DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 3, 2025

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

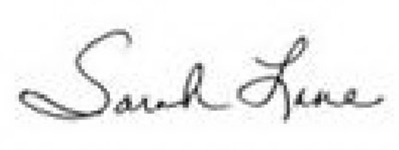
RE: CCN: 245183
Cycle Start Date: December 18, 2025

Dear Administrator:

On January 27, 2025, the Minnesota Department of Health 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 3, 2025

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

Re: Reinspection Results
Event ID: 85RP12

Dear Administrator:

On January 27, 2025 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 December 18, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2024

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

RE: CCN: 245183
Cycle Start Date: December 18, 2024

Dear Administrator:

On December 18, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 18, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 18, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 85RP11

Dear Administrator:

The above facility was surveyed on December 17, 2024 through December 18, 2024 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 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

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 12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/17/24 - 12/18/24, 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. H51831831C/MN108647 H51832661C/MN109062 The following complaints were reviewed. H51832983C/MN109125 & MN109190 with a deficiencey issued at F641 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess a resident's skin condition for 1 of 3 residents (R3) reviewed. R3 was found to have an inflammatory skin condition	F 641	Res #3 discharged from facility. Current residents have had the revised weekly skin assessment completed, all	1/17/25

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

Electronically Signed | 01/09/2025

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 641	Continued From page 1 on both of his hands and elbow that was not identified on R3's Minimum Data Set (MDS) and R3's assessments. Findings include: R3's admission nursing assessment dated 8/27/24 indicated R3's skin condition, temperature, turgor (skin elasticity), and integrity (health of the skin) were all normal. The assessment indicated R3 had redness to his coccyx (tailbone area), necrotic (death of tissues) of his second and third toes, a wound on the left foot and other skin discoloration. The assessment did not indicate where the skin discoloration was located or a description of it. R3's admission Minimum Data Set (MDS) dated 8/31/24 indicated R3 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating R3 was severely cognitively impaired. R3 was dependent upon staff for dressing, grooming, and transferring. R3 did not have any pressure ulcers but had a risk of developing pressure ulcers. R3 had diabetic foot ulcers. The assessment did not indicate any other skin concerns. R3's care plan dated 9/3/24 indicated R3 had a potential/actual impairment to skin integrity related to left leg necrotic toes plantar bottom and moisture associated skin damage to his bottom. His goal was to have no complication to his skin injury. R3's interventions were to: -Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. -Educate resident/family/caregivers of causative factors and measure to prevent skin injury. -Follow facility protocols for treatment of pressure injury.	F 641	new admissions will have the revised skin assessment completed on admit. Nursing Admission Assessment and Weekly Skin Assessment have been updated to include an area to indicate rashes, plaques, callouses or other skin alterations. Licensed nurses have been educated on the changes to these assessments. DON/ADON/Designee will audit 3 weekly skin assessments weekly x 4 then 2 weekly skin assessments weekly x 2 weeks. Audit results will be reviewed at QAPI	

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F 641	Continued From page 2 -Identify/document potential causative factors and eliminate/resolve where possible. -Pad rails, wheelchair arms or any other source of potential of potential injury if possible. -Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The Care plan did not indicate any skin conditions on R3's hands or elbow. R3's weekly skin evaluation dated 9/3/24 indicated R3 had open areas which were not skin tears to his left outer ankle and left toes. The general comment indicated R3 had a wound on the left leg which the provider was aware of and R3 was being treated for it. No dryness, rash, redness, skin tears or blisters. R3's weekly skin evaluation dated 9/10/24 indicated R3 had open areas, not skin tears to his left outer ankle and left toes. No dryness, rash, redness, skin tears or blisters. No other documented information on the assessment. R3's weekly skin evaluation dated 9/19/24 indicated R3's skin was intact. No dryness, rash, redness, skin tears or blisters. No other documented information on the assessment. R3's weekly skin evaluation dated 9/27/24 indicated R3's skin was intact. No dryness, rash, redness, skin tears or blisters. Under general comments the assess indicated wound dressing to left foot was intact. R3's weekly skin evaluation dated 10/4/24 indicated R3's skin was intact. No dryness, rash, redness, skin tears or blisters. No other documented information on the assessment.	F 641		

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F 641	Continued From page 3 R3's weekly skin evaluation dated 10/10/24 did not indicate if skin was intact, was dry, had a rash, redness, skin tears or blisters. The assessment indicated a left foot wound with no other documentation. R3's weekly skin evaluation dated 10/17/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, or open areas. General comments indicated the skin was intact per baseline. R3's weekly skin evaluation dated 10/24/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated visible skin assessed only, intact per baseline. R3's weekly skin evaluation dated 11/1/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated no change noted to the skin condition. R3's weekly skin evaluation dated 11/8/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated R3's skin was intact per his baseline. R3's weekly skin evaluation dated 11/15/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated no new skin issues noted. R3's progress notes dated 11/17/24 - 12/13/24 did not indicate any skin concerns.	F 641		

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F 641	Continued From page 4 R3's weekly skin evaluation dated 11/22/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated R3 refused skin assessment, visible skin intact. R3's skin and wound evaluation dated 11/24/24 indicated R3 had a diabetic wound to the dorsum of his left third digit (toe) which was present on admission. The area was 23.3 centimeters squared (cm), length was 8.6 cm and width was 3.9 cm. The wound evaluation did not indicate any other skin concerns. R3's skin and wound evaluation dated 12/1/24 indicated R3 had a diabetic wound to the left dorsum of his left third digit (toe). Area was 18.5 cm, length 7.2 cm and width 3.1 cm. The wound evaluation did not indicate any other skin concerns. R3's weekly skin evaluation dated 11/29/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas. No other comments documented. R3's weekly skin evaluation dated 12/6/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments skin intact per baseline. R3's admission hospital note dated 12/11/24 indicated R3 presented with well demarcated pink annular plaques (an inflammatory skin disorder characterized by expanding circular plaques on the skin) with overlying silvery scales noted on the bilateral (both) hands, elbows, legs, and right foot. Thick hyperkeratosis (thickness of the outer	F 641		

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F 641	Continued From page 5 layer of the skin) of the hands and feet. Resultant hyperpigmented (dark patches on the skin) patches on the legs. Greasy loose scale (flaky skin) along the central face, ears, and scalp. R3's nursing facility progress note dated 12/13/24 at 1:15 p.m. indicated R3's wound was noticed to be infected, the provider had noticed and had R3 sent to the emergency department for evaluation. R3 was sent to the hospital on 12/11/24. R3's hospital course note dated 12/13/24 indicated R3 had Psoriasis (chronic skin disease that causes skin to become inflamed) noted on his hands, feet, elbows, legs, face, and scalp. Dermatology was consulted and recommended the following: -Ketoconazole 2% cream mixed with hydrocortisone 2.5% ointment twice daily to affected areas of scaling/rash on face, ears, and scalp. -Clobetasol 0.05 ointment twice daily to affected pink scaly plaques on arms, legs, hands, and feet. -Wet wraps - Apply triamcinolone 0.1% ointment to both hands and feet. -Dampen kerlix (woven gauze wrap) in warm water and wrap around hands/feet over the triamcinolone ointment. -Cover the damp wraps with dry ones. -Cover with warm blankets. To be done twice daily at least for an hour, longer duration if patient can tolerate. -Vaseline or Aquaphor for moisture for patient to keep at bedside for the hands. Upon interview on 12/18/24 at 8:47 a.m. a hospital physician assistant (PA)-A stated R3 presented to the hospital with dirty hands and	F 641		

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F 641	Continued From page 6 long fingernails. She stated she cleaned his hands and trimmed his fingernails. When she observed his hands, it looked like he had psoriasis covering his hands and later upon skin assessment his right elbow as well. She requested a dermatology evaluation, and the findings were psoriasis and flaky skin with treatment orders given. PA-A stated R3 was not clean, he was greasy and had flaking skin on his face, scalp, and hands upon initial observation. PA-A had worked with R3 in the past and stated he was totally dependent on others for his cares, so he could not clean himself or lotion himself. Upon interview on 12/18/24 at 9:15 a.m. licensed practical nurse (LPN)-A stated he had worked with R3 since his admission back in 8/2024. He was aware R3 had a" lot of callouses" on his hands. He did not believe R3's "callouses" were documented anywhere because the facility was not doing any sort of treatment for his hands. Upon interview on 12/18/24 at 1:25 p.m. registered nurse (RN)-A stated she had noticed over the past "few" months R3's skin was "really crusted with callouses." She did not ever ask him about it about it because she believed the providers had seen his hands as well. She stated the skin condition should have been on R3's weekly assessments to make sure the facility was watching for changes. Upon interview on 12/18/24 at 2:18 p.m. R3's wound nurse practitioner (NP) stated she had noticed R3 had a scaly build-up on his hands, however her focus was completing the dressing change on his foot and leg. She stated the facility should have documented the findings and notified her with concerns.	F 641		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 Upon interview on 12/18/24 at 2:45 p.m. the assistant director of nursing, (ADON) stated the skin assessments need to include any skin alterations, bruises, redness, not just open areas in the skin. The ADON stated she noticed the facility had documented "other skin discoloration" on his admission assessment on 8/27/24 and stated she did not know what "other skin discoloration" meant. Upon interview on 12/18/24 at 3:19 p.m. RN-B stated she was nurse who admitted R3 but could not recall what she meant by "other skin discoloration." A policy regarding skin assessment was requested however none provided.	F 641		

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	00238	A. BUILDING: _____ B. WING _____	C 12/18/2024

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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 12/17/24 - 12/18/24, 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 was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued. H51831831C MN108647 H51832661C MN109062 The following complaints were reviewed. H51832983C/MN109125 & MN109190 with a licensing order issued at ST0550 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. 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	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to accurately assess a resident's skin condition for 1 of 3 residents (R3) reviewed. R3 was found to have an inflammatory skin condition on both of his hands and elbow that was not identified on R3's Minimum Data Set (MDS) and R3's assessments. Findings include: R3's admission nursing assessment dated 8/27/24 indicated R3's skin condition, temperature, turgor (skin elasticity), and integrity (health of the skin) were all normal. The	2 550	CORRECTED	1/17/25

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2 550	Continued From page 3 assessment indicated R3 had redness to his coccyx (tailbone area), necrotic (death of tissues) of his second and third toes, a wound on the left foot and other skin discoloration. The assessment did not indicate where the skin discoloration was located or a description of it. R3's admission Minimum Data Set (MDS) dated 8/31/24 indicated R3 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating R3 was severely cognitively impaired. R3 was dependent upon staff for dressing, grooming, and transferring. R3 did not have any pressure ulcers but had a risk of developing pressure ulcers. R3 had diabetic foot ulcers. The assessment did not indicate any other skin concerns. R3's care plan dated 9/3/24 indicated R3 had a potential/actual impairment to skin integrity related to left leg necrotic toes plantar bottom and moisture associated skin damage to his bottom. His goal was to have no complication to his skin injury. R3's interventions were to: -Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. -Educate resident/family/caregivers of causative factors and measure to prevent skin injury. -Follow facility protocols for treatment of pressure injury. -Identify/document potential causative factors and eliminate/resolve where possible. -Pad rails, wheelchair arms or any other source of potential of potential injury if possible. -Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The Care plan did not indicate any skin conditions on R3's hands or elbow. R3's weekly skin evaluation dated 9/3/24	2 550		

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2 550	Continued From page 4 indicated R3 had open areas which were not skin tears to his left outer ankle and left toes. The general comment indicated R3 had a wound on the left leg which the provider was aware of and R3 was being treated for it. No dryness, rash, redness, skin tears or blisters. R3's weekly skin evaluation dated 9/10/24 indicated R3 had open areas, not skin tears to his left outer ankle and left toes. No dryness, rash, redness, skin tears or blisters. No other documented information on the assessment. R3's weekly skin evaluation dated 9/19/24 indicated R3's skin was intact. No dryness, rash, redness, skin tears or blisters. No other documented information on the assessment. R3's weekly skin evaluation dated 9/27/24 indicated R3's skin was intact. No dryness, rash, redness, skin tears or blisters. Under general comments the assess indicated wound dressing to left foot was intact. R3's weekly skin evaluation dated 10/4/24 indicated R3's skin was intact. No dryness, rash, redness, skin tears or blisters. No other documented information on the assessment. R3's weekly skin evaluation dated 10/10/24 did not indicate if skin was intact, was dry, had a rash, redness, skin tears or blisters. The assessment indicated a left foot wound with no other documentation. R3's weekly skin evaluation dated 10/17/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, or open areas. General comments indicated the skin was intact per baseline.	2 550		

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2 550	Continued From page 5 R3's weekly skin evaluation dated 10/24/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated visible skin assessed only, intact per baseline. R3's weekly skin evaluation dated 11/1/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated no change noted to the skin condition. R3's weekly skin evaluation dated 11/8/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated R3's skin was intact per his baseline. R3's weekly skin evaluation dated 11/15/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated no new skin issues noted. R3's progress notes dated 11/17/24 - 12/13/24 did not indicate any skin concerns. R3's weekly skin evaluation dated 11/22/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments indicated R3 refused skin assessment, visible skin intact. R3's skin and wound evaluation dated 11/24/24 indicated R3 had a diabetic wound to the dorsum of his left third digit (toe) which was present on admission. The area was 23.3 centimeters squared (cm), length was 8.6 cm and width was 3.9 cm. The wound evaluation did not indicate	2 550		

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2 550	Continued From page 6 any other skin concerns. R3's skin and wound evaluation dated 12/1/24 indicated R3 had a diabetic wound to the left dorsum of his left third digit (toe). Area was 18.5 cm, length 7.2 cm and width 3.1 cm. The wound evaluation did not indicate any other skin concerns. R3's weekly skin evaluation dated 11/29/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas. No other comments documented. R3's weekly skin evaluation dated 12/6/24 indicated R3's skin was intact, no dryness, rash, redness, skin tears, blisters, or open areas, general comments skin intact per baseline. R3's admission hospital note dated 12/11/24 indicated R3 presented with well demarcated pink annular plaques (an inflammatory skin disorder characterized by expanding circular plaques on the skin) with overlying silvery scales noted on the bilateral (both) hands, elbows, legs, and right foot. Thick hyperkeratosis (thickness of the outer layer of the skin) of the hands and feet. Resultant hyperpigmented (dark patches on the skin) patches on the legs. Greasy loose scale (flaky skin) along the central face, ears, and scalp. R3's nursing facility progress note dated 12/13/24 at 1:15 p.m. indicated R3's wound was noticed to be infected, the provider had noticed and had R3 sent to the emergency department for evaluation. R3 was sent to the hospital on 12/11/24. R3's hospital course note dated 12/13/24 indicated R3 had Psoriasis (chronic skin disease that causes skin to become inflamed) noted on	2 550		

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2 550	Continued From page 7 his hands, feet, elbows, legs, face, and scalp. Dermatology was consulted and recommended the following: -Ketoconazole 2% cream mixed with hydrocortisone 2.5% ointment twice daily to affected areas of scaling/rash on face, ears, and scalp. -Clobetasol 0.05 ointment twice daily to affected pink scaly plaques on arms, legs, hands, and feet. -Wet wraps - Apply triamcinolone 0.1% ointment to both hands and feet. -Dampen kerlix (woven gauze wrap) in warm water and wrap around hands/feet over the triamcinolone ointment. -Cover the damp wraps with dry ones. -Cover with warm blankets. To be done twice daily at least for an hour, longer duration if patient can tolerate. -Vaseline or Aquaphor for moisture for patient to keep at bedside for the hands. Upon interview on 12/18/24 at 8:47 a.m. a hospital physician assistant (PA)-A stated R3 presented to the hospital with dirty hands and long fingernails. She stated she cleaned his hands and trimmed his fingernails. When she observed his hands, it looked like he had psoriasis covering his hands and later upon skin assessment his right elbow as well. She requested a dermatology evaluation, and the findings were psoriasis and flaky skin with treatment orders given. PA-A stated R3 was not clean, he was greasy and had flaking skin on his face, scalp, and hands upon initial observation. PA-A had worked with R3 in the past and stated he was totally dependent on others for his cares, so he could not clean himself or lotion himself. Upon interview on 12/18/24 at 9:15 a.m. licensed	2 550		

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2 550	Continued From page 8 practical nurse (LPN)-A stated he had worked with R3 since his admission back in 8/2024. He was aware R3 had a" lot of callouses" on his hands. He did not believe R3's "callouses" were documented anywhere because the facility was not doing any sort of treatment for his hands. Upon interview on 12/18/24 at 1:25 p.m. registered nurse (RN)-A stated she had noticed over the past "few" months R3's skin was "really crusted with callouses." She did not ever ask him about it about it because she believed the providers had seen his hands as well. She stated the skin condition should have been on R3's weekly assessments to make sure the facility was watching for changes. Upon interview on 12/18/24 at 2:18 p.m. R3's wound nurse practitioner (NP) stated she had noticed R3 had a scaly build-up on his hands, however her focus was completing the dressing change on his foot and leg. She stated the facility should have documented the findings and notified her with concerns. Upon interview on 12/18/24 at 2:45 p.m. the assistant director of nursing, (ADON) stated the skin assessments need to include any skin alterations, bruises, redness, not just open areas in the skin. The ADON stated she noticed the facility had documented "other skin discoloration" on his admission assessment on 8/27/24 and stated she did not know what "other skin discoloration" meant. Upon interview on 12/18/24 at 3:19 p.m. RN-B stated she was nurse who admitted R3 but could not recall what she meant by "other skin discoloration."	2 550		

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2 550	Continued From page 9 A policy regarding skin assessment was requested however none provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 550		