DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 9, 2025

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

RE: CCN: 245183
Cycle Start Date: September 11, 2025

Dear Administrator:

On November 21, 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,

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

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Electronically delivered

December 9, 2025

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

Re: Reinspection Results
Event ID: 1DB45D-H2

Dear Administrator:

On November 21, 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 September 11, 2025. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 24, 2025

Administrator
North Ridge Health And Rehab

5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

RE: CCN:245183
Cycle Start Date: September 11, 2025

Dear Administrator:

On September 11, 2025, a survey was completed at your facility by the Minnesota Departments 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 December 11, 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 March 11, 2026(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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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 09/11/2025

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
F0000	INITIAL COMMENTS From 9/9/25 to 9/11/25, 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. The following complaints were reviewed with no deficiency issued: H51833702C (2609311) and H51833781C (2609608 and 2609283). The following complaints were reviewed: H51833630C (2610177 and 2607839) with a deficiency cited at F550. 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.	F0000		10/03/2025
F0550 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	F0550	Cited Residents: R3 has discharged. R6 was assisted with toileting needs. Call light response log reviewed. Like Residents: Current residents were reviewed for those who require toileting assistance. Staff are responding to call lights in a timely manner, and residents are receiving toileting assistance timely. Education: Nursing staff have been re-educated about resident rights, particularly the right to dignity, respect and timely toileting assistance. Facility expectation reinforced about answering call lights timely (under 10 minutes, up to 15 minutes in unforeseen situations) and providing toileting and/or incontinence care timely. Nursing staff have been educated that for residents who	10/03/2025

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

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 09/11/2025

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F0550 SS = D	Continued from page 1 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. §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 interview and document review, the facility failed to promote dignity for 2 of 3 residents (R3, R6) who required assistance with toileting and staff did not respond timely to requests for assistance with toileting and toileting hygiene, which resulted in incontinence or not getting changed timely. Findings include: R3 R3's admission Minimum Data Set (MDS) dated 9/1/25, indicated intact cognition, a urinary catheter (removed 9/8/25), incontinence of bowel, full dependence upon staff for transfers, and an inability to walk. R3's care plan dated 9/2/25, indicated a risk for falls, keep the call light in reach, bowel incontinence, care in pairs, and prompt response to all requests for assistance. Additionally, the care plan dated 9/3/25, indicated R3 was resistive to care and would yell at staff to leave the room. R3’s progress notes indicated many refusals of care including lab work and medications, and further	F0550	Continued from page 1 require 2 persons they should notify the nurse if they are having difficulty finding the 2nd CNA timely so that the nurse may intervene. Audit: The DON or designee will audit 3 residents who require assistance with toileting weekly x4 weeks, then 2 residents who require assistance with toileting x2 weeks to ensure call lights are being answered timely and toileting assistance is being provided. 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.	

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F0550 SS = D	Continued from page 2 indicated R3 was verbally abusive to staff, yelling at them, and kicking them out of the room when they were trying to provide assistance with care. R3's call light log dated 9/10/25, indicated from 8/30/25 to 9/9/25, there were 41 call lights activated that were answered from 15 to 77 minutes after initiation. During an interview on 9/9/25 at 9:49 a.m., family member (FM)-A stated while he was on the phone with R3 for about an hour, he noted it took about an hour and a half for staff to answer R3's call light the evening of 9/8/25. FM-A stated when he called, R3 indicated she activated her call light 20 minutes prior to the call, and he hung up when staff came to change R3's brief. R3 reported to FM-A she was sitting in urine and feces in her brief while waiting for help and was getting irritated having to wait. During an interview on 9/9/25 at 3:50 p.m., R1 stated she waited 40 minutes for her call light earlier that day, was "terrified" at the facility, kept her daughter on the phone all night some nights in fear, and was afraid if she fell, she would not get help, and staff would find her deceased on the floor. R3 stated she was irritated about having to wait for her call light to be answered, was tearful during the interview, and did not feel safe in the facility. Additionally, R3 stated she was occasionally incontinent of bowel and bladder, and "It strips me of my dignity," having to wait for her brief to be changed, or to wait more than 10-15 minutes for staff to take her to the bathroom, and then wet her brief while waiting. Review of R3's call light logs on 9/10/25, did not support the statement about a 40-minute call light wait prior to the interview on 9/9/25, but call light response times of 49 minutes on 9/8/25 at 9:51 p.m., and 41 minutes on 9/9/25 at 9:14 p.m. were indicated in the log. During an interview on 9/10/25 at 4:18 p.m., nursing assistant (NA)-A stated the facility had enough staff to answer lights, but due to R3's behaviors, R3 required two staff to be present for cares, so it could take longer to answer the light because staff had to find help first. NA-A acknowledged R3 would not feel good about having to wait for lights to be answered and would be angry and yell at staff if staff didn't answer the light immediately. During an interview on 9/10/25 at 4:26 p.m., NA-B stated the facility had enough staff to answer lights,	F0550		

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F0550 SS = D	Continued from page 3 therapy staff, nurses answered call lights when they were able, and the practice was to try to answer call lights in 5-10 minutes. NA-B stated it was possible R3 had incontinence when she had to wait too long for help, which could be uncomfortable and embarrassing. R6 R6's annual MDS dated 9/1/25, indicated severe cognitive impairment, substantial assistance for ADLs, inability to walk, and incontinence of bowel and bladder. R6's care plan dated 7/4/23 indicated a risk for falls and ensure the call light was in reach. Additionally, the care plan dated 7/14/23 indicated episodes of bowel and bladder incontinence and indicated staff should change R6's disposable briefs when soiled and as needed, and further indicated starting 12/6/24, R6 required care in pairs. R6's call light log date 9/10/25, indicated from 9/3/25 to 9/10/25, there were 19 call lights activated that were answered from 15 to 63 minutes. During an interview on 9/10/25 at 12:33 p.m., R6 stated it sometimes took staff 15-20 minutes to answer her call lights, but could not recall when that happened, but waited for help to get changed (incontinent brief) and laid wet. R3 further stated she did not like to smell of urine or being wet. During an interview on 9/10/25 at 4:34 p.m., registered nurse (RN)-A acknowledged some of R3's call light response times, "were not great," but R3 required two staff to provide care and may be incontinent while waiting for staff assistance to toilet. RN-A further stated all staff, including the providers, required a second staff presence when working with R3, and NA staff was afraid to help R3 because R3 was verbally abusive to staff and would yell at them, kick them out of her room, and make false accusations about staff care. RN-A acknowledged the facility would need to come up with a plan to provide more timely care for R3, and staff was required to meet R3's care needs even with care challenges. RN-A stated the expectation was to answer call lights in 10-15 minutes for all residents. During an interview on 9/10/25 at 4:55 p.m., the director of nursing (DON) stated the expectation was to answer call lights as soon as possible, per the facility policy. The DON acknowledged she reviewed the call light reports prior to providing them to the surveyor, call light response times were not the	F0550		

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F0550 SS = D	Continued from page 4 facility's best, and the facility would develop a plan to answer them timelier for residents who required care in pairs. The Call Light policy dated 10/24, indicated staff would answer call lights as soon as possible. The Resident Rights policy dated 11/24, indicated residents had the right to a dignified existence and access to persons and services inside the facility, regardless of diagnoses and severity of condition.	F0550		

DEPARTMENT OF HEALTH

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Electronically delivered

September 24, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1D6394-H1

Dear Administrator:

The above facility survey was completed on September 11, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health And Rehab	**5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 55428**

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20000	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: From 9/9/25 to 9/11/25, 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 identify the date when they will be completed.	20000		10/03/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

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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
20000	Continued from page 1 The following complaints were reviewed with no deficiency issued: H51833702C (2609311) and H51833781C (2609608 and 2609283). The following complaints were reviewed: H51833630C (2610177 and 2607839) with a licensing order cited at 1805. 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 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.	20000		
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 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	21805	Cited Residents: R3 has discharged. R6 was assisted with toileting needs. Call light response log reviewed. Like Residents:	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health And Rehab	**5430 BOONE AVENUE NORTH , NEW HOPE, Minnesota, 55428**

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21805	Continued from page 2 providing service in a health care facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promote dignity for 2 of 3 residents (R3, R6) who required assistance with toileting and staff did not respond timely to requests for assistance with toileting and toileting hygiene, which resulted in incontinence or not getting changed timely. Findings include: R3 R3's admission Minimum Data Set (MDS) dated 9/1/25, indicated intact cognition, a urinary catheter (removed 9/8/25), incontinence of bowel, full dependence upon staff for transfers, and an inability to walk. R3's care plan dated 9/2/25, indicated a risk for falls, keep the call light in reach, bowel incontinence, care in pairs, and prompt response to all requests for assistance. Additionally, the care plan dated 9/3/25, indicated R3 was resistive to care and would yell at staff to leave the room. R3’s progress notes indicated many refusals of care including lab work and medications, and further indicated R3 was verbally abusive to staff, yelling at them, and kicking them out of the room when they were trying to provide assistance with care. R3's call light log dated 9/10/25, indicated from 8/30/25 to 9/9/25, there were 41 call lights activated that were answered from 15 to 77 minutes after initiation. During an interview on 9/9/25 at 9:49 a.m., family member (FM)-A stated while he was on the phone with R3 for about an hour, he noted it took about an hour and a half for staff to answer R3’s call light the evening of 9/8/25. FM-A stated when he called, R3 indicated she activated her call light 20 minutes prior to the call, and he hung up when staff came to change R3’s brief. R3 reported to FM-A she was sitting in urine and feces in her brief while waiting for help and was getting irritated having to wait. During an interview on 9/9/25 at 3:50 p.m., R1 stated she waited 40 minutes for her call light earlier that day, was “terrified” at the facility, kept her daughter on the phone all night some nights in fear, and was afraid if she fell, she would not get help, and staff	21805	Continued from page 2 Current residents were reviewed for those who require toileting assistance. Staff are responding to call lights in a timely manner, and residents are receiving toileting assistance timely. Education: Nursing staff have been re-educated about resident rights, particularly the right to dignity, respect and timely toileting assistance. Facility expectation reinforced about answering call lights timely (under 10 minutes, up to 15 minutes in unforeseen situations) and providing toileting and/or incontinence care timely. Nursing staff have been educated that for residents who require 2 persons they should notify the nurse if they are having difficulty finding the 2nd CNA timely so that the nurse may intervene. Audit: The DON or designee will audit 3 residents who require assistance with toileting weekly x4 weeks, then 2 residents who require assistance with toileting x2 weeks to ensure call lights are being answered timely and toileting assistance is being provided. 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.	

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21805	Continued from page 3 would find her deceased on the floor. R3 stated she was irritated about having to wait for her call light to be answered, was tearful during the interview, and did not feel safe in the facility. Additionally, R3 stated she was occasionally incontinent of bowel and bladder, and "It strips me of my dignity," having to wait for her brief to be changed, or to wait more than 10-15 minutes for staff to take her to the bathroom, and then wet her brief while waiting. Review of R3's call light logs on 9/10/25, did not support the statement about a 40-minute call light wait prior to the interview on 9/9/25, but call light response times of 49 minutes on 9/8/25 at 9:51 p.m., and 41 minutes on 9/9/25 at 9:14 p.m. were indicated in the log. During an interview on 9/10/25 at 4:18 p.m., nursing assistant (NA)-A stated the facility had enough staff to answer lights, but due to R3's behaviors, R3 required two staff to be present for cares, so it could take longer to answer the light because staff had to find help first. NA-A acknowledged R3 would not feel good about having to wait for lights to be answered and would be angry and yell at staff if staff didn't answer the light immediately. During an interview on 9/10/25 at 4:26 p.m., NA-B stated the facility had enough staff to answer lights, therapy staff, nurses answered call lights when they were able, and the practice was to try to answer call lights in 5-10 minutes. NA-B stated it was possible R3 had incontinence when she had to wait too long for help, which could be uncomfortable and embarrassing. R6 R6's annual MDS dated 9/1/25, indicated severe cognitive impairment, substantial assistance for ADLs, inability to walk, and incontinence of bowel and bladder. R6's care plan dated 7/4/23 indicated a risk for falls and ensure the call light was in reach. Additionally, the care plan dated 7/14/23 indicated episodes of bowel and bladder incontinence and indicated staff should change R6's disposable briefs when soiled and as needed, and further indicated starting 12/6/24, R6 required care in pairs. R6's call light log date 9/10/25, indicated from 9/3/25 to 9/10/25, there were 19 call lights activated that were answered from 15 to 63 minutes.	21805		

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21805	Continued from page 4 During an interview on 9/10/25 at 12:33 p.m., R6 stated it sometimes took staff 15-20 minutes to answer her call lights, but could not recall when that happened, but waited for help to get changed (incontinent brief) and laid wet. R3 further stated she did not like to smell of urine or being wet. During an interview on 9/10/25 at 4:34 p.m., registered nurse (RN)-A acknowledged some of R3's call light response times, "were not great," but R3 required two staff to provide care and may be incontinent while waiting for staff assistance to toilet. RN-A further stated all staff, including the providers, required a second staff presence when working with R3, and NA staff was afraid to help R3 because R3 was verbally abusive to staff and would yell at them, kick them out of her room, and make false accusations about staff care. RN-A acknowledged the facility would need to come up with a plan to provide more timely care for R3, and staff was required to meet R3's care needs even with care challenges. RN-A stated the expectation was to answer call lights in 10-15 minutes for all residents. During an interview on 9/10/25 at 4:55 p.m., the director of nursing (DON) stated the expectation was to answer call lights as soon as possible, per the facility policy. The DON acknowledged she reviewed the call light reports prior to providing them to the surveyor, call light response times were not the facility's best, and the facility would develop a plan to answer them timelier for residents who required care in pairs. The Call Light policy dated 10/24, indicated staff would answer call lights as soon as possible. The Resident Rights policy dated 11/24, indicated residents had the right to a dignified existence and access to persons and services inside the facility, regardless of diagnoses and severity of condition. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could write/review/revise policies on how to answer call lights timely for residents who require care in pairs and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents were treated with dignity and had call lights answered timely to meet their needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		