DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2025

Administrator
North Ridge Health And Rehab

5430 BOONE AVENUE NORTH
NEW HOPE, MN 55428

RE: CCN:245183
Cycle Start Date: July 10, 2025

Dear Administrator:

On July 10, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 October 10, 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 January 10, 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

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 07/10/2025

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 On 7/10/25, 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: H51839229C (MN00114479) with incidental findings at F684 and F695 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		07/14/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement resident-directed care and treatment consistent with provider orders and professional standards for 1 of 3 residents (R2)	F0684	1. Corrective Action for Affected Resident: · R2's oxygen order was changed to PRN. Oxygen saturation checks are being completed each shift. 2. Identification of Other Residents: · An audit was conducted of current residents receiving oxygen to ensure their provider orders align with what is being administered and that oxygen saturation monitoring is appropriately documented. 3. Systemic Changes: · Licensed nurses have been re-educated on the facility's Oxygen Administration and Pulse Oximetry policies with additional emphasis on ensuring any resident who has orders for oxygen whether continuous or PRN, has their oxygen saturation checked at least 1x per shift to assess oxygen needs. Also, when entering	07/14/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0684 SS = D	Continued from page 1 reviewed for supplemental oxygen use. Findings include: R2's quarterly minimum data set (MDS) dated 6/27/25, identified moderately impaired cognition with diagnoses which include acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). R2 utilized oxygen therapy while at the facility. R2's provider order dated 12/18/24, instructed staff to apply continuous oxygen at 2 liters per minute (lpm) by nasal cannula to maintain oxygen saturations above 90% with a frequency check of every shift. Required supplementary documentation included oxygen saturations. R2's care plan dated 7/10/25, instructed staff to administer oxygen according to provider order. Review of R2's vital signs documentation from 5/8/25, through 7/10/25, revealed R2's oxygen saturation had been checked once on 5/8/25, 5/15/25, 5/22/25, 5/29/25, 6/13/25, 6/20/25, 6/27/25 and 7/4/25. The electronic health record (EHR) lacked documentation staff checked R2's Oxygen saturation levels every shift. During an interview on 7/10/2025 at 9:07 a.m., R2 stated he always utilized supplemental oxygen at night however, he did not like to use it during the day. Staff checked his oxygen saturations "once and a while", however, not every day. During an interview on 7/10/2025 at 11:04 a.m., licensed practical nurse (LPN)-A stated a resident should have their oxygen saturation levels checked at least once a shift if they had a provider order to maintain oxygen saturations at a certain level. There should have been a task on the treatment administration record (TAR) to check oxygen saturations. LPN-A confirmed there was no task to check oxygen saturations on R2's TAR. LPN-A had not checked R2's oxygen saturation on his shift which had started at 6 a.m. that morning. During an interview on 7/10/2025 at 3:38 p.m., nurse practitioner (NP)-A stated if a resident was on supplemental oxygen, they should be monitored according to the provider orders. If the staff were not following provider orders, whatever was being monitored would not be accurate. Lack of monitoring placed the residents at risk of not receiving the correct amount of supplemental oxygen.	F0684	Continued from page 1 oxygen orders, we must ensure it is going to the TAR or RT flowsheet so it can be documented on. O2 sats and liter flow should be added for supplement documentation. 4. Quality Assurance Monitoring: · The DON or designee will audit 3 residents on oxygen therapy weekly x4 weeks, then 2 residents on oxygen therapy x2 weeks to ensure compliance with monitoring oxygen saturation. · 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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F0684 SS = D	Continued from page 2 During an interview on 7/10/2025 at 4:04 p.m., director of nursing (DON) stated R2 had a provider order to monitor oxygen saturation each shift. DON confirmed R2's electronic health recorded lacked documentation of oxygen saturation monitoring every shift. Review of the facility policy titled The Oxygen Administration policy dated 10/2024, instructed while the resident was receiving oxygen therapy, assess for signs or symptoms of cyanosis (blue tone to skin and mucous membranes), hypoxia (rapid breathing, rapid pulse, restlessness, confusion), and oxygen toxicity (difficulty breathing or slow, shallow breathing), vital signs, lung sounds, arterial blood gases and oxygen saturation if applicable; and other laboratory results if applicable.	F0684		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide respiratory care consistent with professional standards and the comprehensive person-centered care plan for 1 of 3 (R3) residents reviewed for supplemental oxygen use. Findings include: R3's quarterly minimum data set (MDS) dated 6/27/25, indicated intact cognition with diagnoses which included chronic kidney disease and heart failure. R3 did not use oxygen therapy at the facility. R3's provider order list dated 7/10/25, lacked an order for supplemental oxygen use and monitoring. R3's care plan lacked information regarding supplemental oxygen use. Review of R3's vital signs documentation from 5/1/25 through 7/10/25, revealed R3 utilized oxygen via nasal	F0695	1. Corrective Action for Affected Resident: · R3 has discharged. 2. Identification of Other Residents: · A facility-wide audit was completed for current residents receiving supplemental oxygen to ensure a valid provider order was in place and reflected on their care plan. 3. Systemic Changes: · Education provided to all licensed nurses on the requirement that oxygen is considered a medication and must have an active provider order before administration. Anyone on oxygen must have it listed on their care plan as well. 4. Quality Assurance Monitoring: · The DON or designee will audit 3 residents on oxygen therapy weekly x4 weeks, then 2 residents on oxygen therapy x2 weeks to ensure there is a physician's order for the oxygen and that the oxygen is noted on their care plan. · 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.	07/14/2025

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F0695 SS = D	Continued from page 3 cannula (NC) on six days in July, at least 17 days in June (9 days there was no information documented), and 11 days in May starting on 5/16/25 (3 days there was no information documented). A nursing note dated 6/2/25, indicated R3 utilized 2 liters per minute (L) of supplemental oxygen. A provider visit note written by nurse practitioner (NP)-A dated 5/20/25, indicated acute and chronic respiratory failure with hypoxia: no change was made, on 4L oxygen through NC. The note lacked an order for supplemental oxygen. A provider visit note written by NP-A dated 5/29/25, indicated R3's acute and chronic respiratory failure with hypoxia was stable on 3L oxygen through NC. The note lacked an order for supplemental oxygen. A provider visit note written by NP-A dated 6/26/25, indicated R3's acute and chronic respiratory failure with hypoxia was stable on 3L oxygen through NC. The note lacked an order for supplemental oxygen. A provider visit note dated 7/7/25, indicated R3's acute and chronic respiratory failure with hypoxia was stable on 3L oxygen through NC. The note lacked an order for supplemental oxygen. On 7/10/2025 at 10:24 a.m., R3 was observed laying in bed wearing a nasal cannula. The nasal cannula tubing was connected to an oxygen tank with the liters per minute set at 2L. During an interview on 7/10/2025 at 12:22 p.m., licensed practical nurse (LPN)-B stated R3 was on 2L supplemental oxygen when LPN-B checked R3's vital signs at the beginning of LPN-B's shift. During an interview on 7/10/2025 at 12:42 p.m., registered nurse (RN)-A stated R3 did not have an order for supplemental oxygen prior to 7/10/25. During an interview on 7/10/2025 at 3:38 p.m., NP-A stated a provider order was needed for supplemental oxygen. R3 had utilized supplemental oxygen when NP-A had seen her for provider visits in May 2025, and June 2025. NP-A stated a facility nurse should have contacted the provider if an order for supplemental oxygen was needed. During an interview on 7/10/2025 at 4:04 p.m., director of nursing (DON) confirmed R3 did not have a provider order for supplemental oxygen before 7/10/25. Oxygen	F0695		

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F0695 SS = D	Continued from page 4 was considered a medication, so it required a provider order. Review of facility policy titled The Oxygen Administration policy dated 10/2024, instructed staff to verify there was a physician's order for oxygen administration	F0695		

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August 1, 2025

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

Re: Event ID: KEZ511

Dear Administrator:

The above facility survey was completed on July 10, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Minnesota State Department of Health

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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: On 7/10/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed: H51839229C (00114479).	20000		07/14/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		