Electronically delivered
April 13, 2022

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

RE: CCN: 245183
Cycle Start Date: March 24, 2022

Dear Administrator:

On March 24, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 13, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 13, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 13, 2022.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 13, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, North Ridge Health And Rehab will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 13, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 24, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 03/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/21/22 through 3/24/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/21/22 through 3/24/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5183470C (MN81824) H5183473C (MN81890) H5183474C (MN81825) H5183476C (MN81672) The following complaints were found to be UNSUBSTANTIATED: H5183469C (MN81532) H5183471C (MN81898) H5183472C (MN81896) H5183475C (MN81801) H5183477C (MN80781)	F 000		

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

Electronically Signed | 04/15/2022

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

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		4/26/22

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F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a dignified environment for 1 of 4 residents (R86) reviewed for dignity. Findings include: R86's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R86 had intact cognition. Further, R86 required supervision with transfers and personal hygiene, and extensive assistance with toilet use. R86's diagnoses included weakness, morbid obesity, and difficulty in walking. R86's care plan dated 9/16/21 included, "The resident has episodes of bladder and bowel incontinence," and "The resident has limited physical mobility r/t [related to] weakness." Staff were instructed, "Toileting: ind [independent] with transfer. Occasional assist upon request for	F 550	F 550 Resident Rights/Exercise of Rights R 86 Blanket on resident wheelchair has been changed. Current residents soiled linen is being removed when observed or during routine cares as needed. Staff have been educated regarding providing a dignified environment including removing soiled linens when observed or during routine cares. The DON or Designee will audit 3 resident rooms 3 times a week for 2 weeks then 3 resident rooms weekly for 2 weeks, then 3 resident rooms monthly for one month to ensure soiled linens have been removed. The results of the audits will be forwarded	

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F 550	Continued From page 3 toileting hygiene," and "get up into chair 1-2x/day." During an interview which occurred in R86's room on 3/21/22, at 3:06 p.m. a blanket covering the seat of R86's wheelchair was observed to have multiple streaks of brown matter. R86 was lying in bed wearing a hospital gown. R86 stated she was aware of the soilage and identified it been there for "2-3 days." R86 added, "Its embarrassing that its there. People coming in [my room] and seeing that. It should be changed." On 3/22/22, at 3:13 p.m. a clean blanket was observed on the seat of R86's wheelchair which was in R86's room. R86 was asleep in bed. During an interview on 3/23/22, at 8:08 a.m. R86 stated yesterday afternoon she requested the nursing assistant remove and replace the soiled blanket on the seat of her wheelchair. R86 stated, "I asked them to. It had been there three to four days. It was embarrassing." During this visit various streaks of light brown matter were observed down the center of the sheet on R86's wheelchair. On 3/23/22, at 2:12 p.m. the sheet on R86's wheelchair appeared unchanged. The same streaks of light brown matter were observed down the center of the sheet in the wheelchair. R68 was asleep in bed. On 3/24/22, at 7:24 a.m. the sheet on R86's wheelchair appeared unchanged from previous observation. The same light brown streaks remained. R86 stated, "I noticed it [streaks] yesterday. I don't like it. I want it changed, but I shouldn't have to tell them to do it."	F 550	to the QAPI committee for continued quality improvement and compliance.	

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F 550	Continued From page 4 On 3/24/22, at 7:34 a.m. nurse manager, registered nurse (RN)-B observed the brown streaks on the sheet on R86's wheelchair. RN-B identified the streaks as likely fecal matter. RN-B added nursing assistants were expected to remove all soiled linens from a resident's room after assisting with cares. The sheet should not be left in the wheelchair if visibly soiled. It should be changed right away." On 3/24/22, at 8:32 a.m. the director of nursing (DON) stated, staff were expected to change linens as soon as they were aware the linens were soiled. Facility policy, "Respect and Dignity; Right to Personal Property," dated 5/21 included, "Resident have the right to be treated with respect and dignity." The policy also included, "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristic include: a. Cleanliness and order."	F 550		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		4/26/22

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F 676	Continued From page 5 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed reassess for the need of a functional maintenance program for 1 of 1 resident (R184) who was reviewed for an activity of daily living (ADL) decline. Findings include: R184's significant change Minimum Data Set (MDS) dated 3/1/22, indicated R184 had moderately impaired cognition and required	F 676	R 184 is currently receiving physical therapy and speech therapy. A functional maintenance program, if appropriate, will be developed as part of the therapy service discharge plan. Current residents with delayed discharges, have been assessed for and if appropriate, are receiving services through a functional maintenance program.	

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F 676	Continued From page 6 extensive assistance with bed mobility and transfers. Additionally, the MDS indicated R184 needed limited assistance with ambulation. 184's diagnoses included anoxic brain damage (damage caused by lack of oxygen), muscle weakness, and abnormalities of gait and mobility. R184's care plan revised on 2/7/22, included, "[R184] will improve current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene to ensure a safe discharge home." R184's Physical Therapy Discharge Summary dated 2/21/22, indicated R184 needed minimal assistance to complete stand-pivot transfers, supervision/touch assistance with bed mobility, and contact guard assistance when ambulating with a walker. Additionally, the summary indicated a functional maintenance program was not established at the time of discharge from therapy services as it was "not indicated" at that time. During an interview on 3/22/22, at 7:32 p.m. family member (FM)-A stated R184 had regressed in his abilities, specifically ambulation, since being discharged from physical therapy services at the end of February. FM-A added R184 had no exercise program to assist with maintaining the level of function achieved while working with therapy services. FM-A stated R184's discharge plan to home was delayed and she asked the assistant administrator about resuming therapy services, however, did not receive follow-up to the inquiry and R184 had not been reassessed for services. During an interview on 3/23/22, at 11:15 a.m. the assistant administrator stated R184 admitted to	F 676	Future residents with delayed discharges from TCU will be assessed for and if appropriate, receive services through a functional maintenance program. Staff have been educated regarding functional maintenance programs for residents with delayed discharges The DON or Designee will audit 2 residents a week with delayed discharges after therapy services have been discontinued to ensure that functional maintenance programs have been established. The results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance.	

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F 676	Continued From page 7	F 676		

the transitional care unit (TCU) and received physical, occupational, and speech therapy services with a goal of discharging home upon completion of these services. R184 was discharged from PT and OT services, but his discharge home was delayed. As a result, he transferred from the TCU to long-term care (LTC) where he would stay until a new discharge date was established.

During an interview on 3/23/22, at 1:36 p.m. the therapy services director (TD)-F stated R184 discharged from therapy services approximately one month ago as had reached his maximum potential. The plan was for R184 to discharge home within a couple of days of discharge. TD-F stated he was aware R184's discharge plan was delayed which resulted in R184 being moved from the TCU to LTC. TD-F added no maintenance program was developed for R184 to assist with maintaining his current level of functioning while waiting for discharge. TD-F explained if the therapists had been aware delay in discharging to the community was going to be significant, an exercise program would had been developed. "We thought he was discharging sooner than he has. We didn't anticipate him being here this long." TD-F stated when there was a change or delay in a resident's discharge plan social services should initiate communication with the interdisciplinary team, which included therapy, to determine if a physical maintenance program should be added or if additional therapy services were needed.

During an interview of 3/24/22, at 7:36 am registered nurse (RN)-D stated he had worked with R184 since he transferred to LTC. RN-D was not aware of any maintenance program, had not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 8 ever seen R184 walk, and said R184 needed extensive assistance to get in and out of bed. During an interview on 3/24/22, at 10:45 a.m. physical therapist (PT)-A stated she evaluated R184 that morning to complete an assessment of R184's current level of function. The assessment determined R184 needed increased assistance with transfers and bed mobility and he had decreased stamina with ambulation. Based on the finding from the assessment PT-A recommended R184 resume physical therapy services 5 days a week to "get him back to where he was when he discharged from therapy" then establish a functional maintenance program prior to discharging from therapy services if his discharge to the community remains uncertain. Although R184 was discharged from therapy on 2/21/22, without a functional maintenance program, R184 was not reassessed to determine if a maintenance program would be necessary to maintain his current abilities when his discharge was delayed. The facility policy, "Goals and objectives, Restorative Services, dated 5/2021, included, "Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessment."	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		4/26/22

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F 684	Continued From page 9 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct bowel monitoring to promptly identify potential constipation for 1 of 1 residents reviewed for constipation. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/12/21, indicated R9 was cognitively intact, required extensive assist of one staff for bed mobility and two staff for toilet use, and required maximum assistance with toilet transfers and toilet hygiene. The MDS indicated R9 was always incontinent of bladder and occasionally incontinent of bowel. The 'yes/no' MDS question pertaining to constipation lacked documentation. The MDS identified R9 had diagnoses of aphonia (difficulty speaking), heart disease, kidney failure, diabetes, stroke, respiratory failure, and epilepsy. A nurse practitioner (NP) progress note dated 1/2/22, and a physician progress note dated 1/13/22, both indicated R9 had a history of constipation. R9's care plan included an intervention dated 8/9/21, which directed staff to monitor/document for side effects of pain medication and observe for constipation. R9's Order Summary Report dated 3/24/22, indicated R9 was prescribed the following	F 684	R 9 is receiving bowel monitoring. Current residents are receiving bowel monitoring by nursing staff. Staff have been educated regarding bowel monitoring. The DON or Designee will audit 3 residents twice a week for 2 weeks then 3 residents weekly for 2 weeks the 3 residents monthly for one month, to ensure bowel monitoring has occurred. The results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance.	

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F 684	Continued From page 10 medications on 1/3/22: - Ferrous Sulfate, (an iron supplement with side effect of constipation), Give 325 mg orally in the morning for anemia. - Polyethylene Glycol Powder (a laxative), Give 17 grams orally in the evening for constipation. - Senna Tablet 8.6 milligrams (a laxative), Give 2 tablets orally one time a day for constipation. - Fiber Powder, Give 1 tablespoon orally in the morning for constipation. During interview on 3/21/22, at 1:46 p.m. R9 stated she had constipation and her medications did not help. She stated staff knew, but could not recall who she told or when. R9's Task Flowsheet dated 3/21/22, indicated nursing assistants (NAs) were to document BMs every shift. R9's Bowel Movement/Continence Task documentation reviewed 3/22/22, indicated R9 had three bowel movements (BMs) documented within the previous 30 days. R9's Documentation Survey Report v2 dated 3/24/22, indicated R9 had a total of four BMs from 2/1/22, through 3/21/22. During interview on 3/24/22, at 8:03 a.m. R9 stated she still had concerns with constipation. During interview on 3/24/22, at 8:08 a.m. nursing assistant (NA)-A stated NAs always documented BMs in the electronic record, including consistency, but she had not helped R9 recently. During interview on 3/24/22, at 8:23 a.m. registered nurse (RN)-A stated NAs documented	F 684		

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F 684	Continued From page 11 BMs and told nurses how many days it had been since the last BM. She stated without this information nurses would not know if a resident was constipated, especially when some residents couldn't express that they were unable to have a BM. She stated if a resident had constipation, nurses followed PRN (as needed) orders for interventions, communicated with the NAs, reassessed, and tried something else if the intervention was unsuccessful. She stated BM information was documented on every shift, and if there was an extended period without a BM, management would inform the nurse. She stated sometimes the aide left without telling the nurse and the nurse would have to look in the NA documentation to review the resident BM history. RN-A was observed attempting to review NA documentation for R9 and RN-A received a message that maintenance was being performed on the computer system. During interview on 3/24/22, at 9:02 a.m. RN-C stated nurses listened to bowel sounds and watched for physical signs of discomfort to identify if a resident was constipated for residents with inability or difficulty communicating needs. She stated NAs recorded the actual physical BM on each shift and updated the nurse if it had been three days since the last BM. Nurses could also review the NA documentation to determine if a resident was constipated. She stated if there was no BM after three days the nurse implemented an intervention from the standing house order bowel program. She stated if a PRN medication was given for constipation staff followed up with the resident to determine if it was effective, but they did not follow up with scheduled medications. RN-C stated constipation could lead to unfortunate outcomes including discomfort and	F 684		

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F 684	Continued From page 12 "other issues." She stated there was no constipation issue with R9 based on the lack of documentation in the nursing notes. She stated R9 was able to communicate and did not report anything to nursing staff. Upon review of R9s the Bowel Monitoring Task in the EHR which indicated R9 had three BMs in the past 30 days, RN-C stated she needed to dig further and declined to answer additional questions pertaining to R9's documentation. During interview on 3/24/22, at 10:57 a.m. physician assistant (PA)-A stated she expected staff to be monitoring and tracking resident bowel movements. She stated R9 was taking three medications for constipation and expected staff to inform her of any concerns so they could be addressed. PA-A reviewed R9's bowel movement documentation in the electronic record and stated it looked like R9 only had three bowel movements in the past month. She stated she expected more than that, and if a resident had unmonitored constipation issues it could lead to hemorrhoids, pain, and bowel obstruction. During interview on 3/24/22, at 1:56 p.m. director of nursing (DON) stated nurses asked residents about bowels and completed assessments when they gave medications to residents. She stated some residents had scheduled medications due to chronic constipation, and BM results were documented by NAs in their charting. She stated there may be an absence of charting due to staffing concerns. She stated the nurses asked the NA about resident bowel status and charted by exception, she stated if a resident was constipated, she believed her staff would notice during their day-to-day work and nurses would enter a note and follow the facility bowel program.	F 684		

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F 684	Continued From page 13 She stated she directed staff to create late entry notes to address R9's bowel movements for the previous few days, and stated R9 had no issues. A policy pertaining bowel monitoring was requested, however staff indicated one does not exist.	F 684		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bed rails were assessed for safety and necessity for 2 of 2 residents (R184, R9) who had bed rails/grab bars	F 700	R 9 and R 184 have been assessed for safety and necessity of bed rails. Current residents with bed rails have been	4/26/22

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F 700	Continued From page 14 affixed to their beds. Findings include: R184's significant change Minimum Data Set (MDS) dated 3/1/22, indicated R184 had moderately impaired cognition and needed extensive assistance with bed mobility and transfers. 184's diagnoses included anoxic brain damage, muscle weakness, and abnormalities of gait and mobility. R184's care plan revised on 2/7/22, included, R184 will improve current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene to ensure a safe discharge home. During observation on 3/21/22, at 2:13 p.m. R184 was observed lying in bed with grab bars on the left and right side of the bed. R184's medical record contained no evidence an assessment, risk versus benefits, or informed consent was completed/obtained prior to the use of grab bars. R9's quarterly Minimum Data Set (MDS) dated 12/12/21, indicated R9 was cognitively intact and required extensive assist of one staff for bed mobility. The MDS identified R9 had diagnoses of aphonia (difficulty speaking), heart disease, kidney failure, diabetes, stroke, respiratory failure, and epilepsy (seizure). R9's Nursing: Side Rail Evaluation - V3 dated 10/13/2020, indicated R9 utilized both right and left grab bars for turning side to side, moving up and down in bed, holding self to one side, pulling	F 700	assessed for safety and necessity. Staff have been educated regarding the need to perform an assessment to determine safety and necessity of bed rails. The DON or Designee will audit 3 residents with bed rails, twice a week for 2 weeks, then 3 residents weekly, then 3 residents for a month to determine if an assessment was completed to determine the safety and necessity of their use of bed rails. The results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance.	

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F 700	Continued From page 15	F 700		

self from lying to sitting position, and supporting self. The assessment indicated the rail would not impede R9's freedom of movement, identified the care plan was updated, and specified a physician order was obtained. R9's electronic health record (EHR) lacked any additional follow-up assessments since 10/13/2020.

During interview on 3/21/22, at 1:48 p.m. R9 stated she had a grab bar to assist with repositioning on the left side of her bed, but would like one on the right as well. She stated she used to have one on the right, but it was taken off. A grab bar was observed attached to the left-hand side of the bed, and another on the floor on the right-hand side of her bed next to the back wall.

During observation on 3/24/22, at 8:03 a.m. R9's bed had a grab bar attached to the left-hand side of her bed, and another on the floor of the right-hand side of her bed next to the back wall.

During interview on 3/24/22, at 8:57 a.m. occupational therapist (OT)-A stated sometimes therapy recommended grab bars if they would assist with independence and mobility, however, sometimes nursing addressed it themselves. She stated she did not know R9's circumstances and did not know why the right-hand grab bar was on the floor.

During interview on 3/24/22, at 9:02 a.m. registered nurse (RN)-C stated nursing always completed a side rail assessment before grab bars were placed on a resident bed. If the resident "passed" staff obtained a provider order, called maintenance to put bars on the bed, and updated the care plan. She stated the need for the grab bars was assessed with each MDS

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F 700	Continued From page 16	F 700		

update and as needed. She stated if a resident's condition changed and grab bars were a hindrance or no longer helpful, they would update the provider and the care plan as they would not want something that wasn't helpful, appropriate, or resident centered. She stated she would need to look into R9's situation and suggested one grab bar was removed based on therapy recommendations.

During interview on 3/24/22, at 1:56 p.m. the director of nursing (DON) stated grab bars were added to resident beds based upon therapy recommendations, but sometimes nursing would complete the assessment tool if a resident was not in therapy. She stated staff reviewed the care plan quarterly and asked therapy to reassess if a resident had a change in condition, however, the need for grab bars was not included in the quarterly assessment. She stated they would reassess the need for bed rails if they appeared to be detrimental. She stated she was unsure of the status of R9's grab bars.

During interview on 3/24/22, at 4:20 p.m. the DON confirmed she was unable to locate a bed rail assessment for R184 and stated he was moved from the transitional care unit to another room and the bed in the new room had grab bars. She stated R184 was in his assessment period, and were removed earlier that day.

The facility policy Bed Safety F 689, Bed Rails F 700 dated 5/2021, identified bed rails as adjustable metal or rigid plastic bars attached to the bed in a variety of types and shapes, which included side rails, bedside rails, safety rails, grab bars, and assist bars. The policy indicated the residents sleeping environment shall be assessed

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F 700	Continued From page 17 by the interdisciplinary team (IDT), considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. The initial evaluation is to be completed with the interim plan of care, a full evaluation by the IDT after completion of the MDS, and ongoing evaluation by the IDT, after the completion of quarterly MDS or with change in condition. The policy further specified if bed rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the attending physician, and input from the reside and/or legal representative. The staff shall obtain a physician's order and consent for the use of bed rails from the resident or the resident's legal representative prior to their use.	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		4/26/22

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F 880	Continued From page 18 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 19 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed appropriately utilize personal protective equipment (PPE) and perform hand hygiene for 2 of 2 residents (R354, R356), who were reviewed for transmission based precautions, and subsequently touched high touch surfaces and/or a resident's environment (R108). Findings include: R354's Face Sheet dated 3/18/22, indicated R354 had an active diagnoses of Clostridioides difficile (C.diff) (a germ that causes severe diarrhea and inflammation of the colon) and sepsis (severe infection). R108's admission Minimum Data Set (MDS) dated 2/11/22, indicated R109 had diagnoses of traumatic brain injury and diabetes. R354's Order Summary Report dated 3/18/22, indicated R354 required enteric precautions (use of a gown and gloves in addition to hand hygiene using soap and water) for C. diff until further advised by the infection preventionist or provider to discontinue. The order further directed staff to ensure residents and staff used soap and water	F 880	F 880 Infection Prevention and Control Directed Plan of Correction R 354 and R 356 staff are utilizing appropriate personal protective equipment and hand hygiene according to their transmission-based precautions. This has been achieved by reeducation and monitoring. Current Residents with transmission-based precautions are receiving care with appropriate personal protective equipment and hand hygiene. The facility□s Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, and Governing Body oversight conducted a root cause analysis (RCA) to identify the problems (s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. The DON and Infection Preventionist have reviewed the facility hand hygiene policies and procedures to ensure they meet CDC	

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F 880	Continued From page 20 for hand hygiene. Additionally, hospital discharge orders dated 3/18/22, indicated R354 was not free from communicable disease due to C. diff. R354's care plan dated 3/20/22, indicated R354 was incontinent of bowel and required assistance of one staff for toileting. During an observation on 3/21/22, at 9:16 a.m. an isolation cart was outside of R354's room with a sign above the cart which indicated R354 was on enteric isolation precautions. Housekeeper (HK)-A was observed to put on a gown and gloves and entered R354's room and proceeded to clean. HK-A had entered R354's bathroom to spray surfices, wiped down bedside table, and re-entered R354's bathroom. HK-A exited R354's room and obtained a broom and dustpan from a cart located outside of R354's room. In doing so, HK-A touched a housekeeping cart, broom, dustpan handles, and the outside of R354's door while wearing the same gloves. HK-A again entered R353's room and subsequently exited and placed the broom and dustpan back on the housekeeping cart and placed a bag of garbage from the room into a larger garbage bag hanging on the cart. HK-A then obtained a mop. In doing so, HK-A again touched the housekeeping cart and the outside doorknob of R354's room door wearing the same gloves. HK-A then returned the mop to the housekeeping cart while still wearing the same gloves. After cleaning R354's room, HK-A removed and disposed of their isolation gown and shut R354's door. HK-A had not removed their gloves. At 9:28 a.m. HK-A proceeded to R108's room who was not on TBP, wearing the same gloves she used to clean R354's room. HK-A shut	F 880	guidance and CMS requirements. The DON and Infection preventionist have reviewed the policies and procedures for donning and doffing PPE during Covid-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care. The facility has current policies and procedures for source control masks, proper use of gowns, as well as standard and transmission -based precautions. Current staff have been educated regarding proper hand hygiene and completed an observed competency for hand hygiene. Current staff have been educated and trained regarding standard infection control practices including transmission-based precautions, appropriate PPE use, and donning and doffing PPE. This training included a competency for the application and removal of PPE. Residents and their representatives have received education on the facility□s Infection Control Program as it relates to them and consistent with their capacity. The Director of Nursing, Infection Preventionist and/or other facility leadership will conduct audits on all shifts, every day for one week. These audits will include hand hygiene, proper use of gowns, donning 4/25/2022 DPOC Items 1-6 attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 03/24/2022

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F 880	Continued From page 21 R354's door upon entering the room. HK-A exited R108's room twice to obtain items from the housekeeping cart; each time HK-A touched the cart, the outside of R108's door, and handles of broom and mop. Upon completion of cleaning R108. HK-A removed their gloves and used hand sanitizer to perform hand hygiene. During an interview on 3/21/22, at 9:47 a.m. HK-A stated the process for cleaning rooms was the same for all residents which included removing garbage, wiping tables, cleaning the bathroom, sweeping, and mopping floors. HK-A stated they changed their gloves every two rooms and hand sanitizer was used. HK-A stated gowns were always worn for isolation rooms. HK-A verified the same gloves were used to clean R354's room and R108's room. HK-A reviewed the enteric precautions sign outside of R354's room, noted the sign instructed the use of soap and water for hand hygiene and confirmed they had not used soap and water to perform hand hygiene. During an interview on 3/21/22, at 1:21 p.m. R354 stated he did not use the bathroom, just a urinal and wore an incontinence product as he was incontinent of bowel. R354 stated staff helped clean him up when he had a bowel movement, but had not offered to wash his hands with soap and water. R354's room had a foul odor noted during the interview. During an interview on 3/21/22, at 1:26 p.m. HK-C stated they attempted clean TBP rooms last. When entering a TBP room, all supplies were gathered and brought into the room in bags as they could not leave a room until PPE could be removed. HK-C further stated there were no dedicated supplies for TBP rooms, but she tried	F 880		

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F 880	Continued From page 22 to clean the toilet brushes with bleach and water after use. HK-C stated hand sanitizer was used upon exit from all rooms, including resident rooms with enteric precautions. A progress note dated 3/21/22, at 2:10 p.m. indicated R354 had two loose stools with no fowl odor noted. During an interview on 3/21/22, at 2:56 p.m. HK-D stated staff were expected to remove isolation gowns at the door and should not exit rooms with a gown or gloves on. Glove removal and hand hygiene was expected after exit of each room. Furthermore, HK-D stated staff normally could use hand sanitizer after cleaning rooms, but staff needed to wash their hands with soap and water after exiting a TBP room. HK-D stated there were disposable toilet brushes for use in TBP rooms, but was not sure how often they were used. HK-D stated removal of PPE before exiting rooms and proper hand hygiene was important for infection prevention and making sure bacteria was not carried room-to-room. During an interview on 3/21/22, at 3:22 p.m. the medical director (MD) stated they expected staff to follow appropriate TBP for any suspected or confirmed transmittable infection. Furthermore, the MD stated handwashing with soap and water was best practice, but hand sanitizer was sufficient for any infections. The MD stated not performing hand hygiene was not acceptable and placed other residents at risk for infection. A progress note dated 3/21/22, at 4:18 p.m. indicated R354 had a history of C.diff and had formed stools since admission (contrary to the progress note on 3/21/22, at 2:10 p.m.). A	F 880		

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F 880	Continued From page 23 message was left with the nurse practitioner to determine if isolation was still needed. A subsequent progress note dated 3/22/22, at 7:54 a.m. indicated R354's isolation orders were okay to remove after a conversation with the provider. During an observation on 3/23/22, at 2:11 p.m. the isolation cart and signage was no longer placed outside of of R354's room. Nursing assistant (NA)-A and occupational therapist (OT)-B were also observed changing R354's incontinence product at this time. R354's stool was noted to be loose and had soaked through the sheet underneath R354. OT-B stated R354 had a large bowel movement that was loose and had leaked through the sheet. During an observation on 3/24/22, at 9:33 a.m. R354 was sitting in bed with his incontinence product unfastened. No isolation cart or signage was placed outside of R354's room. R354's incontinence product was noted to be saturated with loose yellow stool which was leaking out. The stool, which was foul smelling, had soaked out of the brief and onto the bed linens. NA-C, who was not wearing an isolation gown, was in the room and assisted R354 turn to wash his bottom. Additionally, NA-C rolled the soaked/soiled sheets underneath R354. NA-C described R354's stool as loose, slippery, and maybe a little watery. At this time, an isolation cart and enteric isolation sign was observed to be placed outside of R354's room. Registered nurse (RN)-F then gowned, gloved and entered room and assisted NA-C put on an isolation gown and provided incontinence cares for R354. RN-F described stool as soft and watery as the stool had leaked through the bedding completely and on the mattress.	F 880		

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F 880	Continued From page 24 During an interview on 3/24/21 at 7:52 a.m. RN-G stated each type of infection had a protocol on how to remove isolation. RN-G stated R354's chart showed formed stools documented since admission, however, she was not aware of the progress note indicating R354's loose stool on 3/21/22. Furthermore, RN-G stated there was not collaboration with staff, or observation of R354's stools, when deciding to discontinue R354's enteric precautions on 3/22/22. During an interview on 3/24/22, at 8:27 a.m. RN-H stated a protocol which included a chart review, review of labs, vital signs, progress notes, other relevant documentation, and staff/provider collaboration was used to determine if TBP could be discontinued. RN-H stated he expected all staff to follow any TBP signs in-place for residents. Furthermore, not following TBP placed other residents at risk for infection. A progress note dated 3/24/21, at 9:22 a.m. indicated nurse practitioner (NP)-A requested to start enteric isolation for R354. During an interview on 3/24/22, at 10:57 a.m. nurse practitioner (NP)-A stated R354 was a new admission and the facility reached out regarding isolation precautions on 3/21/22. NP-A stated while C.diff precautions "can be discontinued, it was up to the facility to determine if R354 had met the criteria as I had not seen the resident yet." NP-A further stated R354's enteric precautions were removed prematurely and there was risk for other residents by doing so. During an interview on 3/24/22, at 11:31 a.m. the director of nursing (DON) stated R354 had no	F 880		

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F 880	Continued From page 25	F 880		

loose stools for 48 hours prior to discontinuing TBP. The DON stated she was unaware of the progress note documenting loose stools on 3/21/22. The DON further stated RN-G discussed the criteria with NP-A and NP-A discontinued TBP for R354. The DON stated after a second discussion with NP-A on 3/24/22, TBP were reordered. DON expected all staff to follow TBP signs posted at a residents door.

R356's Face Sheet dated 3/16/22, indicated R356 had diagnoses of sepsis, diabetes, and weakness.

R356's hospital discharge summary dated 3/16/22, indicated R356 had a catheter-associated urinary tract infection due to ESBL Klebsiella.

R356's care plan dated 3/18/22, indicated R356 had a suprapubic catheter (inserted through the abdomen) related to urinary retention and history of bladder rupture.

R356's Order Summary Report dated 3/22/22, indicated R356 required contact precautions for extended spectrum beta-lactamase (ESBL) (an infection resistant to multiple antibiotics) in urine.

During an observation on 3/23/22 at 9:32 a.m. HK-B put on a gown and gloves and entered R356's room and went into R356's bathroom and sprayed surfaces with bleach cleaner. HK-B then wiped down R356's room surfaces and bedside table. At 9:40 a.m. HK-B exited R356's room, without removing her gown or gloves, and touched the housekeeping cart to obtain the broom and dustpan. HK-B also touched the outside of R356's door and re-entered the room.

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F 880	Continued From page 26 HK-B again exited R356's room, without removing her gown or gloves, and pulled the housekeeping cart closer to the doorway and exchanged the broom and dustpan for the mop and placed R356's garbage bag into a larger garbage bag hung on the cart. At 9:42 a.m. HK-B then exited R356's room, removed and discarded their gown and gloves in the hallway and placed them in a garbage bag hung on the cart and performed hand hygiene. During an interview on 3/23/22, at 9:43 a.m. HK-B stated a gown and gloves was needed to clean R356's room. HK-B stated she sprayed a bleach cleaner in bathroom, removed garbage, wiped down surfaces, and wiped down the bathroom. HK-B stated the process was to remove isolation gowns and gloves after cleaning a residents room was completed and it was okay to leave on the gown and gloves to obtain supplies from the housekeeping cart. During an observation on 3/23/22, at 2:30 p.m. RN-E walked into R356's room to help R356 swing her legs back up in bed. RN-E did not put on a gown or gloves before walking into R356's room. Upon exiting R356's room, RN-E had not performed hand hygiene and walked down to obtain a vital sign machine and brought it down the other hallway for use. RN-E then stopped at the medication cart and performed hand hygiene. During an interview on 3/23/22, at 2:40 p.m. RN-E stated they were not sure why R356 was on TBP. Furthermore, RN-E verified they had not performed hand hygiene upon exit of R356's room. Facility policy titled Isolation- Categories of	F 880		

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F 880	Continued From page 27 Transmission-Based Precautions. Reviewed 3/2022, directed transmission-based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. Furthermore, the policy directed staff must remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or waterless agent. Gastrointestinal illness may require soap and water for hand hygiene (ex. C. diff).	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 13, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: ZYB711

Dear Administrator:

The above facility was surveyed on March 21, 2022 through March 24, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/21/22 through 3/24/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED, however, NO licensing orders were issued due to actions implemented by the facility prior to survey: H5183470C (MN81824) H5183473C (MN81890) H5183474C (MN81825) H5183476C (MN81672) The following complaints were found to be UNSUBSTANTIATED: H5183469C (MN81532) H5183471C (MN81898) H5183472C (MN81896) H5183475C (MN81801) H5183477C (MN80781) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin	2 000		

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2 000	Continued From page 2 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other	2 915		4/26/22

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2 915	Continued From page 3 functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed reassess for the need of a functional maintenance program for 1 of 1 resident (R184) who was reviewed for an activity of daily living (ADL) decline. Findings include: R184's significant change Minimum Data Set (MDS) dated 3/1/22, indicated R184 had moderately impaired cognition and required extensive assistance with bed mobility and transfers. Additionally, the MDS indicated R184 needed limited assistance with ambulation. 184's diagnoses included anoxic brain damage (damage caused by lack of oxygen), muscle weakness, and abnormalities of gait and mobility. R184's care plan revised on 2/7/22, included, "[R184] will improve current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene to ensure a safe discharge home." R184's Physical Therapy Discharge Summary dated 2/21/22, indicated R184 needed minimal assistance to complete stand-pivot transfers, supervision/touch assistance with bed mobility, and contact guard assistance when ambulating with a walker. Additionally, the summary indicated a functional maintenance program was not established at the time of discharge from therapy	2 915	See correction plan above F676	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 4 services as it was "not indicated" at that time. During an interview on 3/22/22, at 7:32 p.m. family member (FM)-A stated R184 had regressed in his abilities, specifically ambulation, since being discharged from physical therapy services at the end of February. FM-A added R184 had no exercise program to assist with maintaining the level of function achieved while working with therapy services. FM-A stated R184's discharge plan to home was delayed and she asked the assistant administrator about resuming therapy services, however, did not receive follow-up to the inquiry and R184 had not been reassessed for services. During an interview on 3/23/22, at 11:15 a.m. the assistant administrator stated R184 admitted to the transitional care unit (TCU) and received physical, occupational, and speech therapy services with a goal of discharging home upon completion of these services. R184 was discharged from PT and OT services, but his discharge home was delayed. As a result, he transferred from the TCU to long-term care (LTC) where he would stay until a new discharge date was established. During an interview on 3/23/22, at 1:36 p.m. the therapy services director (TD)-F stated R184 discharged from therapy services approximately one month ago as had reached his maximum potential. The plan was for R184 to discharge home within a couple of days of discharge. TD-F stated he was aware R184's discharge plan was delayed which resulted in R184 being moved from the TCU to LTC. TD-F added no maintenance program was developed for R184 to assist with maintaining his current level of functioning while waiting for discharge. TD-F	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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2 915	Continued From page 5	2 915		

explained if the therapists had been aware delay in discharging to the community was going to be significant, an exercise program would had been developed. "We thought he was discharging sooner than he has. We didn't anticipate him being here this long." TD-F stated when there was a change or delay in a resident's discharge plan social services should initiate communication with the interdisciplinary team, which included therapy, to determine if a physical maintenance program should be added or if additional therapy services were needed.

During an interview of 3/24/22, at 7:36 am registered nurse (RN)-D stated he had worked with R184 since he transferred to LTC. RN-D was not aware of any maintenance program, had not ever seen R184 walk, and said R184 needed extensive assistance to get in and out of bed.

During an interview on 3/24/22, at 10:45 a.m. physical therapist (PT)-A stated she evaluated R184 that morning to complete an assessment of R184's current level of function. The assessment determined R184 needed increased assistance with transfers and bed mobility and he had decreased stamina with ambulation. Based on the finding from the assessment PT-A recommended R184 resume physical therapy services 5 days a week to "get him back to where he was when he discharged from therapy" then establish a functional maintenance program prior to discharging from therapy services if his discharge to the community remains uncertain.

Although R184 was discharged from therapy on 2/21/22, without a functional maintenance program, R184 was not reassessed to determine if a maintenance program would be necessary to maintain his current abilities when his discharge

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	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

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2 915	Continued From page 6 was delayed. The facility policy, "Goals and objectives, Restorative Services, dated 5/2021, included, "Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessment." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure residents are given appropriate treatment and services to maintain their abilities. The director of nursing (DON), or designee, could then educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed appropriately utilize personal protective equipment (PPE) and perform hand hygiene for 2 of 2 residents (R354, R356), who were reviewed for transmission based precautions, and subsequently touched high	21375	See plan above for F880	4/26/22

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	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

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21375	Continued From page 7 touch surfaces and/or a resident's environment (R108). Findings include: R354's Face Sheet dated 3/18/22, indicated R354 had an active diagnoses of Clostridioides difficile (C.diff) (a germ that causes severe diarrhea and inflammation of the colon) and sepsis (severe infection). R108's admission Minimum Data Set (MDS) dated 2/11/22, indicated R109 had diagnoses of traumatic brain injury and diabetes. R354's Order Summary Report dated 3/18/22, indicated R354 required enteric precautions (use of a gown and gloves in addition to hand hygiene using soap and water) for C. diff until further advised by the infection preventionist or provider to discontinue. The order further directed staff to ensure residents and staff used soap and water for hand hygiene. Additionally, hospital discharge orders dated 3/18/22, indicated R354 was not free from communicable disease due to C. diff. R354's care plan dated 3/20/22, indicated R354 was incontinent of bowel and required assistance of one staff for toileting. During an observation on 3/21/22, at 9:16 a.m. an isolation cart was outside of R354's room with a sign above the cart which indicated R354 was on enteric isolation precautions. Housekeeper (HK)-A was observed to put on a gown and gloves and entered R354's room and proceeded to clean. HK-A had entered R354's bathroom to spray surfices, wiped down bedside table, and re-entered R354's bathroom. HK-A exited R354's room and obtained a broom and dustpan from a	21375		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 8	21375		

cart located outside of R354's room. In doing so, HK-A touched a housekeeping cart, broom, dustpan handles, and the outside of R354's door while wearing the same gloves. HK-A again entered R353's room and subsequently exited and placed the broom and dustpan back on the housekeeping cart and placed a bag of garbage from the room into a larger garbage bag hanging on the cart. HK-A then obtained a mop. In doing so, HK-A again touched the housekeeping cart and the outside doorknob of R354's room door wearing the same gloves. HK-A then returned the mop to the housekeeping cart while still wearing the same gloves. After cleaning R354's room, HK-A removed and disposed of their isolation gown and shut R354's door. HK-A had not removed their gloves.

At 9:28 a.m. HK-A proceeded to R108's room who was not on TBP, wearing the same gloves she used to clean R354's room. HK-A shut R354's door upon entering the room. HK-A exited R108's room twice to obtain items from the housekeeping cart; each time HK-A touched the cart, the outside of R108's door, and handles of broom and mop. Upon completion of cleaning R108. HK-A removed their gloves and used hand sanitizer to perform hand hygiene.

During an interview on 3/21/22, at 9:47 a.m. HK-A stated the process for cleaning rooms was the same for all residents which included removing garbage, wiping tables, cleaning the bathroom, sweeping, and mopping floors. HK-A stated they changed their gloves every two rooms and hand sanitizer was used. HK-A stated gowns were always worn for isolation rooms. HK-A verified the same gloves were used to clean R354's room and R108's room. HK-A reviewed the enteric precautions sign outside of R354's room, noted

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	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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21375	Continued From page 9	21375		

the sign instructed the use of soap and water for hand hygiene and confirmed they had not used soap and water to perform hand hygiene.

During an interview on 3/21/22, at 1:21 p.m. R354 stated he did not use the bathroom, just a urinal and wore an incontinence product as he was incontinent of bowel. R354 stated staff helped clean him up when he had a bowel movement, but had not offered to wash his hands with soap and water. R354's room had a foul odor noted during the interview.

During an interview on 3/21/22, at 1:26 p.m. HK-C stated they attempted clean TBP rooms last. When entering a TBP room, all supplies were gathered and brought into the room in bags as they could not leave a room until PPE could be removed. HK-C further stated there were no dedicated supplies for TBP rooms, but she tried to clean the toilet brushes with bleach and water after use. HK-C stated hand sanitizer was used upon exit from all rooms, including resident rooms with enteric precautions.

A progress note dated 3/21/22, at 2:10 p.m. indicated R354 had two loose stools with no fowl odor noted.

During an interview on 3/21/22, at 2:56 p.m. HK-D stated staff were expected to remove isolation gowns at the door and should not exit rooms with a gown or gloves on. Glove removal and hand hygiene was expected after exit of each room. Furthermore, HK-D stated staff normally could use hand sanitizer after cleaning rooms, but staff needed to wash their hands with soap and water after exiting a TBP room. HK-D stated there were disposable toilet brushes for use in TBP rooms, but was not sure how often they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 10	21375		

used. HK-D stated removal of PPE before exiting rooms and proper hand hygiene was important for infection prevention and making sure bacteria was not carried room-to-room.

During an interview on 3/21/22, at 3:22 p.m. the medical director (MD) stated they expected staff to follow appropriate TBP for any suspected or confirmed transmittable infection. Furthermore, the MD stated handwashing with soap and water was best practice, but hand sanitizer was sufficient for any infections. The MD stated not performing hand hygiene was not acceptable and placed other residents at risk for infection.

A progress note dated 3/21/22, at 4:18 p.m. indicated R354 had a history of C.diff and had formed stools since admission (contrary to the progress note on 3/21/22, at 2:10 p.m.). A message was left with the nurse practitioner to determine if isolation was still needed. A subsequent progress note dated 3/22/22, at 7:54 a.m. indicated R354's isolation orders were okay to remove after a conversation with the provider.

During an observation on 3/23/22, at 2:11 p.m. the isolation cart and signage was no longer placed outside of of R354's room. Nursing assistant (NA)-A and occupational therapist (OT)-B were also observed changing R354's incontinence product at this time. R354's stool was noted to be loose and had soaked through the sheet underneath R354. OT-B stated R354 had a large bowel movement that was loose and had leaked through the sheet.

During an observation on 3/24/22, at 9:33 a.m. R354 was sitting in bed with his incontinence product unfastened. No isolation cart or signage was placed outside of R354's room. R354's

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	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

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21375	Continued From page 11 incontinence product was noted to be saturated with loose yellow stool which was leaking out. The stool, which was foul smelling, had soaked out of the brief and onto the bed linens. NA-C, who was not wearing an isolation gown, was in the room and assisted R354 turn to wash his bottom. Additionally, NA-C rolled the soaked/soiled sheets underneath R354. NA-C described R354's stool as loose, slippery, and maybe a little watery. At this time, an isolation cart and enteric isolation sign was observed to be placed outside of R354's room. Registered nurse (RN)-F then gowned, gloved and entered room and assisted NA-C put on an isolation gown and provided incontinence cares for R354. RN-F described stool as soft and watery as the stool had leaked through the bedding completely and on the mattress. During an interview on 3/24/21 at 7:52 a.m. RN-G stated each type of infection had a protocol on how to remove isolation. RN-G stated R354's chart showed formed stools documented since admission, however, she was not aware of the progress note indicating R354's loose stool on 3/21/22. Furthermore, RN-G stated there was not collaboration with staff, or observation of R354's stools, when deciding to discontinue R354's enteric precautions on 3/22/22. During an interview on 3/24/22, at 8:27 a.m. RN-H stated a protocol which included a chart review, review of labs, vital signs, progress notes, other relevant documentation, and staff/provider collaboration was used to determine if TBP could be discontinued. RN-H stated he expected all staff to follow any TBP signs in-place for residents. Furthermore, not following TBP placed other residents at risk for infection.	21375		

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	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 12 A progress note dated 3/24/21, at 9:22 a.m. indicated nurse practitioner (NP)-A requested to start enteric isolation for R354. During an interview on 3/24/22, at 10:57 a.m. nurse practitioner (NP)-A stated R354 was a new admission and the facility reached out regarding isolation precautions on 3/21/22. NP-A stated while C.diff precautions "can be discontinued, it was up to the facility to determine if R354 had met the criteria as I had not seen the resident yet." NP-A further stated R354's enteric precautions were removed prematurely and there was risk for other residents by doing so. During an interview on 3/24/22, at 11:31 a.m. the director of nursing (DON) stated R354 had no loose stools for 48 hours prior to discontinuing TBP. The DON stated she was unaware of the progress note documenting loose stools on 3/21/22. The DON further stated RN-G discussed the criteria with NP-A and NP-A discontinued TBP for R354. The DON stated after a second discussion with NP-A on 3/24/22, TBP were reordered. DON expected all staff to follow TBP signs posted at a residents door. R356's Face Sheet dated 3/16/22, indicated R356 had diagnoses of sepsis, diabetes, and weakness. R356's hospital discharge summary dated 3/16/22, indicated R356 had a catheter-associated urinary tract infection due to ESBL Klebsiella. R356's care plan dated 3/18/22, indicated R356 had a suprapubic catheter (inserted through the abdomen) related to urinary retention and history of bladder rupture.	21375		

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	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 13 R356's Order Summary Report dated 3/22/22, indicated R356 required contact precautions for extended spectrum beta-lactamase (ESBL) (an infection resistant to multiple antibiotics) in urine. During an observation on 3/23/22 at 9:32 a.m. HK-B put on a gown and gloves and entered R356's room and went into R356's bathroom and sprayed surfaces with bleach cleaner. HK-B then wiped down R356's room surfaces and bedside table. At 9:40 a.m. HK-B exited R356's room, without removing her gown or gloves, and touched the housekeeping cart to obtain the broom and dustpan. HK-B also touched the outside of R356's door and re-entered the room. HK-B again exited R356's room, without removing her gown or gloves, and pulled the housekeeping cart closer to the doorway and exchanged the broom and dustpan for the mop and placed R356's garbage bag into a larger garbage bag hung on the cart. At 9:42 a.m. HK-B then exited R356's room, removed and discarded their gown and gloves in the hallway and placed them in a garbage bag hung on the cart and performed hand hygiene. During an interview on 3/23/22, at 9:43 a.m. HK-B stated a gown and gloves was needed to clean R356's room. HK-B stated she sprayed a bleach cleaner in bathroom, removed garbage, wiped down surfaces, and wiped down the bathroom. HK-B stated the process was to remove isolation gowns and gloves after cleaning a residents room was completed and it was okay to leave on the gown and gloves to obtain supplies from the housekeeping cart. During an observation on 3/23/22, at 2:30 p.m. RN-E walked into R356's room to help R356	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

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21375	Continued From page 14 swing her legs back up in bed. RN-E did not put on a gown or gloves before walking into R356's room. Upon exiting R356's room, RN-E had not performed hand hygiene and walked down to obtain a vital sign machine and brought it down the other hallway for use. RN-E then stopped at the medication cart and performed hand hygiene. During an interview on 3/23/22, at 2:40 p.m. RN-E stated they were not sure why R356 was on TBP. Furthermore, RN-E verified they had not performed hand hygiene upon exit of R356's room. Facility policy titled Isolation- Categories of Transmission-Based Precautions. Reviewed 3/2022, directed transmission-based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. Furthermore, the policy directed staff must remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or waterless agent. Gastrointestinal illness may require soap and water for hand hygiene (ex. C. diff). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review/revise facility policies regarding PPE, cleaning process/procedures, and hand hygiene. The DON, or designee, could then educate staff and perform audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

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21805	Continued From page 15	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to provide a dignified environment for 1 of 4 residents (R86) reviewed for dignity. Findings include: R86's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R86 had intact cognition. Further, R86 required supervision with transfers and personal hygiene, and extensive assistance with toilet use. R86's diagnoses included weakness, morbid obesity, and difficulty in walking. R86's care plan dated 9/16/21 included, "The resident has episodes of bladder and bowel incontinence," and "The resident has limited physical mobility r/t [related to] weakness." Staff were instructed, "Toileting: ind [independent] with transfer. Occasional assist upon request for toileting hygiene," and "get up into chair 1-2x/day." During an interview which occurred in R86's room on 3/21/22, at 3:06 p.m. a blanket covering the seat of R86's wheelchair was observed to have multiple streaks of brown matter. R86 was lying in bed wearing a hospital gown. R86 stated she was	21805	See plan above F550	4/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 16 aware of the soilage and identified it been there for "2-3 days." R86 added, "Its embarrassing that its there. People coming in [my room] and seeing that. It should be changed." On 3/22/22, at 3:13 p.m. a clean blanket was observed on the seat of R86's wheelchair which was in R86's room. R86 was asleep in bed. During an interview on 3/23/22, at 8:08 a.m. R86 stated yesterday afternoon she requested the nursing assistant remove and replace the soiled blanket on the seat of her wheelchair. R86 stated, "I asked them to. It had been there three to four days. It was embarrassing." During this visit various streaks of light brown matter were observed down the center of the sheet on R86's wheelchair. On 3/23/22, at 2:12 p.m. the sheet on R86's wheelchair appeared unchanged. The same streaks of light brown matter were observed down the center of the sheet in the wheelchair. R68 was asleep in bed. On 3/24/22, at 7:24 a.m. the sheet on R86's wheelchair appeared unchanged from previous observation. The same light brown streaks remained. R86 stated, "I noticed it [streaks] yesterday. I don't like it. I want it changed, but I shouldn't have to tell them to do it." On 3/24/22, at 7:34 a.m. nurse manager, registered nurse (RN)-B observed the brown streaks on the sheet on R86's wheelchair. RN-B identified the streaks as likely fecal matter. RN-B added nursing assistants were expected to remove all soiled linens from a resident's room after assisting with cares. The sheet should not be left in the wheelchair if visibly soiled. It should	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/24/2022

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21805	Continued From page 17 be changed right away." On 3/24/22, at 8:32 a.m. the director of nursing (DON) stated, staff were expected to change linens as soon as they were aware the linens were soiled. Facility policy, "Respect and Dignity; Right to Personal Property," dated 5/21 included, "Resident have the right to be treated with respect and dignity." The policy also included, "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristic include: a. Cleanliness and order." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review/revise policies and procedures related to the provision of dignified care and services. The DON, or designee, could then re-educate staff on these policies and develop system for evaluating and monitoring consistent implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/22/2022. At the time of this survey, North Ridge Health and Rehab Bldg 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/22/2022

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

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. North Ridge Health & Rehab-Bldg 01 is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type	K 000		

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 000	Continued From page 2 1(332) construction. The facility is fully protected throughout by an automatic fire sprinkler system. It has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 320 beds and had a census of 212 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of the available documentation, and staff interview, the facility failed to test and maintain the emergency egress lighting system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/22/2022 at 10:06 AM, it was revealed by a review of available documentation that there was not a complete list of which emergency lights are being tested monthly or annually. 2. On 03/22/2022 at 02:12 PM, it was revealed by observation that there was no exit lighting at	K 291	A complete list of all emergency lights in the building has been created. A schedule for monthly and annual testing has been created. The emergency lighting fixture on the exterior maintenance shop wall was installed and is operable. The Plant Operations Director will create a task in TELs for emergency lights and monitor for compliance. Completion will be audited monthly x 3 months and results will be brought to QAPI Committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	5/6/22

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K 291	Continued From page 3 the exit discharge from the maintenance shop. An interview with the Administrator and Vice President of Operations verified these deficient findings at the time of discovery.	K 291		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the exit signage per NFPA 101 (2012 edition), Life Safety Code sections 7.10.1.2.1 and 7.10.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/22/2022 at 11:00 AM, it was revealed by observation that the North Exit Sign across from the kitchen doors was inoperable when tested. 2. On 03/22/2022 at 11:12 AM, it was revealed by observation that the exit sign to the locker room was inoperable when tested. 3. On 03/22/2022 at 11:44 AM, it was revealed by observation that the exit sign in RCU by resident	K 293	The north exit sign across from the kitchen doors was repaired and is operable. The exit sign to the locker room was repaired and is operable. The exit sign in RCU near room 401 was repaired and is operable. Exit signs will be audited on a monthly basis to ensure operability. A task has been created in TELs to ensure compliance. Completion will be audited monthly x 3 months and the results will be brought to QAPI for review and discussion. Administrator or designee is responsible for compliance.	5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 293	Continued From page 4 room 401 was inoperable when tested. An interview with the Administrator verified these deficient findings at the time of discovery.	K 293		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 321	Continued From page 5 Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022, between 09:53 AM and 11:55 AM, it was revealed by observation that the following hazard room doors were deficient, as evidenced by: 1. Housekeeping/Storage Room 369 A door did not positively latch. 2. 60 sq foot Linen storage 345 D had a broken latch 3. 60 sq foot storage in room 327 did not have a closer and did not positively latch. 4. Combustible Storage Room 287 D did not have a closer 5. Soiled Utility room on the 500 Wing did not positively latch An interview with the Administrator verified these deficient findings at the time of discovery.	K 321	The door labeled Housekeeping/storage room 369A was repaired and now latches. The door labeled Linen Storage 345D was repaired and now latches. The door labeled 327 was repaired and now latches, and a closer was installed. Combustible Storage Room 287 had a closure installed. The door labeled Soiled Utility Room on the 500 wing was repaired and now latches. Doors in the facility will be routinely monitored to ensure they meet compliance. Doors in the facility will be audited monthly x 3 months for compliance and results will be brought to QAPI for review and discussion. The Administrator or designee will be responsible for compliance.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed	K 341		5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 341	Continued From page 6 at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to install smoke detection per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/22/2022 at 10:38 AM, observation revealed that the room across from Resident Room 281 is being used for charting and is open to the corridor without smoke detection. An interview with the Administrator verified this deficient finding at the time of discovery.	K 341	A hard wired smoke detector has been installed in the charting room near 281. The other charting areas have been inspected to ensure they either have a door or a hard wired smoke detector in them. No doors will be removed from hallway areas without approval from the Safety Committee. The Administrator or designee will be responsible for compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 345	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:30 AM, it was revealed by a review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Vice President of Operations verified these deficient findings at the time of discovery.	K 345	The semi-annual fire alarm test was completed. A schedule has been created to ensure annual and semi annual fire alarm tests are completed with appropriate documentation retained. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. The Administrator or designee with be responsible for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 8 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2 and 5.2.1.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 03/22/2022 at 09:53 AM, it was revealed by a review of available documentation the last completed Annual Sprinkler test was completed on 08/31/2020. 2) On 03/22/2022 between 09:39 AM and 11:44 AM, it was revealed by observation in the following locations escutcheon rings were missing: 1) 3 West North by employee restroom by room 380 A. 2) Room 386 3) 3 West Activities Room 4) Linen Room 287 D on 2 North 5) 2 South Nurses Station 6) 2 West Activities Room 7) Room 101 8) Room 103 9) Laundry	K 353	The Annual Fire Alarm Inspection/Test was completed by a vendor. Installation of escutcheon rings in the areas identified (3WN by room 380A, 386, 3W Activity Room, Linen Room 287D, 2S nurses station, 2W Activities Room, 101, 103, Laundry, 900 wing). Replacement of ceiling tiles occurred in the areas identified (3W Activities Room, Linen Room 287D, 2 north 287C utility room, 2WN nurses station, room 269A, room 269B, Housekeeping Room 243D, RCU o2 Storage, 100 wing by shower suite, room 105, clean linen on 700, employee locker room, employee breakroom, 900 wing). Annual and quarterly sprinkler tests will be scheduled out for future completion. Routine monitoring of escutcheon rings and missing/broken ceiling tiles will occur. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. Administrator or designee will be responsible for compliance.	

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 353	Continued From page 9 10) Multiple in the 900 Wing 3) On 03/22/2022 between 10:16 AM and 12:17 AM, it was revealed by observation in the following locations ceiling tiles were missing or in need of replacement: 1) 3 West Activities Room 2) Linen Room 287 D on 2 North 3) 2 North Room 287 C Utility Room 4) 2 North nurses Station 5) Room 269 A on 2 North 6) Room 269 B on 2 North 7) Housekeeping Room 243 D 8) RCU O2 Storage 9) 100 Wing by shower suite 10) Room 105 11) Clean Linen on 700 Wing 12) Employee Locker room 13) Employee Breakroom 14) Multiple in the 900 Wing An interview with the Administrator verified these deficient findings at the time of discovery.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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

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K 363	Continued From page 10 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain resident room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/22/2022 at 11:55 AM, it was revealed that resident room door 514 would not shut and positively latch when tested.	K 363	The door labeled 514 was repaired and latches. Doors will be routinely monitored to ensure compliance and positive latching. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. The Administrator or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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

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K 363	Continued From page 11 An interview with the Administrator verified this deficient finding at the time of discovery.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, and 8.5.6 through 8.5.6.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022, between 09:59 AM and 10:49 AM, it was revealed by observation the following smoke barriers were not maintained: 1. 3 North Smoke Barrier has a 2 X 2.5 hole around communication wires above the doors. 2. 3 South Smoke Barrier 2.5 X 2.5 hole around wires above doors.	K 372	Fire caulking was installed in the follow areas : 3N smoke barrier, 3S smoke barrier, 2N smoke barrier, 2S smoke barrier. Door sequencers/longer door brushes were also installed for 2S and 2N smoke barrier doors. Doors and smoke barrier walls will be inspected on a routine basis to ensure compliance. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. The Administrator or designee will be	5/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 372	Continued From page 12 3. 2 North Smoke Barrier 2.5 inch Conduit was not Fire Caulked and missing a coordinating device. 4. 2 South Smoke Barrier door is missing the coordinating device. An interview with the Administrator verified these deficient findings at the time of discovery.	K 372	responsible for compliance.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:23 AM, it was revealed by a review of available documentation the fire drill for the 1st Shift of the Second Quarter of 2021.	K 712	A calendar was created to outline all dates and times that fire drills will occur in 2022. The Fire Drill Calendar will be monitored for compliance. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. Administrator or designee will be responsible for compliance.	5/6/22

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K 712	Continued From page 13 An interview with the Vice President of Operations verified this deficient finding at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct inspections of all fire-rated doors required per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 03/22/2022 at 09:30 AM, it was revealed by a review of available documentation that the annual inspection of fire-rated doors was last	K 761	The annual inspection of fire rated doors was completed. The door labeled 2West Fire Doors was repaired to ensure a 1/2 gap does not exist. A schedule was created to routinely monitor fire doors, including the annual fire door inspection. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. Administrator or designee will be responsible for compliance.	5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 761	Continued From page 14 completed on 01/22/20. 2) On 03/22/2022 at 11:09 AM, it was revealed by observation a 1/2 inch gap in the 2 West Fire Doors. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 761		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to verify the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99 (2012 Edition), Health Care Facilities Code, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:45 AM, it was revealed by a review of available documentation that the facility	K 901	The NFPA 99 Risk Assessment has been completed. The Safety Committee will review the Risk Assessment annually and as needed. Safety Committee Minutes will be reviewed to ensure compliance. Administrator or designee will be responsible for compliance.	5/6/22

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 901	Continued From page 15 did not have NFPA 99 Facility Risk Assessment at the time of the survey. An interview with the Vice President of Operations verified this deficient finding at the time of discovery.	K 901		

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	245183	A. BUILDING **04 - 800 WING** B. WING _____	**03/22/2022**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2022

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

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

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K 000	Continued From page 2 census of 212 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of the available documentation, and staff interview, the facility failed to test and maintain the emergency egress lighting system per NFPA 101 (2012 edition), Life Safety Code, sections 18.2.9.1 and 7.9.3.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 10:06 AM, it was revealed by a review of available documentation that there was not a complete list of which emergency lights are being tested monthly or annually. An interview with the Administrator and Vice President of Operations verified these deficient findings at the time of discovery.	K 291	A complete list of all emergency lights in the building has been created. A schedule for monthly and annual testing has been created. The emergency lighting fixture on the exterior maintenance shop wall was installed and is operable. The Plant Operations Director will create a task in TELs for emergency lights and monitor for compliance. Completion will be audited monthly x 3 months and results will be brought to QAPI Committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	5/6/22
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		5/6/22

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K 345	Continued From page 3 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:30 AM, it was revealed by a review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Vice President of Operations verified these deficient findings at the time of discovery.	K 345	The semi-annual fire alarm test was completed. A schedule has been created to ensure annual and semi annual fire alarm tests are completed with appropriate documentation retained. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. The Administrator or designee with be responsible for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		5/6/22

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	245183	A. BUILDING **04 - 800 WING** B. WING _____	**03/22/2022**

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K 353	Continued From page 4 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems Safety Code sections 4.1.5.2 and 5.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 03/22/2022 at 09:53 AM, it was revealed by a review of available documentation the last completed Annual Sprinkler test was completed on 08/31/2020. 2) On 03/22/2022 at 12:15 AM, it was revealed by observation a ceiling tile in the storage room of the 800 Wing has a 3/4 inch hole in it. An interview with the Administrator verified these deficient findings at the time of discovery.	K 353	The Annual Fire Alarm Inspection/Test was completed by a vendor. Installation of escutcheon rings in the areas identified (3WN by room 380A, 386, 3W Activity Room, Linen Room 287D, 2S nurses station, 2W Activities Room, 101, 103, Laundry, 900 wing). Replacement of ceiling tiles occurred in the areas identified (3W Activities Room, Linen Room 287D, 2 north 287C utility room, 2WN nurses station, room 269A, room 269B, Housekeeping Room 243D, RCU o2 Storage, 100 wing by shower suite, room 105, clean linen on 700, employee locker room, employee breakroom, 900 wing). Annual and quarterly sprinkler tests will be scheduled out for future completion. Routine monitoring of escutcheon rings and missing/broken ceiling tiles will occur. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion.	

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K 353	Continued From page 5	K 353	Administrator or designee will be responsible for compliance.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 18.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:23 AM, it was revealed by a review of available documentation the fire drill for the 1st Shift of the Second Quarter of 2021. An interview with the Vice President of Operations verified this deficient finding at the time of discovery.	K 712	A calendar was created to outline all dates and times that fire drills will occur in 2022. The Fire Drill Calendar will be monitored for compliance. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. Administrator or designee will be responsible for compliance.	5/6/22
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		5/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**03/22/2022**

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K 761	Continued From page 6 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct inspections of all fire-rated doors required per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:30 AM, it was revealed by a review of available documentation that the annual inspection of fire-rated doors was last completed on 01/22/20. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 761	The annual inspection of fire rated doors was completed. The door labeled 2West Fire Doors was repaired to ensure a 1/2 gap does not exist. A schedule was created to routinely monitor fire doors, including the annual fire door inspection. Completion will be audited monthly x 3 months and results will be brought to QAPI for review and discussion. Administrator or designee will be responsible for compliance.	
K 901 SS=F	Fundamentals - Building System Categories	K 901		5/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING _____	**03/22/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 7 CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to verify the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99 (2012 Edition), Health Care Facilities Code, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022 at 09:45 AM, it was revealed by a review of available documentation that the facility did not have NFPA 99 Facility Risk Assessment at the time of the survey. An interview with the Vice President of Operations verified this deficient finding at the time of discovery.	K 901	The NFPA 99 Risk Assessment has been completed. The Safety Committee will review the Risk Assessment annually and as needed. Safety Committee Minutes will be reviewed to ensure compliance. Administrator or designee will be responsible for compliance.	