DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 19, 2025

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

RE: CCN: 245183
Cycle Start Date: January 28, 2025

Dear Administrator:

On February 14, 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

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 19, 2025

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

Re: Reinspection Results
Event ID: 24CI12

Dear Administrator:

On February 14, 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 January 28, 2025. 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
February 5, 2025

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

RE: CCN: 245183
Cycle Start Date: January 28, 2025

Dear Administrator:

On January 28, 2025, 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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 April 28, 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 July 28, 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)

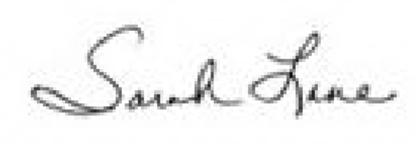
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 5, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 24CI11

Dear Administrator:

The above facility was surveyed on January 27, 2025 through January 28, 2025 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.

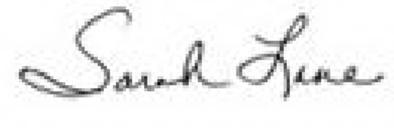
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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,



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

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 01/28/2025

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 1/27/25 through 1/28/25, 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 complaint was reviewed: H51834323C (MN00109636) with a deficiency cited at F558. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring call lights were within reach for 3 of 5 (R3, R4, R5) residents reviewed for call	F 558	R3, R4 and R5 all have their call lights within reach with a clip attached to keep in place.	2/11/25

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

Electronically Signed | 02/06/2025

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.

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 01/28/2025

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

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F 558	Continued From page 1 light usage. R3's admission Minimum Data Set (MDS) dated 1/22/25 indicated intact cognition with diagnoses that included dementia, muscle weakness and repeated falls. R3's care plan dated 1/20/25 lacked direction regarding call light usage. On 1/27/25 at 1:13 p.m., R3 was observed seated in her wheelchair with the call light cord lying in a coil on the floor behind her wheelchair. R3 stated she pushed her call light button when she needed help. She could not reach her call light and if she tried to pick it up off the floor, she would probably fall out of her wheelchair. On 1/27/25 at 1:20 p.m., registered nurse (RN)-A confirmed R3's call light button was out of her reach. All residents should have their call lights within reach before a staff person leaves the room. On 1/28/25 at 9:59 a.m., nursing assistant (NA)-B stated R3 used her call light when she needed assistance. A staff person should make sure a resident has their call light before they left their room. R4's quarterly MDS dated 12/20/24 indicated intact cognition with diagnoses that included type 2 diabetes and muscle weakness. R4's care plan dated 1/9/25 directed to be sure the call light is within reach, and encourage to use it for assistance as needed. On 1/27/25 at 1:45 p.m., R4 was observed seated	F 558	All resident rooms were audited for clips on call light cords to help keep call light in place. 2 West had 30 clips added and 6 new call cords with clips. 3 West had 19 clips added and 4 new cords with clips. KCU had 10 clips added, RCU had 9 clips added, and TCU had 13 clips added. Facility wide review of Answering a Call Light Policy. Educating staff that it is everyone's responsibility to answer call lights and to make sure the call light is within easy reach of the resident. DON/ADON/Designee will audit 3 rooms per week per unit x 4 weeks then 2 rooms per week per unit x 2 weeks to ensure the call light is within reach of the resident. Audit results will be reviewed at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 558	Continued From page 2 in her wheelchair with no call light. R4 stated she would push her call light if she needed help. She did not know where her call light button was, and guessed it was between the bed and the wall where she could not reach. On 1/27/25 at 1:53 p.m., licensed practical nurse (LPN)-A confirmed R4's call light button was out of reach. "It's really stuck" as he pulled the cord from between the wall and the bed. All staff should make sure the resident can reach their call light before they left the room. R5's quarterly MDS dated 1/7/25 indicated intact cognition with diagnoses that included encephalopathy. R5's care plan dated 1/21/25 instructed to keep call light within reach. On 1/27/25 at 12:42 p.m., R5 was observed lying in bed with his call light cord lying in a coil on the floor near the head of the bed. R5 stated he did not know where his call light was. If he needed help and could not find his button, he said he would yell out the door. On 1/27/25 at 12:50 p.m., NA-A confirmed R5's call light button was out of his reach. It was the staff member's job to be sure a resident's call light was within reach before leaving the room. R5 was able to use his call light, but didn't always remember why he pressed it. On 1/28/25 at 1:51 p.m., the director of nursing (DON) stated a resident's call light should be within reach before a staff person left the resident's room. A resident needed their call light so they could get help when they needed it.	F 558		

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F 558	Continued From page 3 The facility policy Answering the Call Light dated 10/24 directed when the resident is in bed or confined to a chair be sure the call light is with easy reach of the resident.	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 01/28/2025

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

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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 1/27/25 through 1/28/25, 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 01/28/2025

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

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H51834323C (MN00109636) with a licensing order issued at 144.651 Subd. 6. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring call lights were within reach for 3 of 5 (R3, R4, R5) residents reviewed for call light usage. R3's admission Minimum Data Set (MDS) dated 1/22/25 indicated intact cognition with diagnoses that included dementia, muscle weakness and repeated falls. R3's care plan dated 1/20/25 lacked direction regarding call light usage. On 1/27/25 at 1:13 p.m., R3 was observed seated	21810	R3, R4 and R5 all have their call lights within reach with a clip attached to keep in place. All resident rooms were audited for clips on call light cords to help keep call light in place. 2 West had 30 clips added and 6 new call cords with clips. 3 West had 19 clips added and 4 new cords with clips. KCU had 10 clips added, RCU had 9 clips added, and TCU had 13 clips added. Facility wide review of Answering a Call Light Policy. Educating staff that it is everyone's responsibility to answer call	2/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 3 in her wheelchair with the call light cord lying in a coil on the floor behind her wheelchair. R3 stated she pushed her call light button when she needed help. She could not reach her call light and if she tried to pick it up off the floor, she would probably fall out of her wheelchair. On 1/27/25 at 1:20 p.m., registered nurse (RN)-A confirmed R3's call light button was out of her reach. All residents should have their call lights within reach before a staff person leaves the room. On 1/28/25 at 9:59 a.m., nursing assistant (NA)-B stated R3 used her call light when she needed assistance. A staff person should make sure a resident has their call light before they left their room. R4's quarterly MDS dated 12/20/24 indicated intact cognition with diagnoses that included type 2 diabetes and muscle weakness. R4's care plan dated 1/9/25 directed to be sure the call light is within reach, and encourage to use it for assistance as needed. On 1/27/25 at 1:45 p.m., R4 was observed seated in her wheelchair with no call light. R4 stated she would push her call light if she needed help. She did not know where her call light button was, and guessed it was between the bed and the wall where she could not reach. On 1/27/25 at 1:53 p.m., licensed practical nurse (LPN)-A confirmed R4's call light button was out of reach. "It's really stuck" as he pulled the cord from between the wall and the bed. All staff should make sure the resident can reach their call light before they left the room.	21810	lights and to make sure the call light is within easy reach of the resident. DON/ADON/Designee will audit 3 rooms per week per unit x 4 weeks then 2 rooms per week per unit x 2 weeks to ensure the call light is within reach of the resident. Audit results will be reviewed at QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 01/28/2025

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21810	Continued From page 4 R5's quarterly MDS dated 1/7/25 indicated intact cognition with diagnoses that included encephalopathy. R5's care plan dated 1/21/25 instructed to keep call light within reach. On 1/27/25 at 12:42 p.m., R5 was observed lying in bed with his call light cord lying in a coil on the floor near the head of the bed. R5 stated he did not know where his call light was. If he needed help and could not find his button, he said he would yell out the door. On 1/27/25 at 12:50 p.m., NA-A confirmed R5's call light button was out of his reach. It was the staff member's job to be sure a resident's call light was within reach before leaving the room. R5 was able to use his call light, but didn't always remember why he pressed it. On 1/28/25 at 1:51 p.m., the director of nursing (DON) stated a resident's call light should be within reach before a staff person left the resident's room. A resident needed their call light so they could get help when they needed it. The facility policy Answering the Call Light dated 10/24 directed when the resident is in bed or confined to a chair be sure the call light is with easy reach of the resident. SUGGESTED METHOD OF CORECTION: The administrator or designee could review/revise policies and procedures on call light usage. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff members are confirming a resident's call	21810		

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21810	Continued From page 5 light button is within reach before exiting the room and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21810		

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	245183	A. BUILDING _____ B. WING _____	C 01/28/2025

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F 000	INITIAL COMMENTS On 1/27/25 through 1/28/25, 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 complaint was reviewed: H51834323C (MN00109636) with a deficiency cited at F558. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring call lights were within reach for 3 of 5 (R3, R4, R5) residents reviewed for call	F 558	R3, R4 and R5 all have their call lights within reach with a clip attached to keep in place.	2/11/25

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

Electronically Signed | 02/06/2025

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 558	Continued From page 1 light usage. R3's admission Minimum Data Set (MDS) dated 1/22/25 indicated intact cognition with diagnoses that included dementia, muscle weakness and repeated falls. R3's care plan dated 1/20/25 lacked direction regarding call light usage. On 1/27/25 at 1:13 p.m., R3 was observed seated in her wheelchair with the call light cord lying in a coil on the floor behind her wheelchair. R3 stated she pushed her call light button when she needed help. She could not reach her call light and if she tried to pick it up off the floor, she would probably fall out of her wheelchair. On 1/27/25 at 1:20 p.m., registered nurse (RN)-A confirmed R3's call light button was out of her reach. All residents should have their call lights within reach before a staff person leaves the room. On 1/28/25 at 9:59 a.m., nursing assistant (NA)-B stated R3 used her call light when she needed assistance. A staff person should make sure a resident has their call light before they left their room. R4's quarterly MDS dated 12/20/24 indicated intact cognition with diagnoses that included type 2 diabetes and muscle weakness. R4's care plan dated 1/9/25 directed to be sure the call light is within reach, and encourage to use it for assistance as needed. On 1/27/25 at 1:45 p.m., R4 was observed seated	F 558	All resident rooms were audited for clips on call light cords to help keep call light in place. 2 West had 30 clips added and 6 new call cords with clips. 3 West had 19 clips added and 4 new cords with clips. KCU had 10 clips added, RCU had 9 clips added, and TCU had 13 clips added. Facility wide review of Answering a Call Light Policy. Educating staff that it is everyone's responsibility to answer call lights and to make sure the call light is within easy reach of the resident. DON/ADON/Designee will audit 3 rooms per week per unit x 4 weeks then 2 rooms per week per unit x 2 weeks to ensure the call light is within reach of the resident. Audit results will be reviewed at QAPI.	

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F 558	Continued From page 2 in her wheelchair with no call light. R4 stated she would push her call light if she needed help. She did not know where her call light button was, and guessed it was between the bed and the wall where she could not reach. On 1/27/25 at 1:53 p.m., licensed practical nurse (LPN)-A confirmed R4's call light button was out of reach. "It's really stuck" as he pulled the cord from between the wall and the bed. All staff should make sure the resident can reach their call light before they left the room. R5's quarterly MDS dated 1/7/25 indicated intact cognition with diagnoses that included encephalopathy. R5's care plan dated 1/21/25 instructed to keep call light within reach. On 1/27/25 at 12:42 p.m., R5 was observed lying in bed with his call light cord lying in a coil on the floor near the head of the bed. R5 stated he did not know where his call light was. If he needed help and could not find his button, he said he would yell out the door. On 1/27/25 at 12:50 p.m., NA-A confirmed R5's call light button was out of his reach. It was the staff member's job to be sure a resident's call light was within reach before leaving the room. R5 was able to use his call light, but didn't always remember why he pressed it. On 1/28/25 at 1:51 p.m., the director of nursing (DON) stated a resident's call light should be within reach before a staff person left the resident's room. A resident needed their call light so they could get help when they needed it.	F 558		

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F 558	Continued From page 3 The facility policy Answering the Call Light dated 10/24 directed when the resident is in bed or confined to a chair be sure the call light is with easy reach of the resident.	F 558		