6/1 Goal set to get pain Allina Hospice and Record dated 2/11/ The Physician Orded discontinue Gabape for nerve pain becar	e nerve pain) 800 mg three e pain, methadone (narcotic mg three times daily for ine (narcotic pain medication) (milliliter (ml) give 0.75 ml needed for pain (PRN) or , and acetaminophen (a mild g three times daily for pain. cation and Plan of Treatment indicated R481 was to receive three times a day and care in neuropathic pain. MAR indicated the gabapentin fied on R481's February 2016 and Palliative Care Facility 2/3/16, patient complained of Allina Hospice and Palliative decord dated 2/4/16, R481 oved to 7/10. R481 received rephine 15 mg. in last 18 hours. to increase methadone to 10 ay and increase morphine to PRN. Palliative Care Facility Visit 6, R481 rated pain at 6/10.	F 3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		0:	3/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI 5430 BOONE AVENUE NORT NEW HOPE, MN 55428	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
F 333	Physician Orders of provided. A Medication Error revised 3/3/16, indinformed writer that Gabapentin 800 m arrival. Two nurses transcribed into PC health record]." The had been no injury address the reside analysis section of "resident is a new hospice. Resident 800 mg TID since given d/t [due to] the into PCC. Educated doctor] and family. R481 did not receis medication upon a RN-K said R481's discovered by an eadmission orders in urses but the gate said, "I think it is the someone on the desk but only to 3: R57's admission in R57 was cognitive with all activities of had diagnoses of its said said said said said said said sai	Report dated 2/11/16, and licated: "Hospice nurse at resident has not received ag TID [three times a day] since is checked and it was not CC [Point Click Care-electronic are report further indicated there is to the resident, but failed to ent's pain level. The root cause if the Error Report indicated: admit on 2/2/16. Resident on has not received Gabapentin arrival. Medication was not the fact it was not transcribed a staff update MD [medical at the physician pain arrival and been checked by two papentin was missed. RN-K the consistency of having esk. My assistant can cover the	F3	333		
	A Geriatric Service	es of Minnesota (GSM) long				

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		245183	B. WING _		03	/21/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		,_,,_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	term care (LTC) In indicated R57 had (coronary artery by arteries) in Decemendary and possible in Decemendary and been administer three times weekly friday; and Coreg breakfast four time. Thursday, and Sat Orders also instruct 6.25 mg daily with R57 attended dialy and Fridays at 12: The facility's Order 3/21/16, indicated with evening meal electronic health rewhen Coreg 3.125 weekly Monday, With the Coreg 3.125 weekly Monday, and Sat R57's MAR indicat doses of Coreg 3.2	itial Intake form dated 2/4/16, undergone a CABG x 4 repass graft involving four ober of 2011. Admission Record, indicated nitted to the facility 2/2/16. After dated 2/2/16, indicated staff Coreg 3.125 mg by mouth on Monday, Wednesday, 6.25 mg by mouth with es weekly Sunday, Tuesday, urday. The After Discharge cted staff to give R57 Coreg the evening meal and indicated rsis Mondays, Wednesdays 00 p.m. The Summary Report dated only Coreg 6.25 mg every day had been entered into the ecord from 2/2 through 2/12/15, mg by month three times rednesday, Friday with eg 6.25 mg by mouth with es weekly Sunday, Tuesday, urday were added. Review of ed the resident had missed five 25 mg, and five doses of Coreg	F 33	,			
	dated 3/23/16, indi had been checked systolic 154-195, o 2/2 and 2/11/16. A clarified, R57's blo identified as systol	Veights and Vitals Summary cated R57's blood pressures daily, and had fluctuated, over diastolic 60-96 between fiter the Coreg order had been od pressure range was ic 125-162, over diastolic 64-85 12 to 2/29/16. There were only					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 333	two days between R57's systolic blood 166 compared to me 2/11/16. A Medication Error revised 3/11/16, indicated 3/11/16, indicated new order was not clarificated new order was not clarificated new order redisposing factor similar names. Rocurred with followithout injury from with provider same team to provide or recognized as responding interview or registered nurse (Five receive a new coordinator (HUC) computer and then HUC does not input into the computer check it." During interview or nurse manager said a new admit arrive the orders into PCC clarify any orders responding to provide same team to provide expension of the provide of the prov	2/12 through 2/29/16, where d pressure was greater than ine days between 2/2 through Report dated 2/12/16, and dicated, "Huc [health unit ted that Coreg was not on PCC ton. Res. missed Coreg since admit ion [sic]. Coreg fied." The report further ers received and no injury. It is identified medications with ot cause analysis indicated, alless than prescribed dose of oractitioner] notified. Error w up clarification. Resident med error. Orders clarified aday. IDT [interdisciplinary ducation to individual	F 33	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		5430 BOO	DDRESS, CITY, STATE, ZIP CODE ONE AVENUE NORTH OPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	because, "the HUC clarification and the nurse for several da found the error and communicated to s to write needs clarif been inputted into forders would enter another nurse secon have not had a chard floor nurses having. During interview on DON said, "We chard medication errors in finds a medication computer, notify the The nurse should good monitoring needed needed. They would possible call the DON nurse manager can education, and follow factors, root cause discipline." Once the by nurse manager the errors. The administ the medication error assessment and as minimum effective said, "Our medication errors harm from a medical at increased in monitoric and control and the medical at increased in monitoric clarification and the medical at increased in monitoric clarification and the monitoric clarification and the medical at increased in monitoric clarification and the monitoric clarification and the medical at increased in monitoric clarification and the medical at in	edication error occurred wrote the order needed on we were without a charge ays. The nurse practitioner clarified the order." It was taff that it was not appropriate fication. If an order has not PCC the nurse checking the the order and then have and check it. RN-K said, "We rge nurse consistently. The to pick that up." 3/21/16, at 11:09 a.m. the unged our process for a October. Any nurse who terror should enter it in the the doctor and responsible party. The the new orders and any and any assessments and notify the supervisor and any assessments and notify the supervisor and any in a continuation of the size of the process of the new orders and the process of the new orders and the process of the new orders and the control of the resident the poon of the poon of the resident required or of the resident required or or of the resident required	F3	33			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` /	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 333	Continued From pa	ge 121	F3	333			
F 334 SS=D	2010, indicated, "M administered in a siprescribed." 3. Medications must accordance with orderame. 4. If a dosage is been excessive for a resibeen identified as homeometric consequences for the being associated with person preparing of shall contact the resident facilities Medical concerns." 483.25(n) INFLUEN IMMUNIZATIONS The facility must dethat ensure that (i) Before offering the each resident, or the representative receivenefits and potent immunization; (ii) Each resident is immunization Octobal annually, unless the contraindicated or to the immunized during the contraindicated or to representative has immunization; and (iv) The resident's r	afe and timely manner, and as at be administered in ders, including a required time lieved to be inappropriate or dent, or a medication has laving potential adverse he resident or is suspected of ith adverse consequences, the radministering the medication sident's Attending Physician or all Director to discuss the MZA AND PNEUMOCOCCAL evelop policies and procedures the influenza immunization, he resident's legal lives education regarding the ial side effects of the offered an influenza medically he resident has already been this time period;	F3	334		5/3/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 334	representative was the benefits and poimmunization; and (B) That the residinfluenza immunization influenza immunization contraindications of the facility must detate ensure that (i) Before offering the immunization, each legal representative the benefits and poimmunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unle medically contraince already been immunication; (iii) The resident or representative has immunization; and (iv) The resident's indocumentation that following: (A) That the residing representative was the benefits and population or (b) That the residing pneumococcal immunication or (c) As an alternative and practitioner reconstruction or representation or (c) As an alternative and practitioner reconstruction or coccal immunication immunication immunication immunication coccal immunication immunicati	ent or resident's legal provided education regarding provided education regarding provided education regarding provided effects of influenza ent either received the pation or did not receive the pation due to medical prefusal. Evelop policies and procedures the pneumococcal president, or the resident's preceives education regarding prential side effects of the confered a pneumococcal president a pneumococcal president is legal provided entity to refuse the opportunity to refuse medical record includes to indicated, at a minimum, the provided education regarding prential side effects of munication; and prential either received the munication or did not receive medical munication due to medical	F 33	4		

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F 334	immunization, unless the resident or the refuses the second This REQUIREMENT by:	ss medically contraindicated or resident's legal representative immunization.	F 33			
	facility failed to ensi was offered and/or	r and document review, the ure 1 of 5 residents (R310) received influenza and cinations as recommended by a Control (CDC).		F334 R310 has been discharged All admissions will be offered the appropriate immunizations. Currel residents will be audited related to immunization status at their next q MDS and appropriate immunization offered. Licensed nurses will be educated	their uarterly	
	R310 was admitted Review of R310's falacked documentation pneumococcal vaccontraindicated or r Review of R310's Management of R310's fallowed by Management of R310's Management of	finnesota Immunization etion record provided by the 10 received an influenza 4/14 and lacked any e received a pneumococcal p.m. the director of nursing		regarding immunizations the pneumococcal and influenza immunization. DON or designee will audit the immunization status of 2 residents unit, per week to regarding immun status. Results of audit will be reviewed by	ization	
	Informed Consent f Pneumococcal Vac	mentation should be on the or Influenza and cine sheet, "but the forms and I don't know what all the				

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F 334	(CC), stated "some before they are admonstrated on 3/21/16, at 3:40 infection control nurresidents and "we consider the AL [assisted]. The facility Influenz Revised September be offered the influence provided pertinent is significant risks and "between Octoberated the influenza vaccir unless the vaccinate and the provided pertinent is significant risks and "between Octoberated the influenza vaccir unless the vaccinate and the provided pertinent is significant risks and "between Octoberated the influenza vaccir unless the vaccinate and the provided pertinent is significant risks and "between Octoberated the influenza vaccir unless the vaccinate and the provided pertinent is significant risks and "between Octoberated the influenza vaccir unless the vaccinate and the provided pertinent is significant risks and "between Octoberated the influenza vaccir unless the vaccinate and "between Octoberated the influence and "between Octoberated the infl	p.m. the corporate consultant times they have the vaccines nitted or at the hospital." p.m. DON stated the previous ree had a log for all the can't find it." p.m. CC stated they could not need they could not need they could not need they are and 1310, "he may have had them living], we'll find it." a Vaccine (Residents) - re 2012 indicated residents will enza vaccine annually, will be information about the distance they are shall be offered to residents in the shall be offered to residents.	F 33	34			
F 353 SS=F	September 2012 in offered the pneumo preventing pneumo or upon admission, eligibility to receive offered the vaccina admission to the far 483.30(a) SUFFICI PER CARE PLANS	ENT 24-HR NURSING STAFF	F 3	53		5/3/16	

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			54	REET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	determined by resindividual plans of The facility must propersonnel on a 24-care to all resident care plans: Except when waive section, licensed represonnel. Except when waive section, the facility nurse to serve as a duty. This REQUIREME by: Based on observative review, the facility staffing was provious needs of 3 of 4 reserviewed for press (R4, R257, R481) medication errors reviewed who was facility and seen of R248, R286, R429 unsafe smoking.	well-being of each resident, as dent assessments and care. rovide services by sufficient of the following types of thour basis to provide nursing in accordance with resident and under paragraph (c) of this urses and other nursing and under paragraph (c) of this must designate a licensed a charge nurse on each tour of the lider to ensure sufficient and to meet the individual sidents (R35, R62, R439) ure ulcers; for 3 of 3 residents are viewed for significant for 1 of 1 resident (R104) consuming alcohol in the less at risk for injury to himself ar 7 of 15 residents (R77, R242, R494, R511) reviewed for urther, the facility failed to staffing to provide care and	F3	853	R35 and R4 have been discharged R62,R439, R257, and R481 have rbeing met. R104 is receiving adeq supervision. R77, R42, R248, R42 R494, and R511 have been reasse for smoking. Supervision is provideresidents who require assistance. All current residents have the poter be affected by this alleged deficient. Staff have been re-educated on methe needs of residents requiring turn and repositioning, incontinence, and supervision related to smoking and alcohol. DON/Designee will complete up to	needs uate 9, ssed ed for ntial to cy. eeting ning d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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F 353	Refer to F282: The plan of care was in and R35) were repositioned to prodeterioration of president and R62) revirepositioned to prodeterioration of president and action provide an action provide and safety of the otleration provide and safety of the otleration provide and failed to process, resulting it errors that caused residents R4, R257 Interviews: On 3/17/16, at 2:30 president, identified people to meals and trimmed and dentual timely response to Significant turnover care had declined, disconnect between the nurse staff, the issues. On 3/17/16, at 5:54 stated she had documents and documents are staff, the issues.	a facility failed to ensure the aplemented to ensure (R439 ositioned in a timely manner. If facility failed to ensure (R439, ewed for pressure ulcers were mote healing and prevent assure ulcers. If facility identified R104 was in the facility but failed to alan to ensure his safety and her resident's residing in the e, the facility failed to provide wentions for R77, R242, R286,	F 35	weekly audits to ensure restreceiving care and treatment the plan of care. Audits will be submitted to Creview.	nt needed per		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 353	shift, because ther-At 6:15 a.m. regis census was down building, and so so be admitted, so ha staff. On 3/21/16, at 5:30 (LPN)-H stated, "Syour best." On 3/21/16, at 12:3 (HR) specialist was were open shifts the Time Equivalent and per pay period). A shift for 14 days, in more than 30 full time department. The NA open shifts 17:3 FTE. The HR was advertising, post attending job fairs, partnerships with 1 stated that nursing happened on the under with nursing. reported the open and regional vice per HR. HR stated the turn remained fairly sta January 2016 - Ne and a turnover rate	U stated he had picked up the e was not enough staff. tered nurse (RN)-N stated the because there was flu in the me patients had chosen not to d to decrease the number of U a.m. licensed practical nurse taffing is what it is, you just do U a.m. licensed practical nurse taffing is what it is, you just do U a.m. the human resources interviewed and stated there hat equaled 42.8 FTE (Full 40 hours per week, 80 hours 1.4 FTE would fill one 8-hour other words the facility lacked me employees in the nursing U as were 25.5 FTE's, and nurses specialist stated the facility osting on college boards, and and working to make WA schools. The HR specialist recruitment and retention units and HR did not necessarily The HR specialist stated she positions to the administrator president and vice president of over and new hires rates ble: W hires 22, terminations 25,	F3	53			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 353	33, and a turnover of On 3/21/16, at 1:07 (DON) stated they staff to be recruiting double time and ow the staffing was done two full time and on the night shift was happen supervisor. The DC correlation between according to the Exp.m. on 3/21/16, the number of overtime 800 hours. -At 1:26 p.m. The sbiggest challenge with doing job fairs the open FTE's are are hovering at 297 based on the numb complete patient case (Transitional Care to facility plan was try turnover. The staffind days were the hard mornings. Care and services: R439 was admitted extensive hospitalizand long term acute admission diagnosi included paraplegia	p.m. the director of nursing would "rely on recruiters and g and the facility did use ertime shifts. The DON stated he by the department director, he part time staffers, and that handled by the night nursing his stated she saw no he staffing and incidents hours paid in one week was a lack of people in the had made a huge recruitment has, the staffing manager stated for full census of 341, and we had a huge recruitment had made a huge recruitment had been determined to have a factor of hours required to had the facility on 9/15/15, after that the facility on 9/15/15, after that had been hospitals. R439's a from the face Sheet had functional, pressure ulcer of the 4, Type II Diabetes and	F 3	53			

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	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	The admission Cardated 9/27/15, indistage IV pressure of two stage III pressure of the presents clinically a undermining of adjusticoks. The area prolonged hospitalicomplications. A coand Foley catheter bladder) was initiated well as wound vactor management) to mplastics [plastic surfollowing R439 and closure of the presents and closure of the presents are of the Physician I measurements and Nutrition CAA had pounds over the panutritionally significated secondary to the initial care planed and process and prolondiscussion on the oulcers were or any dated 9/28/15, indices would show signs of infection. The initial care initial care of the present of the presen	re Area Assessment (CAA) cated R439 was admitted with cated areas (full thickness skin age to or necrosis of the that may extend down to, derlying fascia. The ulcer as a deep crater with or without acent tissue) to left and right shad developed during zation with multiple medical plostomy (intestinal diversion) (urine collection system in the ed during the hospitalization as (mechanical wound anage/treat pressure areas. A gery] doctor (MD) was I was considering a flap sure ulcer (surgical covering of romote healing), and the I for 10/1/15. A wound MD was be here and CAA indicated to Progress Notes for a debridement since admit. A triggered as R439 had lost 150 ast six months, which was ant, increased metabolic	F3	353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 353	width and depth wh document status of and healing progres improvements and the resident and far area of skin breakd relieving/reducing das per orders prior ensure comfort." Raprotein, amino acidordered to promote educate R439/familiskin breakdown wh transfer/positioning taking care during a nutrition and freque A review of the nurs 9/15/15 and 10/14/refusals to turn or refusals to turn or refusals to turn or refusals in the pressure uladmission (inaccura progress notes), an noncompliant with clacked supporting efor the statement). The NA care card p staff assist of two s and turn in bed. Grareposition every two minutes when up in assist of staff for mappointments.	ey were to measure length, ere possible. assess and wound perimeter, wound bed as. Staff were directed report declines to the MD. "Inform mily/caregivers of any new own. Pressure levice in bed/chair. Treat pain to treatments/turning etc. to 439 required supplemental s, vitamins, minerals as wound healing. Staff were to ly/caregivers as to causes of ich included requirements; importance of ambulating /mobility, good ent repositioning.	F 3	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE	
F 353	turning and reposition four opportunities per day), a total of 384 actual document On 2/20/16, 2/2816 3/17/16, the night substituting document anything repositioning. On 2/3/10/16, and 3/18/1 documented NO or repositioning. On 2/3/14/16, and 3/15/1 charting indicated the once per shift, howe that the nursing asswas then expected document the risks in the nursing proground on 3/16/16, at 8:36 interview the reside staff do not turn him RN-N and a handfut to care for him. On 3/17/16, continution and fifteen mes:00 a.m. the reside 6:24 RN-P knocked glucose test. At 7:0 knocking, then called room within 15 sections within 15 sections and fifteen the -At 8:03 a.m. R439 he "had not been turned turned to be a	charting for bed mobility, oning which revealed that out a per shift (12 opportunities 360 opportunities there were tation as follows: 3,3/5/16,3/8/16,3/11/16, and hift nursing assistant did not on R439 for turning and (21/16,2/26/16,3/4/16,3/9/16,6, the nursing assistant ace, for turning and (27/16,2/29/16,3/9/16,6 the nursing assistant are resident refused to turn ever there was no evidence sistant informed the nurse who to re-approach R439 or and benefits of refusal to turn ess notes. a.m. during a stage 1 not stated that the night shift of aides was no longer able and observations for two inutes from 5:45 a.m. until and entered room for blood 8 RN-P entered room without and R439's name, she left the onds of entering and placed eatment cart garbage. was interviewed and stated	F3	53				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 353	should be turned expenses on: -Unit 01305, one Lift NA and one TMA wo one NA was floated -Unit 01306, one Riffers and the short of the sugar and the 2nd the 2	d all night. RN-N stated "He very two hours." 6 RN-P stated she had be first time to get his blood sime to give insulin. B stated actually most of the seneed to inform the nurses of ly on the nursing staff to shappening. The aides don't the nurses." 9-C, stated you know with the declined and it was coming to have enough staff, and nat they are doing. D-C akdown in pressure ulcer care. a.m. R439 stated last p.m. (not repositioned for informed that the resident een turned last night, and was orted the allegation of neglect terday. NA-N stated he had DN and consultant nurse (CN). he had interviewed the legation of neglect was I NA-N stated he had talked to asked about being night shift. taffing sheets 3/16/16, showed PN doubled to evenings one ere floated out of unit on days,	F3	53			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245183	B. WING		03/	/21/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 353	out on nightsUnit 01307, 11 NA-Unit 01308, two N floated out on night-Unit 01309, one L LPN floated out on one NA floated out One NA floated out One NA floated out One LPN shift was shift, no NA's were -Unit 01305, one N was floated out on on nightsUnit 10307, one F-Unit 10308, one FLPN and two NA's were floated out on -Unit 01309, one L evenings. One NA A review of nurse son: -Unit 01306, one L one LPN floated out on evenings and to three LPN's floated out on eveningsUnit 01307, one N eveningsUnit 01308, one N RN floated out on on nightsUnit 10309, 1 NA two NA doubled to night shift.	A doubled to evenings. IA doubled to nights, three NA's t shift. PN doubled to evenings, one days and doubled to evenings, one NA doubled to nights. It on nights. It on nights. It on nights. It on higher sheets 3/17/16, showed on the filled, one LPN on night eplanned. IA doubled to nights, one NA evenings, one LPN floated out on evenings, one doubled to nights. Two NA's nights. PN and one NA doubled to floated out on evenings. In hights. PN and one NA doubled to floated out on evenings. It of days, one NA floated out wo NA doubled to nights, and out on nights. IA floated out then doubled to the floated out on hights. IA floated out on evenings, one evenings. IA floated out then doubled to floated out on nights. IA floated out on days, 1 LPN and evenings. One NA floated to	F 35	3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		COMPLETED	
		245183	B. WING		03/	/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 353	one NA doubled to - On 1/2/16, 01305 01306 one LPN and 01307 one NA doubled to night doubled to evenings - On 2/1/16, unit 01 doubled to evenings evenings to nights, NA's doubled to evenings one NA doubled to evenings to nights, a two NA doubled to evenings, one NA doubled to evenings, one NA doubled to evenings, one NA doubled to evenings to nights, to evenings, and un doubled to evenings to nights, to evenings, and un doubled to evenings to nights, to evenings, and un doubled to evenings and un doubled to evenings CALL LIGHT OBSE R161's call light was 3/17/16, from 7:05 a following was noted -7:05 a.m. room 319 -7:28 a.m. RN-G en would tell the aide to off call light. RN-G er eturned to the desi 319 -8:09 a.m. NA-J bro	e NA doubled to nights. 01308 hights. one NA doubled to evenings, done NA doubled to nights, bled to evenings, 01308 two is and 01309 three NA's is, one NA doubled to nights. 305 one LPN and two NA is, one NA doubled from 01306 one LPN and three enings, Unit 01307 one RN is, and Unit 01309 one RN and evenings. 305 one RN and one NA is, Unit 01306 one LPN and evenings, Unit 01307 two enings and one NA doubled ghts, Unit 01308 one LPN and evenings. 305 one LPN doubled to oubled to nights, unit 01306 or evenings and one NA from unit 01308 two NA's doubled it 01309 one LPN and one NA is. CRVATIONS is continuously observed on a.m. to 8:15 a.m. and the	F3	53			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245183	B. WING _		03	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	, = 1, = 2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	-8:10 a.m. NA-J ex-8:12 a.m. call light turned on8:15 a.m. NA-C er over door. NA-C to washed up and dresaid, "Thank you." R161 Quarterly Mir indicated R161 was communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance to dress assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The Visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get from bed to dressed. The visua 3/21/16, instructed assistance and a multiple of the communicate need to get fro	dited room 319. It over door to room 319 was antered room 319 call light offold R161 "I am here to get you essed for breakfast." R161 Inimum Data Set dated 1/13/16, is cognitively intact, able to dis, and was dependent on staffowheel chair after being al/Bedside Kardex report dated staff that R161 required staff the chanical lift to transfer. In 3/17/16, at 7:51 a.m. R161 he nurse she wanted to get up do any one come to get her up. appens every morning." During was observed lying flat in bed 161 had sheet pulled up to attion on 3/17/16 at 7:45 a.m. For the door of 323 tenance man walked by call a without entering room, call antered room 323. The call light turned off NA-A left room 323. Intered room 323 with a	F 3	53		
	LPN-D said,"I have	e one nursing assistant, it has ormal. My census is 29. I used				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03.	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	care charting and the so they do not get work done. Sometimes I am not am so frustrated the wrote letters to my director of nursing a promised me no received me no receive	I am doing the aides point of then I will do the ADL charting written up. I cannot get my mes you do not get a break, it able to get everything done. I at I can't get my work done. I manager, my supervisor, the and the administrator. They sidents with tube feedings, no re two person assist. Well I in tube feeding and several wo person assists. I have I when they are out of bed, very 30 minute checks and utside to smoke every 20 eed to supervise R494. Last smoking aprons and D said, "It is my license and I in afraid for my residents. medication errors, more one falls. 13/21/16, at 5:25 a.m. NA-N est, my nurse helps. We had ost of the night until 4:00 am. I in this unit" 13/21/16, at 5:40 a.m. NA-M a double from evenings to times because of call-ins. I one, but I can do most turns by a stient day)." When asked if if resident acuity increases,	F 35	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
F 353	On 3/21/16, at 5:46 good night. Sometin said, "Sometimes withey are always shot them." On 3/21/16, at 5:56 check TCU they oft and cannot get eve During interview on nurse manager said a new admit arrives the orders into Poin charge nurse would clarification and the them. We try to do check on the same RN-K said R481's rediscovered by an evadmission orders hourses but the gabasaid, "I think it is the someone on the dedesk but only to 3:3 RN-K said R57's mecause, "the HUC clarification and the nurse for several data found the error and communicated to sito write needs clarification inputted into Forders would enter another nurse second	a.m. LPN-G said it was a mes I help the aides. LPN-G re go to the north building, 2N ort on nights. We try to help a.m. LPN-F said, "You should en only have one aid on nights rything done." 3/21/16 at 10:45 a.m. RN-K d, the process for orders when a were The HUC would enter at Click Care (PCC) then the d clarify any orders needing an perform a second check on the clarification and second day as admission. medication error was wening supervisor. The add been checked by two apentin was missed. RN-K are consistency of having sk. My assistant can cover the following." edication error occurred wrote the order needed and we were without a charge ays. The nurse practitioner clarified the order." It was taff that it was not appropriate incation. If an order has not one of the order and then have not check it. RN-K said, "We rege nurse consistently. The	F3	353			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245183	B. WING _	·····	03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353 F 371 SS=E	can have a max of on the day, we work LPN's and TMA's. In need to be cut a da Staffing is good whetwo TMA's. Our per RN-K said, "We sta 483.35(i) FOOD PESTORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	ly have 67 residents, but we 93-95. The schedule depends with a combination RN's, We are told how many hours y by payroll and staffing. en we have three nurses and patient day staffing is 3.18." If by PPD and not acuity." ROCURE, SERVE - SANITARY	F 3:			5/3/16
	by: Based on observate review, the facility for dinnerware was clewater to minimize the illness. This had the residents in the facility of the kitchen. Findings include: During the evening dining observation of	ion, interview and document ailed to assure resident an of food debris and stagnant ne possibility of food borne e potential to affect 288 of 293 lity who were served food out Bridgeway South (BWS) on 3/14/16, at 5:15 p.m. was observed serving food to		F371 Food Procedure/store/prepare/serve Identified serviceware items were wat the time of identification. Current residents who receive mean the kitchen have the potential to be affected by this alleged deficiency. Dietary Staff were educated on propractices for mechanical washing of and coffee cups. Audits to be completed up to 5 times week by Dietary Manager or design Audits will be brought to QAPI mee	per f bowls es per nee.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/:	21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB	5	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	orders at the front of plate warmer was a rack sitting on a thricontinually took bor rack and filled appreciate the back BWS served BWS evening servithree bowls out of track, approximately to run out of each of use the bowls, filling and/or mashed pot to residents seated. During interview on verified the multiple yellow plastic rack been allowed to dryp.m. DA-A removed bowls and brought. During interview on stated he "tries to le in them." A puddle inches in diameter area where the yell. There were also put and third shelf of the verified the water of the yellow plastic racks where the yellow plastic dish racks where yellow plastic dish yellow plas	s who were giving the food of the steam table. Next to the a deep sided yellow plastic dish ee shelf push cart. DA-B was an eeded out of the dish oximately 20 food orders for rice. At 6:03 p.m. the front ce started. When DA-B pulled he same yellow plastic dish a 30cc of water was observed of the bowls. DA-B continued to get them with pureed meat atoes and gravy serving them in the dining room. 3/14/16, at 6:07 p.m. DA-A be blue serving bowls in the were not dry and should have a properly before use. At 6:08 dethe yellow plastic dish rack of a new rack of dry bowls. 3/14/16, at 6:35 p.m. DA-B book out for the ones with water of water approximately 8 was observed underneath the ow dish rack had been sitting. Inddles of water on the second e three shelf push cart. DA-A in the cart had dripped out of	F 371	review.		

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
NORTH RIDGE HEALTH AND REHAB 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 (X5) COMPLE CROSS-REFERENCED TO THE APPROPRIATE			245183	B. WING _		03/	21/2016
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			REHAB		5430 BOONE AVENUE NORTH	•	
	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	(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." 438.30(a)(a)(b) PIARIMACEUTICAL 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	position. In the ten numerous bowls stoleast eight cereal are food debris, some werified the dishess of food debris and rethem. DN stated "we procedure." Review of the facility Revised March 201 "presoak dishes or burnt food, do not or running items through air-dry." On 3/18/16, at 7:58 expect the dishes to "we need to do it rig 483.60(a),(b) PHAFACCURATE PROCEMENT The facility must prodrugs and biological them under an agres \$483.75(h) of this punicensed personnel aw permits, but only supervision of a lice. A facility must provide (including proceduracquiring, receiving administering of all the needs of each received.)	dish racks there were bred with water in them and at and fruit bowls contained dried with water in them. The DN should have been stored clean not stored wet with water in the will be changing that Ty Dishwashing Machine Use - 2 included direction to pots that contain dried or overcrowd racks and after gh entire cycle, allow to a.m. the DN stated she would be clean and dry. DN stated ght, I'm changing it right now." RMACEUTICAL SVC - EDURES, RPH Dovide routine and emergency als to its residents, or obtain the ement described in the ement desc				5/3/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED
		245183	B. WING		03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLÉTION
F 425	services in the facil	e provision of pharmacy	F 425		
	by: Based on observative review, the facility f	tion, interview and document ailed to obtain antibiotic as esident (R305) who was		F425 R305 has received the presonantibiotic. Current residents have the potential affected by this alleged deficiency. Emergency drugs and biological arrayailable to residents.	al to be
	R305 was observed with audible wheez muscles. R305 was interview due to she sitting upright in a v	on 3/16/16, at 10:57 a.m. d to be very short of breathing and usage of accessory unable to complete initial ortness of breath. R305 was wheelchair with oxygen on via re was a nebulizer machine next to R305.		Licensed nurses have been educate regarding the emergency drugs an biological. DON/Designee will audit administrate stat medications weekly Results of audit will be reviewed by	d ation of
	2/9/16, indicated R3 required assistance except for eating w R305 did not have soxygen during the a of the MDS. R305's	mum Data Set (MDS) dated 305 was cognitively intact, with all activities of daily living hich required supervision. Shortness of breath or used assessment reference period annual MDS did indicate as of dementia, anxiety and			
	had shortness of br diagnoses of chron disease, and R305	ted on 3/15/16, indicated R305 eath when lying flat due to a ic obstructive pulmonary used supplemental oxygen for nistory of bronchitis.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		543	EET ADDRESS, CITY, STATE, ZIP CODE O BOONE AVENUE NORTH W HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	indicated staff were 20/milligrams(mg.)/needed (PRN) for coliters by nasal cannows the evening of 3/16 Keflex (antibiotic) 2 mouth for seven da [immediately, witho (breathing treatmer days stat every two Prednisone (steroid 10 mg STAT then etc.) The Geriatric Service Notes dated 3/16/11 and dressed cough antibiotic. Lungs with and audible wheeze "bronchitis, not activate and nebulizer treatment of the service of March 2 Administration Recogiven as ordered or stat was given at 6: Northridge 1 SW Omedication dispensifacility on 3/18/16, a a list of medication emergencies. Cephon the list.	chone Order dated 3/15/16, and give Roxanol milliliter (ml.) every hour as comfort and start oxygen at two rula continuous for comfort. The en by nurse practitioner on the end where the end was the diminished breath sounds with antibiotics, prednisone, ments.	F 4	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	1/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, S 5430 BOONE AVENUE N NEW HOPE, MN 5542	IORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD I CED TO THE APPROPR EFICIENCY)	BE	(X5) COMPLETION DATE
F 425	registered nurse (R short of breath yest yesterday for morph fever, and the oxyg. R305 does not norr. On 3/17/16, at 8:30 (TMA)-A asked RN-Keflex three times a been given and it is. During interview on said, "The order was et up to start at no a.m." RN-G verified given on 3/16/16. During interview on nurse practitioner (I fifteenth and was to dying so I ordered r saw her on the sixte having difficulty breordered nebs, predi'STAT' does not me as soon as possible there was an issue in giving STAT means was an issue with s we start it in the even her doses. There we until the morning. If the pharmacy STAT	N)-F stated R305 was very erday so we obtained orders nine. R305 did not have a en saturations are 92 percent.	F4	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
		245183	B. WING		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB	5	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428 SS=D	said stat means not the medications fro to notify the medication." Administering Medi 2010, indicated, "Madministered in a sprescribed." "3. Meadministered in accar required time frar 483.60(c) DRUG RIRREGULAR, ACT The drug regimen or reviewed at least or pharmacist. The pharmacist muthe attending physicials and the stending physicials are according to the medical statement of the medical s	6 p.m. RN-E nurse manager w. "Sometimes we cannot get m the pharmacy. I expect staff al doctor if they cannot give a cations Policy revised April edications shall be afe and timely manner, and as dications must be cordance with orders, including ne." EGIMEN REVIEW, REPORT	F 428			5/3/16
	by: Based on observation review, the consultion on recommendate reduction for 1 of 5 unnecessary medicine.	NT is not met as evidenced ion, interview and document ng pharmacist failed to follow tions for a gradual dose residents (R422) reviewed for eations.		F428 R422 has been discharged Current residents have the potentia affected by this alleged deficient pr Consultant pharmacist reports recommendations have been addressed Unit managers have been educated regarding consultant pharmacist refrecommendations DON/Designee will audit consultant	actice. essed. d port	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/:	21/2016
	PROVIDER OR SUPPLIER	REHAB		543	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	indicated a recomm Remeron (an anti-omilligrams (mg) at Report was not add R422's quarterly M 1/8/16, indicated he impairments, required ally living and dispondered and dated 1/1 psychotropic medicanxiety, but did not A review of R422's 3/18/16, indicated he mg by mouth at bed During an interview R422 stated he preto 3:00 a.m. He stated 6:00 a.m. make a low During an observated R422 was lying in beyes closed. He ap During an interview registered nurse (Recommendations of and then get distribushe was not aware the pharmacist.	depressant) dose to 7.5 depressed by the Pharmacy dressed by the facility. Ilinimum Data Set dated to had no cognitive red assistance with activities of played no behaviors. R422's 4/16, indicated use of cations for depression and address insomnia. Physician's Orders dated ne was receiving Remeron 15 depression to time for insomnia. If on 3/14/16, at 6:33 p.m., afters to stay up until 2:00 a.m. ted the night staff coming at to of noise and wake him up. Ion on 3/17/16, at 2:36 a.m., and on his left side with his peared to be sleeping. If on 3/18/16, at 8:32 a.m., and on 3/18/16, at 8:32 a.m., and on the director of nursing on the director of nursing and the recommendations by and interview on 3/18/16, at 1:13 "the pharmacy has not followed up on." She	F 4	28	pharmacist report recommendation monthly Results of audit will be reviewed by		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03	3/21/2016	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	2012 was reviewed of medications and	e Reduction, dated September d. The policy indicated tapering I gradual dose reductions will insultation with the physician	F 4	328			
F 431 SS=D	483.60(b), (d), (e)		F4	31		5/3/16	
	a licensed pharma of records of receip controlled drugs in accurate reconcilia records are in orde	mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that druger and that an account of all maintained and periodically					
	labeled in accordar professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the sory and cautionary le expiration date when					
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.					
	permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to in the facility uses single unit ibution systems in which the ninimal and a missing dose can					

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		03/	21/2016
_	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	Continued From pa	_	F 43	1		
	by: Based on observat review, the facility for secured on 1 of 2 uring random observed to be unled 12:54 p.m. nursing cart. 12:55 p.m. staff medication cart delivering supposed to 12:57 p.m. R388 are medication cart. 1:01 p.m. registered medication cart. 1:04 p.m. RN-R verous cart had been unloced Coumadin (blood the medications, over the narcotics in the cart. During interview on director of nursing (locked carts on the	ervation on 3/14/16, at 12:50 rt across from room 607 was ocked. assistant passed medication of the passed the medication of a visitor passed the dia a visitor passed the dia a visitor passed the diffied medication medication ocked and the cart contained of the counter medications and the counter medication and the counter medications and the counter medication and the counter medi		F431 Medications are secure of Current residents have the poter affected by this alleged deficient Medication is secure on all units Nurses have been educated on medications. DON/designee will audit the secure medications on the unit daily. Results of audit will be reviewed.	ntial to be cy. securing urity of	
	secure them in thei medication cart if the supervise it. The Do dished up on top of	order and then they should r room. Staff should lock the ney are not able to adequately ON said medications that were the medication cart are not I if they are out of reach of the aide or nurse.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING _		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441 SS=D	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infe (a) Infection Control The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what preshould be applied to (3) Maintains a reconstruct actions related to infect the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will treat (3) The facility must hands after each dispersional practice (c) Linens Personnel must hand washing is incompressional must hand to hand washing is incompressional must	of Program stablish an Infection Control ch it - Introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective offections. The add of Infection stand Control Program esident needs isolation to of infection, the facility must asset or infected skin lesions with residents or their food, if the ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 44	41		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245183	B. WING _		03/:	21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	.,
NODTH	RIDGE HEALTH AND	DEHAD		5430 BOONE AVENUE NORTH		
NONTH	NIDGE NEALIN AND	NEHAD		NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	by: Based on observareview, the facility of hygiene, glove usarimplemented while residents (R35, R2 personal cares. Findings include: R35 was observed registered nurse (Fright hand without vanitizer. RN-G rearemoved left heel obrown drainage on to visualize the heer RN-G palpated the removed the right of gloves. RN-G push and put R35's feet were touching the gloves, washed hare-entered room. Fright heel dressing dressing to right heel dressing dressing to right he RN-G applied left of square foam cover. During R35's woun at 11:44 a.m. RN-G change the dressing applied gloves, known heels up device froothe clean dressings chair. Nursing assistoward the wall and	Interview and document ailed to ensure proper hand ge and linen handling were providing care for 2 of 3 (82) observed for wound or (8N)-G applied a glove to the washing hands or using sched across R35's legs and dressing. There was yellow and dressing. RN-G moved ankle (1). R35's left heel was black. left wound edges. RN-G then neel dressing without changing ed the right heel skin flap back down so R35's bare heels bed sheets. RN-G removed ands. At 9:23 a.m. RN-G N-G put gloves on and applied then taped square foam cover rel. Without changing gloves eel dressing then taped dressing to left heel. In discovery control of the cont	F 44	F441 R35 has been discharge receiving care consistent with phygiene, glove usage, and line Current residents have the pot affected by this alleged deficien Residents are receiving care cwith proper hand hygiene, glove and linen handling. Nursing staff has been educate regarding hand hygiene, glove linen handling. DON/designee will audit 2 residencounters per unit per week to proper hand hygiene, glove use linen handling. Results of audit will be reviewed.	proper hand in handling. ential to be ncy. possistent e usage ed usage, and dent care o ensure age and	

	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED		
		245183	B. WING		03	/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	removed dressing f wound cleanser to coccyx wound. Coc shaped with two ov strip of slough filled filled with cream co was larger than the dressing to R35's c from R35's bottom. gloves with an inco incontinence brief v removed dressing f cleansed wound wi was circular approx diameter. RN-G ap wound. NA-J did no before applying incremoved gloves, wa gloves. RN-G said dressing change, I just remove one lay remove your gloves on." During interview on verified saying "usu change, I wear two remove one layer a remove your gloves on." RN-G said, "W do not wash my ha	own stool on the brief. RN-G from coccyx. RN-G applied gauze and cleansed the ccyx wound was irregularly als connected by a narrow I skin. The two ovals were slored slough and the right oval left oval. RN-G applied a pink occyx. NA-J cleaned stool NA-J then wiped stool off ntinence wipe. A clean was placed under R35. RN-G from left ischial tuberosity and th wound cleanser. The wound cleanser. The wound climately two centimeters in plied a pink dressing to be wipe the front of peri-area ontinence product. NA-J ashed hands and applied new to NA-J, "usually when I do a wear two to three gloves so I yer at a time because after you is you cannot put the others." In 3/17/16, at 11:55 a.m. RN-G ally when I do a dressing to three gloves so I just at a time because after you so you cannot put the others. Then I do a dressing change I and between gloves or use the my hands when I am done."	F 4	41		
	said I expect them hands after doing p change gloves and	3/18/16, at 1:29 pm RN-E to change gloves and wash peri care. I expect them to wash their hands between We should not double glove				

AND DIAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MUL	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 441	assistant director of expect staff to wash treatment, explain vassesses for pain, expect after they re their gloves and wa contact with anythin on. ADON verified egloves between wo any cross contamin need to wear multiptime while doing ca are to wash their haremove gloves. Stawash hands after distool. It is not accept off stool from glove R282's Minimum Didentified R282 requivith toileting, dress hygiene. During an observation nursing assistant (National Care along with more incontinent of bowe provided incontinent urn to the right side bowel movement was personal care with a the care was provided applied a clean incontined a clea	3/18/16, at 2:10 p.m. the formursing (ADON) stated would in hands before they start what they are going to do, use the bed side table. I move the dressing to change is hands if they came in ing before to put new gloves expected staff to change unds because would not want ation. ADON said there is no ble pairs of gloves at the same res. The ADON stated, "Staff ands or use sanitizer after they iff should remove gloves and ong pericare or cleaning up otable to take a wipe and wipe	F 4	41			

	AND BLAN OF CORRECTION INDESTRUCTION NUMBER:		, ,	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	movement and ther did not wash hands After providing pering gloves and donned proceeded to assist completion of R282 NA-E stated to R28 the room (to put the R282 stated "there' NA-E then threw R2 towel on the floor. NA-E called for add out of bed and into transfer was complehair and handed R2 removed her gloves morning cares were An interview with re 3/17/16, at 11:25 a. should be washed i perineal care and p RN-I also confirmed dirty linen to be put should not be throw A facility policy entit Hygiene dated April employee hands shafter assisting reside	is cleaned R282's bowel in provided perineal care. NA-E is between cares. Ineal cares, NA-E removed a new pair of gloves. NA-E is R282 with dressing. After it's personal care and dressing, it's personal care and dressing, it's that there were no bags in a dirty linen in for laundry) and is nothing unusual about that." 282's gown, washcloth and illitional help to transfer R282 the wheelchair. After the eted, NA-E brushed R282's eted, NA-E then is and indicated that R282's ecomplete. In gistered nurse (RN)-I on im. confirmed staff hands in between incontinent care, roviding other personal cares. It is that each room had bags for in for laundry and soiled linen	F 44	1		
	using soap and wat 483.70(h)		F 46	5		5/3/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	addressed 8, R179, in the rooms ethe alleged elines were m 224. ned. backsplash ette was carpet was all to be as will be roviding a	E SURVEY PLETED
		245183	B. WING _		03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 465	sanitary, and comforesidents, staff and This REQUIREMENT by: Based on observatoreview, the facility functional and sanitequipment was kepteresidents (R10, R19, R282, R329, R368) for environmental of facility did not ensure of 5 kitchenettes. To 130 of 293 resident the Bridgeway South kitchenettes. Findings include: On 3/18/16, at 8:00 environment tour word maintenance direct (DOH), maintenance the facility's administration the facility's administration that the facility is administration that the fa	ovide a safe, functional, ortable environment for the public. NT is not met as evidenced sions, interview, and document ailed to ensure a safe, ary environment, and resident at in good repair for 9 of 10 g, R77, R104, R118, R179, whose rooms were reviewed oncerns. In addition, the re a sanitary environment in 2 his had the potential to affect s who were served food out of th (BWS) and 2 West a.m. to 9:10 a.m. an as conducted with the or, director of housekeeping se staff (MS)-A, at 8:30 a.m. strator joined the tour, during ag environmental concerns	F 46	F465 Safe/functional sanitary environment Environmental concerns were add for R10, R19, R77, R104, R118, FR282, R329, and R368. Current residents who reside in the defined by the deficiency have the potential to be affected by the alle deficiency. Manufacturer guideline reviewed form grab bar in room 20 R104 s wheelchair was cleaned. Bridgeway South kitchenette cleaned. Bridgeway entrance carp replaced. All residents have the potential to affected, rooms and bathrooms we cleaned daily. Staff will be re-educated on provide safe, functional, sanitary, and comenvironment. Environmental audits and TELS as be completed weekly. Audits will reviewed by QAPI committee.	e rooms ged s were 4. splash was et was be ll be ing a fortable udits will	
		and missing handle. or stated staff are to put in a any items needing				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 465	on the wall in the ro	onically.	F 4	465			
	in room - Room 224 had 2 I hallway by the entry in the corner above noted with dirt and o grab bars on the be - R104's wheel cha clear tape on bilate was noted to be filth	arge stains on the carpet on into room, a large spider web the foot of the bed, fan was dust build up, and bilateral ded were loose. ir (w/c) was noted to have a ral arm rests and seat cushion my with food debris. DOH was not a cleanable surface					
	the bathroom had a garbage can in the filled with used inco-Room 338 the car with 3 black/brown - Room 346 had a s-2 large black/browdoorway to room 36 north hallway. DOH stains in the hallway shampooed on Morcheck back after the R368's w/c brakes noted to be loose, a with food debris on cushion. Maintenant	pet was noted to be dirty/filthy stains on the carpet					

21/2016
(X5) COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245183	B. WING		03	3/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	DN verified both are cleaning and stated housekeeping who areas. On 3/18/16, at 9:10 were responsible for asked how often w/she was not aware cleaned. DOH furth bathrooms are cleaned. The facility's Cleanic Cloth Furnishings Findicated that the cleaned that the facility's Cleanic Cloth Furnishings Findicated that the facility is Cleanic Cloth Furnishing Findicated that the	on 3/17/16, at 2:25 p.m., the eas were a concern, needed she would contact is responsible for cleaning the a.m. DOH stated nursing staff r w/c cleaning and when c were cleaned, DOH stated how often the w/c were er stated residents' rooms and ned daily. a.m. maintenance director the electronic teles work order not find any teles work order not find any teles work orders exconcerns that were identified ental tour. Maintenance ed it's the expectation for extronic teles work order the issues are identified. 3/18/16, at 1:11 p.m. the unit E stated that w/c are cleaned led by nursing staff on the ther stated that housekeeping sing schedules. p.m., the director of nursing er expectation is for resident in. Ing/repairing Carpeting and cloth cleaned regularly according	F 4	65		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		03/	21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465 F 520	none provided - A general, residen	ance policy was requested but at equipment, resident room om cleaning policy was	F 46			5/3/16
SS=F	COMMITTEE-MEM QUARTERLY/PLAN A facility must main assurance committ nursing services; a		1 02			5/5/15
	committee meets a issues with respect and assurance active develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.				
	disclosure of the re except insofar as si	retary may not require cords of such committee uch disclosure is related to the committee with the s section.				
		s by the committee to identify deficiencies will not be used as as.				
	by: Based on observat	NT is not met as evidenced tion, interview and document ailed to ensure the Quality		The facility has developed action for residents consuming alcohol,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			03/2	21/2016
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	developed action pinjury for one residial alcohol, becoming for injury to himself addition, the QA coaction plan to addrive sufficient staff needs services in accordation 14 of 23 residen R77, R242, R248, R481, R57). These potential to affect a facility. Findings include: Refer to F314: the and services to previously for 1 of 4 resprovide care result of pressure ulcers failed to prevent defor 2 of 4 residents. Refer to F323: the adequate supervising resident (R104) whalcohol (ETOH) in facility failed to prointerventions to endomination of 15 residents (R494, and R511) whalcohol	committee recognized and plans to address potential for ent who was consuming intoxicated, and posed a risk of and other residents. In promittee failed to develop an ess an identified lack of essary to provide care and ance with their assessed needs ants (R439, R35, R62, R104, R286, R429, R494, R511, R4, endeficient practices had all 294 residents residing in the estate that the estate is a consumeration of the estate is a consumeration while intoxicated for 1 of 1 in was known to consume the facility. In addition, the evide adequate supervision and source safe smoking practices for R77, R242, R248, R286, R429, who currently smoked in the facility failed to ensure 3 of 3 effective facility failed to ensure 3 of 3	F 5	20	ulcers, medication errors, and for providing adequate staffing. Current residents have the potential affected by the alleged deficiency. Facility staff and QAPI committee were-educated on the QAPI action placorrect deficiencies. The NHA is responsible for complian NHA will review QAPI reports mont ensure compliance.	vill be ins to ince.	
	significant medicat	81, and R57) were free from ion errors related to improper resulted in actual harm for R4					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		0:	3/21/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 520	and R481. R4 was activity and R481 srated 10/10. Refer to F353: the sufficient staffing vindividual needs of and R439) revieweresidents (R4, R25 significant medical R104 reviewed who wand others and for R248, R286, R429 unsafe smoking. Fensure adequate services to resider During an interviewed director of nursing ineffective process. She stated during September of 2019 medication error reprocess improvem changed the process omputerized systime nurses can initierrors get recorded was able to track to further stated she and brings them to While the process medication errors, transcription errors occurred for R4, as	facility failed to ensure vas provided to meet the 3 of 4 residents (R35, R62, ed for pressure ulcers; for 3 of 3 of 7, R481) reviewed for tion errors; for 1 of 1 resident o was consuming alcohol in the as at risk for injury to himself 7 of 15 residents (R77, R242, R494, and R511) reviewed for urther, the facility failed to staffing to provide care and ats. If you have a significant of the months of August and 5 she did not receive any exports indicating an area for ent. She stated at that time she as from a paper system to a sem. The DON stated, any of iate a medication error and the dimmediately. She stated she he medication errors daily. She tracked the errors on a report of QA. enabled the facility to track it did not identify prevention of and as a result, actual harm	F 5	20			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	()	COMPLETED	
		245183	B. WING			03/21/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, Z 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD B THE APPROPRIA	
F 520	monthly to review a including infection of medication storage repositioning. The acommittee identified implemented a new program. He further currently working or stated pressure ulder on what comes in fit there was improver building and if they However, he stated particular process of implemented. While the facility ide improvement regard was no evidence of As a result actual horself. The DON was interfarm. regarding R10 aggressive tendance objects when intoxical about R104's Progrip.m. The DON was R104 swinging a knexpect to be inform later stated that she a box cutter, not a knew there was no incide 3/8/16, occurrence not expect an incide every time R104 was indicated with ident "any reasonable and a state of the state o	the facility QA committee met "multitude of projects" control, pressure ulcers, call light response times and administrator stated the QA distaffing concerns and reperformance based incentive ristated the committee was in a pressure ulcer project. He ers are being tracked based rom outside the building, if ment, how many are in the are acquired in the facility.	F 5	320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING			03/2	21/2016	
	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE	
F 520	facility did not have use of alcohol.	ge 161 The DON confirmed the a policy related to resident was requested, but none	F 5	20				

PRINTED: 04/19/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245183 B. WING 03/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5430 BOONE AVENUE NORTH** NORTH RIDGE HEALTH AND REHAB NEW HOPE, MN 55428 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, 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 **EPOC 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: (X6) DATE

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

TITLE

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.

Facility ID: 00238

PRINTED: 04/19/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		COMPLETED		
		245183	B. WING_		03	/16/2016		
	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
K 000	DEFICIENCY MUSE FOLLOWING INFO. 1. A description of to correct the deficiency. 2. The actual, or proceed and a responsible for comprevent a reoccurrency. North Ridge Care (no basement. The 1966 and was determined and was determined and was determined and was a reconstructed and was a recons	tate.mn.us and n@state.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. In title of the person rection and monitoring to ence of the deficiency. Center is a 3-story building with building was constructed in emined to be of Type I(332) 70 an addition was as determined to be of Type 1. In 1978 an addition was as determined to be of Type 1. In 1981 an addition was as determined to be of Type 1. In 1998 an addition was as determined to be of Type 1. Because the original additions are of the same ection type, the facility was						

Facility ID: 00238

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION AND MEDIC			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		
		245183	B. WING			03/1	16/2016
	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From parthe requirement at NOT MET as evide NFPA 101 LIFE SA Doors in an exit particular horizontal exit, smore enclosure are self-position, unless her complying with 7.2 all such doors throus compartment or end (a) The required m (b) Local smoke desmoke passing throus moke detection sy (c) The automatic structure of the second secon	age 2 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD ssageway, stairway enclosure, oke barrier or hazardous area closing and kept in the closed ld open by as release device 1.8.2 that automatically closes ughout the smoke tire facility upon activation of: anual fire alarm system and etectors designed to detect ough the opening or a required	KC	1	K21 Smoke detector will be added West building on the apartment side within 5 feet of the door. Additional smoke detector was added to the Note of the building to activate autodoor release.	d to the le l West matic	5/3/16
	hours of 10:00 AM 16, 2016 between PM, observation re the 2-hour fire rate	March 15, 2016 between the and 11:00 AM and on March the hours of 9:30 AM and 3:30 evealed that the fire doors for d separation between the west partment building did not have			All residents are potentially impacted although none were impacted. Maintenance staff were educated of EII met with Fire Marshal to ensure compliance with regulation prior to installation of smoke detectors. Maintenance Director or designee audit placement of all smoke detectors.	on K21.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - Main Building 01			SURVEY PLETED	
		245183	B. WING			03/	16/2016	
	PROVIDER OR SUPPLIER			54	REET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
K 021	was also revealed detector was opera fire alarm system a doors upon activat	ithin five feet of the doors. It that the closest smoke ated by the apartment building and did not release the fire ion.	KC)21	Audits will be reviewed by QAPI.			
K 066 SS=F	of Maintenance at NFPA 101 LIFE SA	tice was verified by the Director the time of the inspection. AFETY CODE STANDARD as are adopted and include no ving provisions:	K	066			5/3/16	
	compartment wher combustible gases and in any other ha area is posted with or with the internat	hibited in any room, ward, or re flammable liquids, s, or oxygen is used or stored azardous location, and such a signs that read NO SMOKING ional symbol for no smoking.						
		tients classified as not nibited, except when under						
		ncombustible material and safe d in all areas where smoking is						
	devices into which readily available to permitted. 19.7. This STANDARD Based on observa interview, the facili designated resider NFPA LSC (00) Ed	is not met as evidenced by: ations, policy review and staff ty failed to follow policy for the at smoking in accordance with dition Section 19.7.4, and the policy. This deficient practice			K66 Facility updated smoking po Facility added butt receptacles to designated smoking area that are weekly. Smoking area was relocarea where there is no oxygen in Cigarette butts were swept in the Non smoking areas were identifie	the cleaned ated in use. area.		

Facility ID: 00238

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG 01 - Main Building 01		SURVEY PLETED
		245183	B. WING_		03/	16/2016
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 2 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 066	hours of 10:00 AM 16, 2016 between PM, It was observe smoking policy. 1) There are design receptacles, even smoking on the process of the pr	March 15, 2016 between the and 11:00 AM and on March the hours of 9:30 AM and 3:30 and that the facility has a no gnated smoking areas with butt though the policy states no emises. erved that a resident was no smoking sign, while on	K 00	Residents who smoke we re-educated on the smoke Resident council was expected by the smoking policy. Audits will be submitted QAPI.	oking policy. ducated on the ere educated on dits will be compliance.	
K 146 SS=F	of Maintenance at NFPA 101 LIFE SA The nursing home equipment shall ha power separate ar source that will be hour after loss of t 99) This STANDARD Based on observa failed to maintain t (generator) in account (generator) in account (generator). Findings include: On facility tour on hours of 10:00 AM	tice was verified by the Director the time of inspection. AFETY CODE STANDARD /hospice with no life support ave an alternate source of ad independent from the normal effective for minimum of 1 1/2 he normal source 3-6. (NFPA is not met as evidenced by: ation and interview, the facility he alternate source of power ordance with NFPA 99, Section ficient practice could affect 298 March 15, 2016 between the and 11:00 AM and on March the hours of 9:30 AM and 3:30	K 1	K146: Facility will upda automatic switch capab All residents in the Wes potential to be impacted Maintenance staff were automatic switch require generator. Initial generator inspect completed upon install monthly with load transsubmitted to the QAPI for automatic submitted submitted to the QAPI for automatic submitted submitted submitted submitted su	oility. It building have the d. It educated on ements for the distinct will be and audited fer. Results will be	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245183	B. WING		03/	16/2016	
	PROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 146	PM, observation regenerator in the we does not automatic power. During a direction	vealed that the emergency st building transfer switch ally transfer to emergency ected test of the system it was ual transfer was required to	K 1	46			
		ice was verified by the Director he time of the inspection.					