DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 21, 2026

Administrator
North Ridge Health And Rehab
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

RE: CCN: 245183
Cycle Start Date: May 4, 2026

Dear Administrator:

On May 4, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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Administrator
North Ridge Health And Rehab
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

Re: Reinspection Results
Event ID: 2305FD-H1

Dear Administrator:

On May 19, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 4, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
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Office: 651-201-4112

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/04/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| North Ridge Health And Rehab | 5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 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 |
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| F0000 | INITIAL COMMENTS<br><br>On 4/30/26, 5/1/26, and 5/4/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed: H51831704C (299786).<br><br>As a result of the investigation deficiencies were cited at F656 and F698.<br><br>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.<br><br>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. | F0000 | | 05/12/2026 |
| F0656 SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, | F0656 | Education:<br><br>The facility reviewed and reinforced its policy regarding comprehensive care planning for residents receiving dialysis services. Licensed nurses and interdisciplinary team members were re-educated on development of individualized dialysis care plan interventions, timely updating of care plans and implementation and documentation of interventions.<br><br>Corrective Action for Cited Resident:<br><br>R2’s comprehensive care plan was reviewed and revised to include interventions related to hemodialysis care and services. | 05/13/2026 |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0656 SS = D | Continued from page 1<br>mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interviews and document review the facility failed to comprehensively develop and implement care plan interventions for 1 of 3 residents (R2) when R2 required in-center hemodialysis (also known as dialysis) (going to a dialysis center for therapy that filters your blood outside your body using a machine and a manufactured filter) three days a week.<br><br>Findings include:<br><br>R2's Medicare 5-Day Minimum Data Sheet (MDS) dated 2/3/26, indicated R2 admitted to the facility on 1/27/26 with intact cognition, diagnoses included renal (kidney) insufficiency, and required dialysis. | F0656 | Continued from page 1<br>Like Residents:<br><br>An audit of residents currently receiving dialysis services was completed to ensure comprehensive care plans were developed and implemented according to resident-specific dialysis needs.<br><br>Audits:<br><br>The DON or designee will audit 3 dialysis residents' weekly for 4 weeks, then 2 dialysis residents' weekly for 2 weeks to ensure comprehensive care plans were developed and implemented according to resident-specific dialysis needs. If audits identify areas of ongoing concerns, the QAPI team will review/initiate new interventions and re-education for ongoing compliance. Audits would be extended until the QAPI team establishes a pattern of ongoing compliance. | 05/13/2026 |

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| F0656 SS = D | Continued from page 2<br>R2's provider orders dated 1/27/26, indicated dialysis three times weekly and directed nurses to complete a post-dialysis assessment on Tuesdays, Thursdays and Saturdays. On 1/29/26, the provider orders were modified to complete the post-dialysis assessments on Mondays, Wednesdays and Fridays instead.<br><br>R2's care plan reviewed 4/30/26 lacked a focus area and interventions for dialysis treatment.<br><br>During an interview on 5/1/26 at 2:16 p.m., registered nurse (RN)-A stated when a resident required dialysis, the care plan required interventions to perform pre-dialysis assessment of weights, vital signs (VS), and to check for the bruit (the whooshing sound of blood running through a dialysis shunt) and thrill (a vibration that indicates blood is flowing in the dialysis shunt). Post-dialysis assessments included weighing the resident, assessment for the bruit and thrill, assess the dialysis shunt or port site for bleeding, and pain, and assessment of the resident's lung sounds.<br><br>During an interview on 5/1/26 at 4:50 p.m., licensed practical nurse (LPN)-A stated nursing staff was expected to obtain a resident's vitals signs before and after dialysis, and assess for the bruit and thrill. LPN-A stated dialysis interventions should be on a resident's care plan.<br><br>During an interview on 5/4/26 at 11:55 a.m., RN-D stated each resident on dialysis required a dialysis-related care plan, and acknowledged R2 did not have a care plan related to dialysis.<br><br>During an interview on 5/4/26 at 12:19 p.m., the director of nursing (DON) stated each resident on dialysis would have a care plan with appropriate interventions and acknowledged R2 did not have a care plan for dialysis. The assessments helped determine if the treatment was effective.<br><br>The Comprehensive Care Plans policy dated 3/2026 indicated an individualized care plan that included measurable objectives and time frames to meet resident's needs is developed for each resident. The care plan was based on the MDS and physician orders, and included specialized services. | F0656 | | 05/13/2026 |
| F0698 SS = D | Dialysis<br><br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis. | F0698 | Education:<br><br>Dialysis assessment was revised and updated. Licensed nursing staff responsible for the resident's dialysis care received re-education on: | 05/13/2026 |

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| F0698 SS = D | Continued from page 3<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to ensure assessment of the resident's condition and monitoring for complications before and after dialysis, failed to ensure staff was knowledgeable about providing care, and failed to ensure the medical record reflected accurate care and monitoring of the dialysis access site for 1 of 1 resident (R2) reviewed for dialysis.<br><br>Findings include:<br><br>R2's Medicare 5-Day Minimum Data Sheet (MDS) dated 2/3/26, indicated R2 admitted to the facility on 1/27/26 with intact cognition, diagnoses that included renal (kidney) insufficiency, and required dialysis.<br><br>R2's provider orders dated 1/27/26, indicated hemodialysis three times weekly, and nurses would complete a post-dialysis assessment on Tuesdays, Thursdays and Saturdays. On 1/29/26, the provider orders were modified to complete the post-dialysis assessments on Mondays, Wednesdays and Fridays instead.<br><br>R2's care plan reviewed 4/30/26 lacked a focus area and interventions for dialysis treatment.<br><br>R2's progress notes dated 4/27/26 at 12:03 p.m., indicated R2 was administered vancomycin 250 milligrams (mg) in sodium chloride .9% 100 milliliters (ml) at dialysis.<br><br>R2's medical record lacked Dialysis Communication documentation for 4/27/26, which would have contained pre-dialysis and post-dialysis nursing assessments. Other Dialysis Communication assessments (pre-dialysis and post-dialysis assessments) indicated the following assessment dates and data:<br><br>On 4/3/26, at 11:06 a.m., the pre-dialysis and post-dialysis weights were both recorded as 166.5 pounds (lbs). The post-dialysis assessment indicated VS were checked on 4/3/26 at 8:46 a.m. The form lacked an actual post-dialysis weight or VS, but instead included the VS that were were performed pre-dialysis. | F0698 | Continued from page 3<br>Pre/post dialysis assessments<br><br>Monitoring and documentation of dialysis access sites<br><br>Understanding the difference between thrill and bruit<br><br>Recognition and reporting of dialysis complications<br><br>Accurate and timely documentation requirements<br><br>Corrective Action for Cited Resident:<br><br>R2 was assessed for signs and symptoms of dialysis related complications, including assessment of the dialysis access site before and after dialysis treatments.<br><br>The resident's medical record was reviewed and updated to accurately reflect dialysis care, assessments, monitoring, and condition of the access site.<br><br>Like Residents:<br><br>An audit was conducted of current residents receiving dialysis services to ensure:<br><br>Appropriate pre/post dialysis assessments were completed<br><br>Dialysis access sites were monitored and documented accurately<br><br>Audits:<br><br>The DON or designee will audit 3 dialysis residents' pre/post dialysis assessments weekly for 4 weeks, then 2 dialysis residents' pre/post dialysis assessments weekly for 2 weeks to ensure completion of required assessments, appropriate monitoring for complications, accurate documentation of dialysis access sites. If audits identify areas of ongoing concerns, the QAPI team will review/initiate new interventions and | 05/13/2026 |

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| F0698 SS = D | Continued from page 4<br><br>On 4/22/26 at 9:35 p.m., the pre-dialysis and post-dialysis weights and assessment were obtained 4/22/26 at 9:19 p.m., with a weight of 161 lbs. The form lacked an actual pre-dialysis weight and assessment.<br><br>On 4/24/26 at 2:04 p.m., the pre-dialysis weight was dated 4/22/26 at 9:19 p.m., from two days prior. The nurse did not perform a current pre-dialysis weight. The form indicated, “Ports capped and clamped.” .<br><br>On 4/29/26 at 2:18 p.m., the pre-dialysis and post-dialysis weights were both dated 4/29/26 at 7:06 a.m. The form did not include actual post-dialysis weights and VS. Further, the form indicated, “Ports capped and clamped,” and, “bruit (a normal finding of the whooshing sound of blood running through a dialysis shunt) not present."<br><br>During an interview on 5/1/26 at 2:16 p.m., registered nurse (RN)-A stated when a resident required dialysis, the care plan required interventions to perform pre-dialysis assessment of weights, vital signs, and to check for the bruit and thrill (a vibration that indicates blood is flowing in the dialysis shunt). Post-dialysis assessments included weighing the resident, assessment for the bruit and thrill, assess the dialysis shunt or port site for bleeding, and pain. An assessment of the resident’s lung sounds should also be included. RN-A stated R2’s dialysis assessment should not indicate, “Ports capped and clamped” as that was for a kind of dialysis port R2 did not have, the forms should indicate pre-dialysis and post-dialysis weights, and post-dialysis VS. Additionally, RN-A stated R2 should have a bruit present, and if it was documented as not present on 4/29/26, the provider and should have been notified.<br><br>During an interview on 5/1/26 at 3:40 p.m., the medical director (MD)-A stated the expectation was for nurses to obtain a pre-dialysis and post-dialysis weight, and post-dialysis VS, “Ports capped and clamped didn’t make sense for [R2], and if a bruit was not present on 4/29/26, it was concerning and must have been mis-charted." The MD-A stated if the bruit was not present, the resident should have been sent to the hospital because it may indicate the fistula was not working. If weights and VS were not recorded accurately, the facility would not know if the resident was hypovolemic (emergent condition in which severe blood or other fluid loss makes the heart unable to pump enough blood to the body) or the resident’s accurate clinical picture, and for that | F0698 | Continued from page 4<br>re-education for ongoing compliance. Audits would be extended until the QAPI team establishes a pattern of ongoing compliance. | 05/13/2026 |

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| F0698 SS = D | Continued from page 5<br>reason, the facility needed accurate post-weights and VS.<br><br>During an interview on 5/1/26 at 4:50 p.m., licensed practical nurse (LPN)-A stated the nurses were expected to assess VS and weight before and after dialysis and assess for a bruit. LPN-A described the thrill (palpable vibration felt over the dialysis fistula) as the end of the sound of the bruit and was unsure if R2's port had a capped end. LPN-A stated if the post-dialysis VS were not entered manually they would not appear accurately on the form.<br><br>During an interview on 5/4/16 at 11:08 a.m., RN-C stated prior to dialysis the nurses assessed VS, assessed the dialysis site, and assessed for bruit and thrill. Post-dialysis, the nurses assessed for pain, VS, bleeding at the dialysis port site and weight. RN-C stated he was not sure why he charted R2's port was capped and clamped as that would not be accurate for R2's dialysis shunt. If the post-dialysis assessment was not completed, the facility would not know if the resident was well when they returned from dialysis, or if the port was functioning correctly.<br><br>During an interview on 5/4/26 at 11:55 a.m., RN-D stated R2 had dialysis Mondays, Wednesdays and Fridays, and should have had assessments before and after dialysis on 4/27/26, but did not. RN-D stated the Dialysis Communications Assessments were not completed correctly and accurately when they did not contain pre-dialysis and post-dialysis weight, and post-dialysis VS. R2's dialysis assessments were not accurate if they indicated the port was capped and clamped. RN-D stated every nurse should know bruit was the whoosh sound they heard with the stethoscope and the thrill was the feeling of vibration of the fistula. The facility provided dialysis training upon hire and annually.<br><br>During an interview on 5/4/26 at 12:19 p.m., the director of nursing (DON) stated pre and post dialysis assessments were completed every day a resident attended dialysis with current weights and VS. DON stated she was concerned the Dialysis Communication form auto-populated the most recent weights and VS and if the nurses didn't manually enter them, they may not be accurate. DON acknowledged R2 did not have pre/post dialysis assessments completed on 4/27/26, but should have. The 4/22/26 assessment only contained post-dialysis VS, the 4/24/26 assessment contained a weight from two days prior, and the 4/29/26 assessment only contained pre-dialysis VS. The DON acknowledge those assessments were not | F0698 | | 05/13/2026 |

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| F0698 SS = D | Continued from page 6<br>accurate, and each assessment should contain accurate information to assess the resident correctly.<br><br>The Facility Assessment dated 12/18/25 indicated hemodialysis was provided on-site at the facility by an agreement with a dialysis provider. The facility provided pre-dialysis and post-dialysis assessments, and training included training via custom course related to kidney care and pathophysiology of the renal system. A renal power point course was developed and incorporated into the annual training plan with the offering of on-site dialysis.<br><br>The Care for a Resident with Dialysis policy dated 3/2026 indicated:<br><br>Education and training of staff in the care of ESRD/dialysis residents may be<br><br>managed by the contracted dialysis facility or by a clinician with special training in<br><br>End Stage Renal Disease and dialysis care.<br><br>Education of the staff will be provided by a certified dialysis facility if the dialysis is<br><br>to be provided in the community.<br><br>Pre and Post Dialysis Documentation would include any concerns with the access site, post dialysis weight, bleeding at the site or other complications, and if the resident was unable to accept dialysis for any reason. | F0698 | | 05/13/2026 |

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| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 4/30/26, 5/1/26, and 5/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.<br><br>The following complaints were reviewed: H51831704C (299786). | 20000 | | 05/12/2026 |



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| 20000 | Continued from page 1<br><br>As a result of the investigation a licensing order was issued at 0565.<br><br>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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction.<br><br>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/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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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. | 20000 | | 05/12/2026 |
| 20565 | Comprehensive Plan of Care; Use<br><br>CFR(s): MN Rule 4658.0405 Subp. 3<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. | 20565 | Education:<br><br>The facility reviewed and reinforced its policy regarding comprehensive care planning for residents receiving dialysis services. Licensed nurses and interdisciplinary team members were re-educated on development of individualized dialysis care plan interventions, timely updating of care plans and | 05/13/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**05/04/2026** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **North Ridge Health And Rehab** | **5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 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 |
|---|---|---|---|---|
| 20565 | Continued from page 2<br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interviews and document review the facility failed to comprehensively develop and implement care plan interventions for 1 of 3 residents (R2) when R2 required in-center hemodialysis (also known as dialysis) (going to a dialysis center for therapy that filters your blood outside your body using a machine and a manufactured filter) three days a week.<br><br>Findings include:<br><br>R2's Medicare 5-Day Minimum Data Sheet (MDS) dated 2/3/26, indicated R2 admitted to the facility on 1/27/26 with intact cognition, diagnoses included renal (kidney) insufficiency, and required dialysis.<br><br>R2's provider orders dated 1/27/26, indicated dialysis three times weekly and directed nurses to complete a post-dialysis assessment on Tuesdays, Thursdays and Saturdays. On 1/29/26, the provider orders were modified to complete the post-dialysis assessments on Mondays, Wednesdays and Fridays instead.<br><br>R2's care plan reviewed 4/30/26 lacked a focus area and interventions for dialysis treatment.<br><br>During an interview on 5/1/26 at 2:16 p.m., registered nurse (RN)-A stated when a resident required dialysis, the care plan required interventions to perform pre-dialysis assessment of weights, vital signs (VS), and to check for the bruit (the whooshing sound of blood running through a dialysis shunt) and thrill (a vibration that indicates blood is flowing in the dialysis shunt). Post-dialysis assessments included weighing the resident, assessment for the bruit and thrill, assess the dialysis shunt or port site for bleeding, and pain, and assessment of the resident’s lung sounds.<br><br>During an interview on 5/1/26 at 4:50 p.m., licensed practical nurse (LPN)-A stated nursing staff was expected to obtain a resident’s vitals signs before and after dialysis, and assess for the bruit and thrill. LPN-A stated dialysis interventions should be on a resident’s care plan.<br><br>During an interview on 5/4/26 at 11:55 a.m., RN-D stated each resident on dialysis required a dialysis-related care plan, and acknowledged R2 did not have a care plan related to dialysis.<br><br>During an interview on 5/4/26 at 12:19 p.m., the | 20565 | Continued from page 2<br>implementation and documentation of interventions.<br><br>Corrective Action for Cited Resident:<br><br>R2’s comprehensive care plan was reviewed and revised to include interventions related to hemodialysis care and services.<br><br>Like Residents:<br><br>An audit of residents currently receiving dialysis services was completed to ensure comprehensive care plans were developed and implemented according to resident-specific dialysis needs.<br><br>Audits:<br><br>The DON or designee will audit 3 dialysis residents’ weekly for 4 weeks, then 2 dialysis residents’ weekly for 2 weeks to ensure comprehensive care plans were developed and implemented according to resident-specific dialysis needs. If audits identify areas of ongoing concerns, the QAPI team will review/initiate new interventions and re-education for ongoing compliance. Audits would be extended until the QAPI team establishes a pattern of ongoing compliance. | 05/13/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**05/04/2026** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **North Ridge Health And Rehab** | **5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 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 |
|---|---|---|---|---|
| 20565 | Continued from page 3<br>director of nursing (DON) stated each resident on dialysis would have a care plan with appropriate interventions and acknowledged R2 did not have a care plan for dialysis. The assessments helped determine if the treatment was effective.<br><br>The Comprehensive Care Plans policy dated 3/2026 indicated an individualized care plan that included measurable objectives and time frames to meet resident's needs is developed for each resident. The care plan was based on the MDS and physician orders, and included specialized services.<br><br>SUGGESTED METHOD OF CORRECTION:<br><br>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed and implemented for residents who require dialysis. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 20565 | | 05/13/2026 |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 21, 2026

Administrator
North Ridge Health And Rehab
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

RE: CCN: 245183
Cycle Start Date: May 4, 2026

Dear Administrator:

On May 4, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2026

Administrator
North Ridge Health And Rehab
5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

Re: Reinspection Results
Event ID: 2305FD-H1

Dear Administrator:

On May 19, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 4, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112