17. SURVEYOR SIGNATURE

Susanne Reuss, Unit Supervisor

	N SERVICES ICARE/MEDICAI I - TO BE COMP			AND TRAN	SMITTAL	EDICARE & MEDICAID SERVICES ID: WOFB Facility ID: 00238
. MEDICARE/MEDICAID PROVIDER NO. (L1) 245183 .STATE VENDOR OR MEDICAID NO. (L2) 531716900 EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2014	3. NAME AND AD (L3) NORTH RID (L4) 5430 BOONE (L5) NEW HOPE, 7. PROVIDER/SUI 01 Hospital	GE HEALTH E AVENUE NO , MN	AND REHA	I)	.6) 55428 L7) 22 CLIA	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 02/01/2019 (L34) 6. ACCREDITATION STATUS: (L10) 6. Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICI	Ē	FISCAL YEAR ENDING DATE: (L35) 12/31
1. LTC PERIOD OF CERTIFICATION From (a): To (b): 2. Total Facility Beds 3. Total Certified Beds 320 (L18)	Complianc1. A B. Not in Con		gram	2. 3. 4.	proved Waivers Of Th Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code	6. Scope of Services Limit 7. Medical Director) 8. Patient Room Size 9. Beds/Room (L12)
4. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 320 (L37) (L38) (L39) 6. STATE SURVEY AGENCY REMARKS (IF APPLICA)	(L42)	IID (L43)	a.	15. FACILI'	TY MEETS) or 1861 (j) (1):	(L15)

18. STATE SURVEY AGENCY APPROVAL

Douglas Larson, Enforcement Specialist

	PART II - TO BE COMP	LETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE AC	GENCY
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to 2. Facility is not Eligible	Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 21. 1. Statement of Financial Solver 2. Ownership/Control Interest Ω 3. Both of the Above : 	
22. ORIGINAL DATE OF PARTICIPATION 05/01/1972 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEMENT BEGINNING DATE (L41) 27. ALTERNATIVE SANCT A. Suspension of Admiss B. Rescind Suspension Date	ons: (L44)	26. TERMINATION ACTION: VOLUNTARY	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 00270		70 (L31)	30. REMARKS	
	(L32) 12/27/2	018 (L33)	DETERMINATION APPROVAL	

(L19)

04/17/2019

04/17/2019 (L20)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245183

February 8, 2019

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 1, 2019 the above facility is certified for:

320 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 320 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

DOWNERS LADRON

Douglas Larson, Enforcement Specialist

North Ridge Health And Rehab February 8, 2019 Page 2

Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On January 31, 2019,
I, <u>Diane Willette</u> , <u>Administrator</u> , received (Name)(Please Print) (Title)(Please Print) the Notice of Penalty Assessment dated January 31, 2019 and issued to:
North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428
The Penalty Assessments attached hereto have been corrected as of January 31, 2019.
Signed: <u>Diane Willtta</u> , <u>Administrator Date</u> 1-31-19 (Name)(Please Print) (Title)(Please Print)
DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE
On January 31, 2019,
I,,,, of the Division of (Name)(Please Print), of the Division of (Title)(Please Print) Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated January 31, 2019 and issued to:
North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428
The Notice of Penalty Assessment was handed to Name)(Please Print) (Title)(Please Print)
Signed: (Name)(Please Print), (Title)(Please Print), Date 1/3/19



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 8, 2019

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

RE: Project Number S5183030, H5183156, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, H5183167, H5183172, H5183174, and H5183175

Dear Administrator:

On August 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 27, 2018. (42 CFR 488.422)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018. (42 CFR 488.417 (a))

On October 5, 2018, November 29, 2018, and January 19, 2019, we informed you that the following enforcement remedy was being recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office:

• Civil money penalty. (42 CFR 488.430 through 488.444)

On January 25, 2019, the CMS Region V Office notified you of the following actions:

• Mandatory termination effective February 10, 2019.

On February 1, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated standard surveys, completed on August 10, 2018, September 13, 2018, and October 18, 2018, a standard survey, completed on November 8, 2018, as well as a PCR, completed on January 4, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 1, 2019. We have determined, based on our visit, that your facility has corrected the deficiencies issued as of February 1, 2019.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 1, 2019.

However, as we notified you in our letter of August 22, 2018, in accordance with Federal law, as

North Ridge Health And Rehab February 8, 2019 Page 2

specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018 be discontinued as of February 1, 2019. (42 CFR 488.417 (a))
- Civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory termination effective February 10, 2019 be discontinued as of February 1, 2019.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towers Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2019

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

Re: Reinspection Results - Project Numbers S5183030, H5183156, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, H5183167, H5183172, H5183174, and H5183175

Dear Administrator:

On February 1, 2019, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the surveys completed on August 10, 2018, September 13, 2018, October 18, 2018, November 8, 2018, and January 4, 2019, with orders received by you. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towers Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered

March 5, 2019

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

RE: Project Number S5183030, H5183168, H5183170, H5183171, H5183172, H5183173, H5183156

Dear Administrator:

On January 31, 2019, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on January 31, 2019, imposed a daily fine in the amount of \$1500.00.

On January 22, 2019, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on February 1, 2019 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$1500. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$353.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$1853.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

North Ridge Health And Rehab March 5, 2019 Page 2

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL	
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	
2. NAME AND ADDRESS OF FACILITY	Τ

ID: WOFB Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER (L1) 245183 2.STATE VENDOR OR MEDICAID NO (L2) 531716900 5. EFFECTIVE DATE CHANGE OF OV (L9) 01/01/2014 6. DATE OF SURVEY 01/04 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other		3. NAME AND AD (L3) NORTH RID (L4) 5430 BOONI (L5) NEW HOPE. 7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	GE HEALTH A E AVENUE NOI , MN	AND REHA RTH	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint 14 CORF EISCAL YEAR ENDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	320 (L18) 320 (L17)	Compliance	nce With dequirements are Based On:	ram	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: * Code: * Code: * (L12)
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 320 (L37) (L38) 16. STATE SURVEY AGENCY REMA	19 SNF (L39)	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE)	:	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
17. SURVEYOR SIGNATURE Susanne Reuss, Unit	t Supervisor	Date:	01/19/2019	(L19)	18. STATE SURVEY AGENCY APPROVAL Date: Douglas Larson, Enforcement Specialist 02/11/2019 (L20)
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to F 2. Facility is not Eligible	TY Participate	20. COM	BY HCFA RE		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :
22. ORIGINAL DATE OF PARTICIPATION 05/01/1972 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	DATE VE SANCTIONS of Admissions:	4. LTC AGREEM ENDING DATI		26. TERMINATION ACTION: (L30) VOLUNTARY 00 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
OF PARTICIPATION 05/01/1972 (L24) 25. LTC EXTENSION DATE:	BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	DATE VE SANCTIONS of Admissions:	(L25) (L44) (L45) CARRIER NO.	(L31)	VOLUNTARY 00 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 19, 2019

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

RE: Project Number S5183030, H5183156, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, H5183167, H5183172, H5183173, H5183174, H5183175, and H5183176

Dear Administrator:

On August 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 27, 2018. (42 CFR 488.422)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018. (42 CFR 488.417 (a))

Also, we notified you in our letter of August 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

On October 5, 2018, and on November 29, 2018, we informed you that the following enforcement remedy was recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office:

• Civil money penalty. (42 CFR 488.430 through 488.444)

On January 4, 2019, the Minnesota Department of Health, along with the Minnesota Department of Health, Office of Health Facility Complaints, completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated standard surveys, completed on August 10, 2018, September 13, 2018, and October 18, 2018, as well as a standard survey, completed on November 8, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 18, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued. In addition, at the time of the January 4, 2019 PCR the Minnesota Department of Health completed an investigation of complaint numbers H5183174, H5183175, and H5183176. The deficiencies not corrected are as follows:

F0550 -- S/S: D -- 483.10(a)(1)(2)(b)(1)(2) -- Resident Rights/exercise Of Rights

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F0584 -- S/S: E -- 483.10(i)(1)-(7) -- Safe/clean/comfortable/homelike Environment F0677 -- S/S: D -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices F0725 -- S/S: E -- 483.35(a)(1)(2) -- Sufficient Nursing Staff F0761 -- S/S: D -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals
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In addition, at the time of this revisit, we identified the following deficiency:

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F0803 -- S/S: D -- 483.60(c)(1)-(7) -- Menus Meet Resident Nds/prep In Adv/followed
```

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the previously imposed remedies of state monitoring, discretionary denial of payment (42 CFR 488.417 (a)), and civil money penalty (42 CFR 488.430 through 488.444) will remain in effect.

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

• Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

As we notified you in our letter of August 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the standard survey completed November 8, 2018, and revisit completed January 4, 2018), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor Metro C Survey Team Licensing and Certification Program

> Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the abbreviated standard surveys completed August 10, 2018, September 13, 2018, and October 18, 2018, and revisit completed January 4, 2018), i.e., the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us

Phone: (651) 201-4204 Fax: (651) 281-9796

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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 the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by February 10, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 01/30/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COM	E SURVEY IPLETED
		245183	B. WING				R-C 04/2019
	PROVIDER OR SUPPLIER	REHAB		5430	EET ADDRESS, CITY, STATE, ZIP CODE BOONE AVENUE NORTH V HOPE, MN 55428		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 0	00}			
{F 000}	Emergency Prepar conducted on 11/4, recertification survey with the Appendix Requirements. INITIAL COMMEN An on-site revisit v 1/4/19. The facility corrected one or m result of the survey complaints substantinessing at the tinvestigation of this substantiated at F8	liance with CMS Appendix Z redness Requirements, was /18 through 11/8/18, during a ey. The facility is in compliance Z Emergency Preparedness TS vas completed 1/2/19 through was found NOT to have nore deficiencies issued as a vexited on 11/8/18. In addition intiated as a result of the wed as well as additional ations at the time of the revisit: time of the 11/8/18 survey, an a complaint was completed and 584. At the time of the revisit, 72 was not corrected, and	{F 00	00}			
	investigation of this substantiated at F5 F725. At the time of H5183173 was not F686 and F725.	time of the 11/8/18 survey, an a complaint was completed and 580, F677, F686, F690 and of the revisit, complaint corrected, and reissued at estigated at the time of the complaint was substantiated at 303.					
		estigated at the time of the complaint was substantiated at					
ABORATOR'	 Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

Electronically Signed

01/22/2019

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING				-C 04/2019
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB			54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		<i>11</i> - 0 10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000} {F 550} SS=D	revisit survey. The cunsubstantiated. The plan of correctiallegation of complience of the election of the election of the first page of the first page of the first page of the first page of the election of the	estigated at the time of the complaint was found to be ion will serve as your facility's fance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form. acceptable ePOC an on-site y may be conducted to antial compliance with the en attained in accordance with ercise of Rights 1)(2)(b)(1)(2)	{F 06		DEFICIENCY)		1/24/19
	with respect and dig resident in a manne promotes maintena her quality of life, re	cility must treat each resident gnity and care for each er and in an environment that the ance or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca severity of condition must establish and	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			R- 01 /0	-C 04/2019
	PROVIDER OR SUPPLIER	REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
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{F 550}	system to residents regardles system. The resident has the rights as a resident or resident of the U system to resident of the U system. The resident can exercisinterference, coercifrom the facility. System to the facility. System to the facility of the resident can exercise of the facility of the f	es under the State plan for all is of payment source. e of Rights. he right to exercise his or her is of the facility and as a citizen Inited States. facility must ensure that the se his or her rights without ion, discrimination, or reprisal in the series of the facility in exercising his or her opported by the facility in the er rights as required under this in NT is not met as evidenced to the facility in the residents (R701) reviewed for related to staff treatment. Assessment (CAA) 11/27/18, included diagnoses	{F 5	50}	R701 was interviewed and a grieval was completed on 1/2/19 by the Ass Administrator. In response to the grievance, the community has addetask to her Kardex and to her MAR remind the staff to knock on the docintroduce themselves and community what tasks they will be completing erasable white board has been placed the resident some to note the narthe Nurses and Nursing Assistants assigned for the shift. In addition, the resident is being visited daily (M-F) will continue daily until January 31, by a member of the administration stheir designee to follow up on the new process. A weekly call with the resident has been initiated by the States.	ed a to or, icate An eed in mes of and 2019 staff or ew dent s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
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NORTH RIDGE HEALTH AND REHAB			5430 BOONE AVENUE NORTH			
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PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
was observed se indicated her da in her room which themselves, let he the room, and in this was due to sidentify themselves interactions. R70 rude to her many were not respectively and as she entered the room without idea RN-C assisted Factor themselves. As the toilet R701 y further stated "I person before you thing." NA-E stated that she providing pericant During an intervise stated when she uncomfortable a indicated the stated leanse her bott	ew on 1/2/19, at 10:27 a.m. R701 pated in her wheelchair. R701 ughter had recently posted a sign the requested staff to introduce her know why they are entering form her prior to providing cares; staff entering her room refusing to ves and not explaining of also stated staff have been by times and made remarks that afful. Wation on 1/2/19, at 11:37 a.m. (RN)-B entered R701's room; RN-B knocked on R701's door red stated they were going to the bathroom and entered the entifying themselves. RN-B and R701 to the bathroom and exited sing assistant (NA)-E and NA-B in and neither one introduced NA-B moved the lift away from the elled "why did you do that" R701 already wiped, please talk to a but wipe them with that cold wet red, "Sorry."	{F 550	Worker to follow-up on any voiced by her mother. Invest completed on the specific is the 2567 resulted in staff ed starting on 1/07/19, on know door, entering and identifying and explaining why you are Interviewable residents will the administrative staff/ or didentify possible concerns resident rights and dignity. I completion of the interviews will be addressed and outcowill be reviewed to identify a process improvement. Current staff will be re-educated on outprocedures pertaining to rewhich includes dignity by the Education and/or administrated address concerns related to rights and dignity, starting 1 meetings will be led by the address concerns related to the Unit or Social Service ombudsman was notified on the occurrence of the meetings will be reviewed weeks, then monthly x 2 or frequency is identified by Adwith ongoing education to sefindings.	stigation ssue noted in ducation cking on the agyourself, there. be met with by designee to elating to Upon the stated and new repolicies and sident rights, e Director of ative staff. If by 1/24/19. meetings to president /23/19. These Administrator es staff. The in 1/22/19 of lings. In the weekly weekly x 4 until a lesser diministration		

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{F 584} SS=E	what the staff was gedeclined the wipe at the task. Furthermothem to tell me their them to the the tell me their them to the tell me their the their them to the tell me their them to the tell me their them to the their them to the their them to the their them to the the	verbalized had she known going to do she would have she had already completed ore, R701 stated, "I just want r name it's basic manners." on 1/3/19, at 1:51 p.m. the stated it was her expectation hemselves as they begin sident and to explain all espect and Dignity, Right to evised date November 2017, ts have the right to be treated gnity" table/Homelike Environment)-(7) vironment. right to a safe, clean, melike environment, including ceiving treatment and ving safely.	{F 54		Results of the audits will be forward QAPI committee for continued qual improvement and compliance week monthly x 2.	lity kly x 4,	1/24/19

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
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{F 584}	§483.10(i)(2) House services necessary and comfortable int §483.10(i)(3) Clean in good condition; §483.10(i)(4) Privat resident room, as s §483.10(i)(5) Adequation levels in all areas; §483.10(i)(6) Comflevels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observative review, the facility for (R95, R703, R704) In addition, failed to clean for 1 of 1 resiconcerns. Findings include: R95's diagnoses in weakness, profound scoliosis obtained for Data Set (MDS) da MDS indicated R95 cognition, required with transfers, one	ekeeping and maintenance to maintain a sanitary, orderly,	{F 58	R95, R703, and R704 wheelchar cleaned immediately R16 sradiator and CPAP were immediately. An audit will be completed by administrative staff/or designee resident wheelchairs to establish wheelchairs are free of debris. Administrative staff will complete of resident rooms and common identify environmental concerns. Contracted housekeeping staff re-educated on finding and expeof community cleanliness. Nurs re-educated on wheelchair clear	of that an audit spaces to	

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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{F 584}	limitation to both low R95's care plan data limited physical most and profound mention indicated R95 used and staff propelled addition, the care prequired assist of two On 1/2/19, at 1:42 pin bed and her special observed parked at was observed to be and brownish multiple frame. On 1/3/19, at 8:43 at all dressed for the observed parked at was observed to be and brownish multiple frame. On 1/3/19, at 8:43 at all dressed for the observed parked at was observed to be and brownish multiple frame. On 1/3/19, at 8:43 at all dressed for the observed parked at was observed to be and brownish multiple frame. On 1/3/19, at 8:43 at all dressed for the observed parked at was observed to be and brownish multiple frame. On 1/3/19, at 9:00 at an unit product of the observation R9 at 9:23 a.m. RN-A where room. On 1/3/19, at 9:38 at maintenance stated done by the securit maintenance stated done by the securit maintenance staff of When asked how his oiled w/c's when it be cleaned, the direction of the original staff would	wer extremities. Ited 8/20/18, indicated R95 had bility related to cerebral palsy al disability. The care plan a wheelchair for locomotion her to specific destinations. In lan indicated for transfers R95 wo to transfer from bed to w/c. In R95 was observed lying cialized wheelchair (w/c) was a the base of the bed. The w/c e heavily soiled with whitish ple food spills on the w/c. In R95 was observed to be day and was seated on the w/c en as multiple staff went by, nowledged the w/c needed to a.m. to 9:22 a.m. registered ted R95 with breakfast. During 5's w/c was observed soiled. Was observed to wheel R95 to a.m. the director of discompany was y staff at night and at times the cleaned them in the evening. It is department was notified of a was not the scheduled time to ector of maintenance stated notify his department and otification he would pull and	{F 58-	process by nursing administrative staff re-educate wheelchair cleaning process administrative staff. Administrative staff/or design complete five wheelchair aud completed per unit to establi wheelchairs are free of debrid days, twice weekly x 2 weeks and monthly x 3. Administrates designee will complete week weeks with contracted house to establish cleanliness of continue improvement and compliance monthly x2, and quarterly.	nee will dits will be sh that s daily x 7 s, weekly x 4 tor/ or lly rounds x4 ekeeping staff mmunity. forward to the	

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{F 584}	reviewed the month R95's w/c was last December 2018At 9:46 a.m. the did the w/c was soiled, the nurse couple of don't have documed been having proble cleaned. I did not tanot done at night as need to coordinate time to have it clear a shower. The where down to the machin dirty." The undated facility directed staff wheel monthly following the schedule and as nedirected nursing stafor spills and debris wheelchairs the stamaintenance to clear machine. R703 was observed seated in a tilt in sprest of the chair was chair. Staff adjusted foot rest did not state to dangle in the air. match the one on the R703's wheelchair on the cushion, arm	rector of maintenance ally wheelchair log and verified cleaned the first week in rector of maintenance verified "it is dirty for sure. I talked to times about cleaning it but notation for it because we have ms having access to it to be alk to [security staff] why it was a he comes at 11:00 p.m. I with nursing when is a good ned maybe when she is getting elchair needs to be taken he to be cleaned because it is a Wheelchair Cleaning policy chairs were to be washed he wheelchair washing heded. In addition, the policy of the wipe down wheelchairs and for excessively soiled fif was to put in "TELs" for an through the wheelchair. The left foot is hanging off to the side of the dight the foot rest, however, the yin place causing R703's foot. The left foot pedal did not ne right side of the chair. Was covered with food debris	{F 58	34}				

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{F 584}	rest on residents w R704 was observed R704's wheel chair food debris and had wheels of the chair. During interview on practical nurse (LP) wheelchairs were s night shift. She stat been cleaned on 12 she had completed foot rest on R703's At 11:47 a.m. RN-E schedule was poste station. RN-E state	oother unit and indicated: foot heelchair was broken. d on 1/3/19, at 11:47 a.m. and was noted to be covered in d a substance all over the 1/3/19, at 11:40 a.m. licensed N)-C stated the resident upposed to be cleaned on the ed R703's chair should have 2/30/18. LPN-C further stated a work order for the broken	{F 58	34}				
	had diagnoses inclures piratory failure wobstructive pulmon interview for menta (13-15 indicates interview for was obtained to the heater/radiator window sill, was ful blew out cold air. TR16's room at 9:25	served on 1/3/19, at 9:20. If fan, located underneath the lof dirt and debris. The fan The housekeeper went into a.m. after the housekeeper oximately 9:40 a.m.), the fan						

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{F 584}	R16 was interviewe said she washed 2 herself. During the blew out cold air. Do back of the closet of fan. A continuous po (C-PAP) machine (a flow of airway press the airway stays op approximately 8 feed dust and debris on breathing problems C-PAP machine at a Maintenance staff-Cat 1:43 p.m. and incleaned and was la Maintenance staff-Cat 1:43 p.m. and incleaned and was la Maintenance direct maintenance direct maintenance direct schedule to be clean housekeeping staff. The housekeeping staff room each day and room each day and room each day. The unit and the housekeevery 18 days each clean. Number 6 of list included: clean and the clean and	d on 1/3/19, at 1:29 p.m. and of the 7 vent panels of the fan time of the interview, the fan ust debris was noted on the loor that was closest to the ositive airway pressure a machine that is a constant sure to the throat and ensures en during sleep) was et away from the fan, also had it. R16 indicated she had and used oxygen and the night. C was interviewed on 1/3/19, dicated the fan needed to be st cleaned in the summer. C said the fans were cleaned our was done with the or on 1/4/19, at 9:30 a.m The or said the fans are on a need once a month and also cleaned the fans. director was interviewed on a need once a month and also cleaned the fans. director was interviewed on a did general cleaning to a did general cleaning to a did a deep cleaning of one ere were 18 rooms on R16's seeping director indicated that room would receive a deep the daily deep clean check off and wipe done heater/radiator lean and vacuum filter and	{F 58	34}			

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{F 677} {F 677} SS=D	ADL Care Provided CFR(s): 483.24(a)(s) \$483.24(a)(s) A resout activities of dail services to maintain personal and oral has a review, the facility for grooming assistant reviewed for activiti. Findings include: R62's annual Minimal 1/16/18, indicated impaired and required ressing and persouring observation 12:15 p.m. R62 was awaiting his noon mand his pants were be food debris. During interview on assistant (NA)-E stawith cares that mor think R62's pants won him. NA-E further shave R62 with an refused. On 1/3/18, at 12:40 stated R62 did not stated he used to be served.	for Dependent Residents 2) sident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced tion, interview and document ailed to ensure adequate se for 1 of 3 residents (R62) es of daily living. num Data Set (MDS) dated he was severely cognitively red assistance from staff for	{F 677		al razor es vas g the his dirty e care flect his eviewed nces, s, ng. rring as and new kardex hitoring ugh an onitor ewice	1/24/19

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{F 677}	his dirty clothes after morning. She states his closet even thou behavior.	_	{F 67	The Kardex will be developed a reviewed thru the Interdisciplin process upon admission, with change, quarterly and annually Results of the ADL audits will be to the QAPI committee for conquality improvement and compweekly x4, monthly x2, and quantil a lesser frequency is iden	ary Team significant oe forward tinued bliance arterly or	1/24/19	
SS=G	resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that the (ii) A resident with professional standard promote healing, prom	egrity sure ulcers. brehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and bressure ulcers receives and services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced		R28 □ Patient at Risk (PAR) in held on 1/2/19, the coccyx wou evaluated and measurements 1/4/19, the right shoulder wour evaluated, the family was notificare changes included a Brodarelieve pressure on the should encouragement to the resident	and was noted. On nd was ied. The a chair to er and		

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{F 686}	11/9/18, indicated simpaired and required mobility, transfurther indicated R2 ulcer. R28's care protential/actual imprelated to immobility plan directed staff the document location, injuries and remind A facility Progress I pressure ulcer to consider the facility Progress I pressure ulcer to consider the facility Progress I pressure wound to coccyx are pressure wound to and at risk for recurrent for the facility progress I pressure wound the facility progress I pressure ulcer to consider the facility progress I pressure wound the facility progress I pressure wound he and at risk for recurrent for the facility pressure wound he and at risk for recurrent for the facility pressure wound he following was obsessed in her wheeld station. At 7:40 a.m. dining room by staff 9:52 a.m. At that tir room and placed he without repositioning for 1/4/19, at appropriatical nurse (LP had a wound on the was not sure how less that the did not us stated he did not us	nimum data set (MDS) dated she was moderately cognitively red extensive assistance with ers and toileting. The MDS 28 did not have a pressure lan dated 12/11/18, identified a pairment to skin integrity y and fragile skin. The care or lay R28 down after meals, size and treatment of skin ers to turn and reposition. Note dated 9/5/18, indicated: occyx noted on 9/3/18, "1/2x 0.1." R28 with new pressure rea to same spot where recent realed. Area is compromised rent injury given the current and poor appetite. Keep chair in between meals s observation on 1/4/19, the rived: At 7:07 a.m. R28 was up I chair outside the nurses at R28 was escorted to the f where she remained until me, staff escorted R28 to her er in front of the television	{F 68	36}	bed after lunch. On 1/4/19, the resi NP noted that her skin breakdown expected part of her disease progre On 1/7/19 and 1/8/19 the wounds vere-assessed. The shoulder wound superficial and healing. The coccyx was reassessed on 1/9/19 and a Pameeting was held. The shoulder wo has healed. On 1/11/19 a PAR meet was held, the resident is noted to be declining in status. 1/15/19 new orderesidents wound obtained through Hospice provider. On 1/21/19 the coplan was updated to state, encourar resident to lay down after meals insigust after lunch. 1/22/19 an order to a protective dressing to her should obtained. Turning and repositioning re-education based upon our policy begun with the staff on 1/7/18 and ongoing. R143 □ Resident is currently not in community as of 1/21/19. On 1/8/19 resident □s care plan was updated reflect her scratching of her buttock to review her current desire to not reposition. On 1/23/19, a task was to the Point of Care system to refler refusal to offload or reposition in anticipation of her return to the community. At that time a new assessment will be completed. Residents with Braden Scores which reflect moderate to high risk for presinjuries and have existing pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessments (Braden and Pressure injuries were identified through their assessm	ession. vere was wound AR bund eting e ders for are ge the etead of apply er was y was s the the to added ct her ch essure r	

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	PROVIDER OR SUPPLIER RIDGE HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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{F 686}	problems with her is supposed to be repstated it had not be out of bed that more had time to reposition. At 10:30 a.m. LPN-lay down in her bed reddened area on hinch round. LPN-B R28's coccyx. LPN approximately 5 cm wound bed contain was described by L thickness skin loss tissue necrosis, or supporting structurs stated R28 also has shoulder that had be month. R28's Nursing Wee Condition Reports 12/12/18, Right gluobserved on 9/5/18 12/18/18, Skin considentified. 12/25/18, Skin intain 12/26/18, right glutime as ure ments including 1.5 cm is surrounding tissue. The medical records	and been having a lot of pottom. NA-A stated R28 was positioned every two hours and en done since R28 had gotten ning. NA-A stated she had not on R28. B and NA-A assisted R28 to It. R28 was noted to have a per ischium approximately one removed a dressing from the B described R28's wound as a x 4 cm with tunneling. The end slough (dead tissue) and It. PN-B as a stage IV (full with extensive destruction, damage to muscle, bone, or the end should be pressure ulcer). LPN-B and a pressure ulcer on her the end present for about a set of the following: The end	{F 686	Report). This identified sample or residents care plans and kardex were reviewed for accuracy in the repositioning schedules. The rest this sample, whom are also in the room for meals, will be identified monitored by the nursing staff for off-loading and pressure re-distraccording to their care plan and tasks noted in Point of Care. Re-education will be provided to nursing staff on wound assessment documentation, prevention and by a wound certified nurse by 1/2. The Certified Nursing Assistants re-educated on how to access returning and repositioning schedules and the Kardex Monitoring will include audits on current residents with pressure is monitor compliance with reposition administrative staff daily x 7 day weekly x 2 weeks, weekly x 4 ar x 3. The results of the repositioning a be reviewed in daily stand down daily M-F or until a lesser schedidentified. Results of the audits will be forw QAPI committee for continued of improvement and compliance with monthly x2, and quarterly.	tasks rning and idents in e dining and r ibution specific licensed ent, reatment 24/19. will be esidents iles in the njuries to oning by s, twice d monthly audits will meeting, ule is ard to the uality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			R-C / 04/2019	
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	SHOULD BE COMPLÉTIO		
{F 686}	Continued From pa	ge 14	{F 68	6}			
	Following the survey the provider submitted the following Progress Notes:						
	(involve partial thick epidermis, dermis, superficial and pres blister, or shallow c back of left shoulde Hospice nurse upda	ote written by LPN-B: Stage II kness skin loss involving or both. The lesion is sents clinically as an abrasion, enter) pressure ulcer noted to be measuring .5 cm x .5 cm. ated and said she was aware adicated it had been only					
	was not aware R28 ulcers to her coccys aware of the pressu RN-A stated the starepositioning a residevery two hours and	1/4/19, at RN-A stated she had a history of pressure and stated she was not ure ulcer on her shoulder. Indard of practice for dent with a pressure ulcer was distated she expected the done according to the plan of					
	expected staff to fo	rector of nursing stated she llow the plan of care and have been repositioned every					
	she had intact cograssistance from two and transfers and h R143's care plan da incontinence related stage IV pressure u	DS dated 12/24/18, indicated nition, required extensive of staff for bed mobility, toileting and a stage IV pressure ulcer. Tated 10/2/18, identified bladder doto impaired mobility and a ulcer to her coccyx. The care of encourage her to turn and every two hours.					

AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245183	B. WING				-C
NAME OF PRO	VIDER OR SUPPLIER	240100		STREET ADDRESS, CITY, STATE,	ZIP CODE	01/0	04/2019
NORTH RID	OGE HEALTH AND F	REHAB		5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
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A to IV no re D fo ol 8 ro sl ro ro w ro A cl mai ol st al re al R w al w in he A ol	o the facility with a / and an area on hon-compliance with epositioning. Furing continuous of the properties of the propelled herse from and sat in her propelled herse from and sat in her propelled herse from the propelled herse from and sat in her propelled herse from the grown to get a room at 10:13 a.m. R143 hair. R143 stated the thorning and at night and thirty nine minus beervation, RN-A at the the properties of the	ment indicated R143 admitted pressure injury, healing stage ler left heel. History of	{F 68	86}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		245183	B. WING			R· 01 /0	-C 04/2019
	PROVIDER OR SUPPLIER	REHAB		54	REET ADDRESS, CITY, STATE, ZIP CODE 30 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	stated barrier crean covered daily.	tock. Nurses practitioner n should be applied and areas	{F 6				1/24/19
{F 689} SS=D	CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The ras free of accident §483.25(d)(2)Each supervision and assaccidents. This REQUIREMEN by: Based on observat review, the facility father use of a mechat transfers for 1 of 2 accidents. Findings include: R701's Care Area A assessment dated of cerebrovascular hemiparesis. In additional limitation care plan date revishad limited physica and hemiplegia affects affects to assist with standing lift. The care	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document ailed to promote safety with nical standing lift during residents (R701) reviewed for	{F 6	89}	R701 was re-evaluated by therapy safe transfers on 1/09/19. The task Point of Care was added on 1/23/19 reflect the safety concerns of using stand vs a mechanical lift. This was discussed with the resident. The nuassistant involved was re-educated use of the EZ Stand and Mechanica on 1/9/19. Current residents who depend on mechanical lifts will be identified an audited to verify safe transfers are completed by administrative nursing. Current nursing staff will be re-educated and new nursing staff will be educated safe transfers using mechanical lifts follow personalized kardex by direct education or nursing administration. Compliance will be monitored through	in 9 to an EZ sursing on the al Lift d then g staff. cated ted on s that tor of i.	1/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		245183	B. WING			01/0	04/2019	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
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NONTH	NIDGE HEALIH AND	REHAD		N	EW HOPE, MN 55428			
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{F 689}	registered nurse (Ralong with RN-C, Rhelp her use the balift to an upright poswhile bending over socks without gripp was inverted as shelft side of her footstanding lift from Rishe stated, "Pull do starting to slip." Durobserved to have happeared to be slid standing plate, the upper shoulders/ not the sling at her upposerved to remove lowered by the starverbalized they need R701's weakness and RN-C exited the (NA)-E and NA-B easked R701 if she was just very sore IR701 was being raishe stated "ow, ow, to be standing on the foot was inverted During an interview identified R701 had ago for the use of the further stated at timestanding lift and look however therapy salift.	ion on 1/2/19, at 11:37 a.m. IN)-B entered R701's room IN-B stated they were going to athroom. RN-B raised the stand sition, R701 was standing at the waist wearing regular per on the bottom, her left foot the was standing on her outer. While RN-B was pushing the room into the bathroom own her pants quick she's ring this time R701 was per knees bent, both feet ling toward the front of the stand sling was near her eck area and the left side of the rarm/ bi-cep area. RN-C was be R701's pants as she was adding lift to the toilet. RN-B the ded to talk with therapy due to and inability to stand up. RN-B the room as nursing assistant the red the room, and NA-B was ok. R701 responded, "I need to get back to bed." As itsed into an upright position, my foot." R701 was observed the outer left side of her foot as	{F 68	89}	audits of transfers daily x 7 days, to weekly x 2 weeks, weekly x 4 and of x 3 to verify safe transfer with meel lifts per kardex or until a lesser free is identified. Results of the audits will be forward QAPI committee for continued qualimprovement and compliance weel monthly x2, and quarterly.	monthly hanical quency d to the lity		

()		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245183	B. WING				-C 04/2019
	PROVIDER OR SUPPLIER RIDGE HEALTH AND I	REHAB		STREET ADDRESS, CITY, STATE, ZIF 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	, CODE	1 01/1	0-1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
{F 689}	sure when R701's let it was needed for traditional interview stated the observed "pretty frightening be indicated her left foot had a leg brace that support it. Furtherm back from the bathreleft foot as it caused. During an interview physical therapist (Figripper on the standmachine, however, alignment and even should wear gripper transferred with the he was not notified regarding any difficult transfers. PT-A indicate few weeks ago with the standing lift and were notified that R brace during transfer. During an interview stated R701 should only socks during standing lift to buring an interview director of nursing standing lift to during standing lift to be standing lift to be standing lift to be supported by the standing standing lift to be standing lift lift.	on 1/2/19, at 1:54 p.m. R701 It ransfer to the bathroom was ecause I was slipping." R701 of was contracted and that she that should be worn to help fore, R701 stated the transfer room was "very painful" to her dia "sharp pain." on 1/3/19, at 7:25 a.m. on 1/3/19, at 7:25 a.m. on 1/3/19. A tated there was diplate for the standing lift to promote proper foot a weight distribution resident's rock or shoes when being standing lift. PT-A stated that by the nursing department alties or changes with R701's cated a training had occurred then R701 had transitioned to during this training all staff 701 should wear her left leg ers. on 1/3/19, at 8:29 a.m. RN-D be wearing tennis shoes not tanding lift transfers and was the leg brace should be worn.	F 68	89}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			R-C 04/2019	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		04/2010	
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{F 689}	document in the resider and how the resider procedure or any check to participate in the	ge 19 stober 2010, indicated to sident's medical record "5. If nt participated in the nanges in the resident's ability procedure. 6. Any problems by the resident related to the	{F 68	39}			
{F 725} SS=E	Sufficient Nursing SCFR(s): 483.35(a) (**) §483.35(a) Sufficient The facility must have the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the factordance with the at §483.70(e). §483.35(a)(1) The fiby sufficient number types of personnel of nursing care to all resident care plans: (i) Except when wait this section, license (ii) Other nursing personnel of the section of the sectio	nt Staff. ve sufficient nursing staff with opetencies and skills sets to a related services to assure attain or maintain the highest of the mental, and psychosocial resident, as determined by the sand individual plans of care of number, acuity and cility's resident population in a facility assessment required acility must provide services are of each of the following on a 24-hour basis to provide residents in accordance with the ved under paragraph (e) of donurses; and resonnel, including but not reserve as section, the facility must donurse to serve as a charge	{F 72	25}		1/24/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING	3. WING		R-C 01/04/2019
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/1	3 1/2010
NORTH RIDGE HEALTH AND REHAB				5430 BOONE AVENUE NORTH		
NOTTH RIDGE REALTH AND REHAD				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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	HOULD BE COMPLÉTION	
{F 725}	Continued From page 20 by: Based on observation, interview and document		{F 725	A contract with a nursing agency	has	
	review, the facility failed to ensure sufficient staffing was available in order to implement accommodation of needs, with timely assistance, for personal cares according to the residents'			been obtained and contracted nur assistants have been utilized sinc 1/18/19.	sing e	
	assessed needs and as directed by the care plan. This practice had the potential to affect all residents residing on the 2 W unit.			The acuity of the current residents been assessed through reports tit Case Mix Report and ADL Index FA tally of residents has been obtained to feel the fall of th	led Report. ned for	
	residents (R28, R14	facility failed to ensure 2 of 3 43) identified at risk for		the following tasks, feeding assist and those requiring mechanical life each unit.	ts for	
	failure of the facility	eived timely repositioning. The to implement interventions arm for R28 whose pressure		Staffing levels were assigned bathe above reports which reflect at A wage review for nursing assist	uity.	
	Staff interviews:			be completed by 1/24/19.	iits wiii	
	On 1/2/19, at 10:06 a.m. nursing assistant (NA)-C stated staffing was still a concern and times staff was being cut with low census and the management did not pay attention to the care level of the residents including those that needed two assist with transfers and 2 with cares, "It's not about the number it's the care level. They can cut but they need to look at the care level."			At the change of each shift, the N Supervisor verifies all staff schedu present.		
				Monitoring of daily staffing is done Staffing Coordinator and reported stand up (M-F). Staffing will be re by administrative staff/or designed throughout the day and agency wi	at daily viewed	
	not gotten any bette concern that staff w	a.m. NA-D stated staffing had er and this was a facility wide ere being cut without looking f the residents, "sometimes		contacted for any unexpected cha Team Leaders on each shift will v their assigned team members are at the beginning of each shift. The office or shift supervisor will be no staff whom have not reported for	inges. alidate present staffing tified of	
	On 1/4/19, at 9:58 a.m. when NA-G stated, "We don't have enough people, we only have three aides" and "our brakes are taken out of our checks but we don't get them." When asked why			The nursing staff will be re-educa this procedure. Meetings held 5 days a week, M-I	e re-educated on	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			R-C 01/04/2019	
	PROVIDER OR SUPPLIER	REHAB		5	STREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428	1 01/0	3-4/2010
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 725}	care plan. On 1/4/18, at 1:07 phave enough staff to time" when asked witimely according to On 1/4/19, at 11:33 aware R143 wasn't stated, "We are sware Record review: On 1/4/19, at 1:04 prandomly selected sposting with the state and the human resowas revealed on for (NA) on 1 SW and (NA) on 1	o.m. NA-A stated, "We don't or reposition our residents on why R28 was not repositioned the care plan. a.m. NA-A stated she was not repositioned on time and amped, we don't have time." o.m. during a review of staff schedules and staffing fing coordinator, administrator ource director the following ar of seven days selected: vening shift which started at o.m. one nursing assistant one NA on 2 West schedules a 3:00 p.m. to 9:00 p.m. In 3 West had left early but it ow early. vening shift 3 W schedule and a no call no show (NCNS)	(F 72	25}	review open positions and new hire Ongoing exploration of recruitment evaluated weekly. Results of the findings will be forwathe QAPI committee for continued improvement and compliance weekmonthly x2, and quarterly.	efforts ard to quality	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING				-C 04/2019
	PROVIDER OR SUPPLIEF	3		5430 E	T ADDRESS, CITY, STATE, ZIP CODE BOONE AVENUE NORTH HOPE, MN 55428	<u> 01/0</u>	04/2019
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 725}	addition, the same which was never replaced the median replace them. Whe pattern for 2 W was stated the unit was NAs at current aveasked if the acuity residents needed repositioning assis which required months the staffing coording when asked how pattern for the facistated it was deternursing and the accoordinator stated were communicated determine staffing asked what happed the staffing coording coordinated if staff had insufficient staffing stated, "Occasional flex they say they groups. It's when to census." The staff respond to the question of the question of the staff respond to the sta	Ill work as Nurse and CNA." In TCU unit had one NA NCNS eplaced. the staffing coordinator verified NCNS's no staff was found to en asked what the staffing as the staffing coordinator is staffed with 4 nurses and 6 erage census of 66-68. When the level of assistance such as transfer level, stance and other care needs are than one staff assistance, nator was not able to respond. She determined the staffing lity the staffing coordinator mined by the director of diministration team. The staffing admissions and discharges and throughout the day to needs for the facility. When she when the census was low, nator stated when significantly ed down. At 1:24 p.m. when crought complaints of the the staffing coordinator ally on TCU when census is in don't know how to divide the hey are in between the ing coordinator was not able to estion.	{F 7:	25}			
	(MDS) resident co revealed 43 reside over half required of two staff with be	ew of 2 W Minimum Data Set ded level of assistance it was ents in the entire unit which was extensive physical assistance ed mobility, transfers and addition, the facility indicated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
	245183 B. WING				R-C 01/04/2019		
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	7 01/01/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	JLD BE COMPLÉTION	ON	
{F 725}	eating, 13 required required mechanica	ed physical assistance with mechanical transfers and 10 al stand lift.	{F 72				
{F 761} SS=D	Label/Store Drugs a CFR(s): 483.45(g)(l		{F 76	1}	1/24/19		
	Drugs and biological labeled in accordant professional principappropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted eles, and include the ory and cautionary e expiration date when					
	§483.45(h) Storage	of Drugs and Biologicals					
	Federal laws, the fabiologicals in locked	cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.					
	locked, permanentl storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distriquantity stored is more readily detected. This REQUIREMENT by: Based on observative review, the facility from t	facility must provide separately y affixed compartments for d drugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to a the facility uses single unit bution systems in which the minimal and a missing dose can and the facility uses single unit bution systems in which the minimal and a missing dose can and the facility and document ailed to store refrigerated and 36-46 degrees Fahrenheit attion refrigerators. Additionally, remove expired eye		Expired eye medications were refrom the medication cart. Broken thermometer in the 2W refrigerator was replaced immed			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			R- 01 /0	-C)4/2019
	PROVIDER OR SUPPLIER	REHAB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		7172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 761}	medication carts lounit. Findings include: On 1/3/19, at 10:21 (LPN)-A verified the refrigerator temper. Review of the Janurefrigerator temper degrees F., 3 of 3 of LPN-A confirmed the temperature log incomposition to kept within the adegrees F). Stored Novolog flex pen amanufacturer recorbottles, cartridges, refrigerator (between Nurse (RN)-A indice refrigerator temper back in an hour to mindicated the medice was 25 degrees F. had put in a mainter refrigerator. During medication is south medication of with LPN-A, the foll to be expired: -R6 Latanoprost dradated and had a last confirmed the medion 1/2/19 in the even another available be to Drugs.com your	a.m. licensed practical nurse essecond floor west medication ature was 22 degrees F. ary log identified the ature was less than 36 days 1/1/19, 1/2/19, 1/3/19. The medication refrigerator dicated the temperature was allowable range (36-46 in the refrigerator were 1 and 13 Humalog flex pens with mmendations to keep unused and pens of insulin in the en 36°F and 46°F). Registered atted she had just adjusted the ature and she would come recheck. At 11:55 a.m., LPN-A eation refrigerator temperature and stated the nurse manager mance ticket to look at the estorage review the 2 west far art on 1/3/19, at 10:21 a.m. owing medications were found tops 0.0005% 1/4 full were not set filled date of 7/31/18. LPN-A dication was last administered ening and that R6 did not have ottle of Latanoprost. According must discard the bottle within ening it if you choose to keep it	{F 76	31}	Medications carts were audited to verpired medications have been remarked medications have been remarked medications were audited to verify appropriate temperatures by administrative nursing staff. Current nursing staff will be re-educand new nursing staff will be provideducation on expired medications of discard dates and the proper monit of refrigerator temperatures by the director of education and/or administaff. 1 medication cart per unit will be auweekly x 2 weeks, bi-weekly x 4 and monthly x 3 by nursing administration on medicatrons been removed and refrigerator temperatures are accurate. Results of the audits will be forward QAPI committee for continued qualimprovement and compliance weekmonthly x2, and quarterly.	cated led /s. oring strative udited d cation have	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	COMPLETED		
		245183	B. WING		R-C 01/04/2019	
	NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	1 01/	04/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 803 SS=D	director of nursing (replaced the thermore if it was still below 3 would be replaced. expectation to date and dispose of them. Review of the facility policy revised April 2 Medications requiring in a refrigerator local nurses' station or of Medications must be and must be labeled Menus Meet Reside CFR(s): 483.60(c) (1) September 1 Menus must- \$483.60(c) Menus and Menus must- \$483.60(c)(1) Meet residents in accordance guidelines.; \$483.60(c)(2) Be profit \$483.60(c)(3) Be for \$483.60(c)(4) Reflereasonable efforts, ethnic needs of the	on 1/3/19, at 1:31 p.m. the DON) stated the facility had ometer in the refrigerator and 66 degree F., the refrigerator The DON indicated it was her eye drop bottles when opened in prior to expiration. y's Storage of medication 2007, indicated "9. In grefrigeration must be stored ated in the drug room at the other secured location. In the estored separately from food accordingly." Intent Nds/Prep in Adv/Followed 1)-(7) Indicated "9. In the drug room at the other secured location. In the other secured location. In the other secured location. In the other secured location is stored accordingly." Intent Nds/Prep in Adv/Followed 1)-(7) In the nutritional adequacy. It is nutritional needs of the ance with established national in the other secured in advance; and it is a stored and	F 76			1/24/19
	§483.60(c)(5) Be up	odated periodically;				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		R-C 01/04/2019	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	5-1/ 2 015
NORTH RIDGE HEALTH AND REHAB				5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 803	F 803 Continued From page 26		F 80	3		
	dietitian or other cli	eviewed by the facility's inically qualified nutrition tritional adequacy; and				
	§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 1 of 1 resident (R701) dietary preferences.					
				Registered Dietician interviewed review dietary preferences. The tr was reviewed and updated for die preferences.	ay card	
	Findings include:			The Food Services Staff will comp	Noto	
	of cerebrovascular addition, the CAA in cognition. R701's condicated R701 rec	11/27/18, included diagnoses accident and anemia. In ndicated R701 had intact are plan revised on 11/26/18, eived a regular diet.		interviews of currents residents, we interviewable to obtain and update and dislikes by 1/24/19. Likes and are updated in the tray card system Additionally staff were made awar communication form to note likes dislikes as the need arises.	thom are ed likes dislikes m. e of the	
		on 1/2/19, at 10:27 a.m. R701 ferred to eat hot foods and t sandwiches.		The Food Services staff will be re-educated on establishing and u tray identification system to verify		
	During an observation on 1/2/19, at 1:06 p.m. nursing assistant (NA)-E was observed passing room trays to the 700 unit where R701 resided. At			each resident receives his/her preferences as ordered by 1/24/19		
	speech therapist at was "very late" as i around noon. At 2: room and offered to	atted that she had been with the had not eaten lunch and it twas supposed to be here 14 p.m. a NA entered R701's assist her to bed. R701 and the had to eat my lunch I am hungry		Dietary preferences will be review residents during care plan meeting Interdisciplinary Team upon admis quarterly, annually, and with signif change.	gs by ssion,	
	and I haven't eaten ask the kitchen." A	t 2:30 p.m. registered nurse om the kitchen with R701's		Results of the audits will be forward QAPI committee for continued qualimprovement and compliance week	ality	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			R-C / 04/2019
	PROVIDER OR SUPPLIER	REHAB	;	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		704/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 803	eaten lunch earlier. observed eating a land a hardboiled extended in the sandwich, it to eat the sandwich interested to know. During an interview. R701's speech their with R701 on 1/2/12 p.m. to 1:50 p.m. a eaten prior to their confirmed staff did during their session. During an interview dietary manager stated soup, toast, were always availal lunch hot food item of by 1:15 p.m During an interview director of nursing a for staff assigned to residents have been designated meal tir. The facility policy Towarch 2016, indicated Manager will establicentification system receives his or her	unaware of why R701 had not At 2:58 p.m. R701 was ettuce salad with ham, cheese gg and a turkey sandwich. eferred hot food and did not nowever, verbalized, "I will try I am hungry, I would be what the hot food choice was." on 1/3/19, at 7:22 a.m. rapist confirmed she worked 9, from approximately 1:00 nd stated R701 should have session. The speech therapist not offer R701 her room tray in. To on 1/3/19, at 7:25 a.m. the lated the nursing staff would the kitchen when a resident a food option would be The dietary manager further oatmeal, sandwich and salad ble as options however, the for the day would be disposed on 1/3/19, at 1:51 p.m. the stated it was her expectation to the unit to ensure all in served their meal during the me.	F 803	monthly x 2, and quarterly.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245183	B. WING			R-C / 04/2019
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		104/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 803	2019, indicated, "N	denus reflect, based on the ell as input received from	F8	03		



Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On January 31, 2019,
I, <u>Diane Willette</u> , <u>Administrator</u> , received (Name)(Please Print) (Title)(Please Print) the Notice of Penalty Assessment dated January 31, 2019 and issued to:
North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428
The Penalty Assessments attached hereto have been corrected as of January 31, 2019.
Signed: <u>Diane Willtta</u> , <u>Administrator Date</u> 1-31-19 (Name)(Please Print) (Title)(Please Print)
DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE
On January 31, 2019,
I,,,, of the Division of (Name)(Please Print), of the Division of (Title)(Please Print) Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated January 31, 2019 and issued to:
North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428
The Notice of Penalty Assessment was handed to Name)(Please Print) (Title)(Please Print)
Signed: (Name)(Please Print), (Title)(Please Print), Date 1/3/19



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on January 31, 2019.

January 31, 2019

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

Re: Project # S5183030, H5183168, H5183170, H5183171, H5183172, H5183173, H5183156,

Dear Administrator:

On January 4, 2019, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 8, 2018 with orders received by you electronically on November 29, 2018.

State licensing orders issued pursuant to the last survey completed on November 8, 2018 and found corrected at the time of this January 4, 2019 revisit:

20265 - MN Rule 4658.0085 -- Notification of Change in Resident Health Status

20505 - MN Rule 4658.0300 Subp. 1 A-E -- Use of Restraints

20555 - MN Rule 4658.0405 Subp. 1 -- Comprehensive Plan of Care; Development

20830 - MN Rule 4658.0520 Subp. 1 -- Adequate and Proper Nursing Care; General

20895 - MN Rule 4658.0525 Subp. 2 B -- Rehab - Range of Motion

20910 - MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence

21015 - MN Rule 4658.0610 Subp. 7 -- Dietary Staff Requirements - Sanitiary Conditions

21426 - MN Rule 144A.04 Subp. 3 -- Tuberculosis Prevention and Control

21435 - MN Rule 4658.0900 Subp. A -- Activity and Recretion Program; General

21800 - MN Rule 144.651 Subp. 4 -- Patients & Residents of Health Care Facilities Bill of Rights

State licensing orders issued pursuant to the last survey completed on November 8, 2018, found not corrected at the time of this January 4, 2019 revisit and subject to penalty assessment are as follows:

20800 - MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing Requirements	\$300.00
20850 - MN Rule 4658.0520 Subp. 2 D Adequate And Proper Nursing Care; Shaving	\$350.00
20900 - MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	\$350.00
21610 - MN Rule 4658.1340 Subp. 1 Medicine Cabinet And Preparation Area; storage	\$300.00

North Ridge Health And Rehab January 31, 2019 Page 2

21695 - MN Rule 4658.1415 Subp. 4 -- Plant Housekeeping, Operation, & Maintenance \$200.00

The details of the violations noted at the time of this revisit completed on January 4, 2019 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$1500.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Susanne Reuss, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Shellae Dietrich, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

North Ridge Health And Rehab January 31, 2019 Page 3

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

DWENTS SLAPSON

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

Enclosure

cc: Licensing and Certification File

Kami Fiske-Downing, Licensing and Certification Program

Penalty Assessment Deposit Staff

PRINTED: 01/30/2019 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ R-C B. WING ___ 00238 01/04/2019

		00238		B. WING		01/04/2019
NAME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE	
NORTH I	RIDGE HEALTH AND	REHAB		PE, MN 5542		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
{2 000}	Initial Comments			{2 000}		
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION OF	RDER			
	In accordance with 144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of the Minnesota Depart	ction order has bee by. If, upon reinspe iency or deficiencie ected, a fine for eac be assessed in acc ines promulgated b	en issued ction, it is es cited ch violation cordance			
	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 that may result from orders provided that the Department with notice of assessment.	n non-compliance wat a written request hin 15 days of rece	with these is made to ipt of a			
Minnesota D	INITIAL COMMENT On 1/2/19, through Department's staff and the following of The facility was fou or more correction the survey exited of orders will remain in	1/4/19, surveyors of re-visited the above or rection orders are nd NOT to have coorders issued as a n 11/8/18. The under the coorder of the c	e provider e issued. prected one result of corrected			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE 01/22/19

Electronically Signed

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.		l R	-C
		00238		B. WING			04/2019
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAB		ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{2 000}	Continued From pa	ige 1		{2 000}			
	the next site visit.						
	You have agreed to receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a Department of Hea you electronically. is necessary for State necessary for State licensure procompletion date, the corrected prior to e Minnesota Department.	ensure orders or artment of Hea tin 14-01, availate.mn.us/divs te licensing orde ttached Minnes. Ith orders being Although no plate Statutes/Ru rected" in the be indicate in the cess, under the e date your ord lectronically sul	onsistent with able at affpc/profinfo/inf ers are sota g submitted to an of correction ales, please ox available for electronic e heading lers will be				
	H5183172: On 11/8/18, an investigation of this complaint was completed. The complaint was substantiated at MN Rule 4658.1415 Subp 4. During the revisit, H5183172 was not corrected and reissued at MN Rule 4658.1415 Subd 4.						
	H5183173: On 11/8/18, an investigation of this complaint was completed. The complaint was substantiated at MN Rule 4658.0085, MN Rule 4658.0520 Subp 2D, MN Rule 4658.0525 Subp 3, MN Rule 4658.0525 Subp 5A. B and MN Rule 4658.0510 Subp 1. During the revisit H518173 was not corrected and reissued at 483.25(b) Skin Integrity, §483.25(b)(1) Pressure ulcers and 4658.0510 Subpart 1. Staffing requirements. H5183174: At the time of the revisit survey, investigation of this complaint was completed and substantiated at MN Rule 4658.0520 Sup 1.						
	H5183175: At the ti		·				

Minnesota Department of Health

STATE FORM WOFB12 If continuation sheet 2 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00000	B. WING		R-C 01/04/2019	
		00238	D. W		01/0	4/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND I	RFHAB	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
{2 000}	Continued From pa	ge 2	{2 000}			
	of this complaint wa	-				
		me of the revisit, investigation as completed and found to be				
{2 800}	MN Rule 4658.0510 Staffing requiremen	Subp. 1 Nursing Personnel; its	{2 800}			1/24/19
	home must have or number of qualified registered nurses, li nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and o meet the needs of the es' stations, on all floors, and ore than one building is ides relief duty, weekends, ements.				
	by: Uncorrected based	ent is not met as evidenced on the following findings. The d on 12/27/18, will remain in ssment issued.		Corrected.		
	review, the facility fa staffing was availab accommodation of for personal cares a assessed needs an	on, interview and document ailed to ensure sufficient ale in order to implement needs, with timely assistance, according to the residents' d as directed by the care planue potential to affect all in the 2 W unit.				
	Findings include:					
	Refer to F686: The	facility failed to ensure 2 of 3				

Minnesota Department of Health STATE FORM

WOFB12 If continuation sheet 3 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING			-C)4/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAR	ONE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 800}	residents (R28, R14 pressure ulcers rec failure of the facility resulted in actual haulcer worsened. Staff interviews: On 1/2/19, at 10:06 stated staffing was was being cut with I management did not level of the resident two assist with transabout the number it but they need to loc On 1/2/19, at 10:13 not gotten any better concern that staff wat the care needs of the teams are split. On 1/4/19, at 9:58 and "our braichecks but we don't have enough aides" and "our braichecks but we don't R28 was not reposite care plan. On 1/4/18, at 1:07 phave enough staff to time" when asked wit time when asked wit timely according to	43) identified at risk for eived timely repositioning. The to implement interventions arm for R28 whose pressure a.m. nursing assistant (NA)-C still a concern and times staff ow census and the of pay attention to the care including those that needed afers and 2 with cares, "It's not's the care level. They can cut ok at the care level." a.m. NA-D stated staffing had be and this was a facility wide are being cut without looking the residents, "sometimes" a.m. when NA-G stated, "We be be seen taken out of our to get them." When asked why tioned timely according to the oreposition our residents on why R28 was not repositioned the care plan.				
	aware R143 wasn't	a.m. NA-A stated she was not repositioned on time and amped, we don't have time."				
	Record review: On 1/4/19, at 1:04 p	o.m. during a review of				

Minnesota Department of Health

STATE FORM WOFB12 If continuation sheet 4 of 19

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		R- 01/0	C 4/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 01/0	7/2013
	RIDGE HEALTH AND	5/30 BOO	NE AVENUE			
	I	NEW HOP	E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 800}	Continued From pa	ge 4	{2 800}			
	posting with the sta and the human reso	staff schedules and staffing ffing coordinator, administrator ource director the following ur of seven days selected:				
	2:00 p.m. to 10:00 p (NA) on 1 SW and had instead worked	vening shift which started at co.m. one nursing assistant one NA on 2 West schedules I 3:00 p.m. to 9:00 p.m. In a 3 West had left early but it ow early.				
		vening shift 3 W schedule ad a no call no show (NCNS) placed.				
	revealed one NA ha a.m. to 2:00 p.m. a	ay shift on 1 SW schedule ad come in late for the 6:00 and one NA only worked 2:00 stead of 2:00 p.m. to 10:00				
	Care Unit (TCU) a 6 was floated to 2 W "Group 8 Nurse will	ay shift in the Transitional 6:00 a.m. to 2:30 p.m. nurse and the schedule indicated work as Nurse and CNA." In TCU unit had one NA NCNS placed.				
	on days staff had N replace them. Whe pattern for 2 W was stated the unit was NAs at current aver asked if the acuity, residents needed s repositioning assist which required mor	the staffing coordinator verified CNS's no staff was found to a sked what the staffing the staffing coordinator staffed with 4 nurses and 6 rage census of 66-68. When the level of assistance uch as transfer level, ance and other care needs than one staff assistance, after was not able to respond.				

Minnesota Department of Health

STATE FORM WOFB12 If continuation sheet 5 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00238	B. WING		R- 01 /0	-C 14/2019
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 800}	When asked how s pattern for the facili stated it was detern nursing and the adr coordinator stated a were communicated determine staffing rasked what happen the staffing coordinal low the facility flexe asked if staff had be insufficient staffing stated, "Occasional flex they say they d groups. It's when the census." The staffir respond to the quest (MDS) resident coordinates for two staff with bed toileting needs. In a 10 residents required	the determined the staffing ty the staffing coordinator nined by the director of ministration team. The staffing admissions and discharges disc	{2 800}			
{2 850}	MN Rule 4658.0520 Proper Nursing Car	Subp. 2 D Adequate and e; Shaving	{2 850}			1/24/19
	proper care. The cadequate and proper D. Assistance	r determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean				

Minnesota Department of Health

STATE FORM WOFB12 If continuation sheet 6 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R-	С
		00238	B. WING			4/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENU PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 850}	Continued From pa	age 6	{2 850}			
	by: Uncorrected based	ent is not met as evidenced on the following findings. The		Corrected.		
	original order issue effect. Penalty asse	d on 12/27/18, will remain in essment issued.				
	review, the facility f	ion, interview and document ailed to ensure adequate be for 1 of 3 residents (R62) ies of daily living.				
	Findings include:					
	R62's annual Minimum Data Set (MDS) dated 11/16/18, indicated he was severely cognitively impaired and required assistance from staff for dressing and personal hygiene.					
	12:15 p.m. R62 wa awaiting his noon n	on 1/3/19, at approximately s seated in the dining room neal. R62's face was unshaved covered in what appeared to	Ŀ			
	assistant (NA)-E st with cares that mor think R62's pants w on him. NA-E furthe	n 1/3/19, at 12:30 p.m. nursing ated she had assisted R62 ming. NA-E stated she did not were dirty when she put them er stated she attempted to electric razor but he had				
	stated R62 did not stated he used to b	p.m. registered nurse (RN)-F have an electric razor. She but it had been missing for a staff should be using a shave him.				
		stated R62 would change into er the staff assisted him in the				

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STATE FORM WOFB12 If continuation sheet 7 of 19

_	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING		R-C 01/04/2019		
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/0	1/2010	
NORTH I	RIDGE HEALTH AND I	RFHAR	NE AVENUE	_			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	PE, MN 5542	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE	
{2 850}	Continued From pa	ge 7	{2 850}				
		d his dirty clothes were kept in ugh she was aware of this					
{2 900}	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	{2 900}			1/24/19	
	comprehensive resi of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and						
	receives necessary	ho has pressure sores treatment and services to event infection, and prevent reloping.					
	by: Uncorrected based	ent is not met as evidenced on the following findings. The d on 12/27/18, will remain in essment issued.		Corrected.			
	review, the facility fa interventions to pro- ulcers and prevent residents (R28, R14	mote healing of pressure pressure ulcers for 2 of 3 43) reviewed for pressure d in actual harm for R28 who's					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R-		
		00238	B. WING		01/0	4/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
NORTH	RIDGE HEALTH AND	RFHAB	NE AVENUE				
(VA) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES	PE, MN 5542	PROVIDER'S PLAN OF CORRECTION)N	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 900}	Continued From pa	ge 8	{2 900}				
	Findings include:						
	11/9/18, indicated s impaired and requir bed mobility, transfe further indicated R2 ulcer. R28's care pl potential/actual imprelated to immobility plan directed staff t document location, injuries and remind. A facility Progress N pressure ulcer to co. 1 cm [centimeters] wound to coccyx ar pressure wound he and at risk for recur underweight status resident off wheel co.	imum data set (MDS) dated he was moderately cognitively red extensive assistance with ers and toileting. The MDS 28 did not have a pressure an dated 12/11/18, identified a pairment to skin integrity and fragile skin. The care to lay R28 down after meals, size and treatment of skin ers to turn and reposition. Note dated 9/5/18, indicated: accyx noted on 9/3/18, "1/2x 0.". R28 with new pressure ea to same spot where recent aled. Area is compromised trent injury given the current and poor appetite. Keep thair in between meals a observation on 1/4/19, the red: At 7:07 a.m. R28 was up					
	seated in her wheel station. At 7:40 a.m dining room by staf 9:52 a.m. At that tin	chair outside the nurses R28 was escorted to the f where she remained until ne, staff escorted R28 to her in front of the television					
	practical nurse (LPI had a wound on the was not sure how to stated he did not us	ximately 10:00 a.m. licensed N)-B stated he was aware R28 e right side of her buttock but ong it had been there. LPN-B sually work on that unit.					
		ad been having a lot of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00238	B. WING			l-C 04/2019
	PROVIDER OR SUPPLIER	SEHAB 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{2 900}	problems with her be supposed to be rep stated it had not be out of bed that morn had time to reposition. At 10:30 a.m. LPN-lay down in her bed reddened area on hinch round. LPN-B R28's coccyx. LPN-approximately 5 cm wound bed contains was described by L thickness skin loss tissue necrosis, or a supporting structure stated R28 also had shoulder that had b month. R28's Nursing Wee Condition Reports of 12/12/18, Right glut observed on 9/5/18 12/18/18, Skin conditions. 12/25/18, Skin intaction identified. 12/26/18, right glute measurements including the surrounding tissue. The medical record of the right gluteal for related to the shoulder that had be surrounding tissue.	pottom. NA-A stated R28 was ositioned every two hours and en done since R28 had gotten ning. NA-A stated she had not on R28. B and NA-A assisted R28 to . R28 was noted to have a ser ischium approximately one removed a dressing from .B described R28's wound as x 4 cm with tunneling. The ed slough (dead tissue) and PN-B as a stage IV (full with extensive destruction, damage to muscle, bone, or es. pressure ulcer). LPN-B d a pressure ulcer on her een present for about a kly Skin Evaluations and Skin evealed the following: teal fold maceration first . dition dry, redness. No area et, no open areas. eal fold macerations. No uded. esure ulcer unstageable at 2.2 cm. Wound bed eschar, macerated. lacked further documentation old and lacked documentation	{2 900}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		R- 01 /0	-C)4/2019
	PROVIDER OR SUPPLIER	REHAB 5430 BOO	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 900}	following Progress No (involve partial thick epidermis, dermis, superficial and presiblister, or shallow or back of left shoulded Hospice nurse updo of the wound and in redness previously. During interview on was not aware R28 ulcers to her coccystaware of the pressure RN-A stated the starepositioning a residency two hours and repositioning to be care. At 11:39 a.m. the diexpected staff to for stated R28 should be two hours. R143's quarterly MI she had intact cognians assistance from two and transfers and her R143's care plan daincontinence related stage IV pressure uplan directed staff to reposition "at least" A care area assess to the facility with a	Notes: Interpretation of the plan of care and have been repositioned every DS dated 12/24/18, indicated interpretation, required extensive or stage IV pressure ulcer noted to be pressured in the plan of care and said she was aware and said she was aware and said she was not are ulcer on her shoulder. Indeed of practice for dent with a pressure ulcer was distant of the plan				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
	00238		B. WING		R- 01/0	-C 4/2019
				STATE, ZIP CODE E NORTH 28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 900}	non-compliance wit repositioning. During continuous of following was observed up in her 8:03 a.m. she was sroom where she rer she propelled herse room. At 9:35 a.m. room and sat in her window. At 9:52 a.m room to get a room At 10:13 a.m. R143 chair. R143 stated the morning and at night and thirty nine minutobservation, RN-A stand using a mechalerted RN-A of the repositioned. R143 and two open areas RN-A stated the the were new. The left area approximately was a superficial opinches in length. A Weekly Skin Conindicated R143 had her coccyx measuring and right but to nurse practitione on left and right but	h off loading and observation on 1/3/19, the rved: At 7:34 a.m. R143 was wheel chair in her room. At seated at a table in the dining mained until 9:01 a.m. when left to an adjoining activity R143 propelled herself to her wheel chair facing the in. a staff member entered the tray and immediately left. remained seated in her wheel the staff only help her in the int. At 10:25 a.m., two hours	{2 900}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00220	B. WING		R-C 01/04/2019	
		00238	B. WIIIG		1 01/0	4/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND I	RFHAR	ONE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{21610}	Continued From pa	ge 12	{21610}			
{21610}	MN Rule 4658.1340 and Preparation Are	Subp. 1 Medicine Cabinet ea;Storage	{21610}			1/24/19
	must store all drugs under proper tempe	of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have				
	by: Uncorrected based	on the following findings. The d on 12/27/18, will remain in essment issued.		Corrected.		
	Based on observation, interview and document review, the facility failed to store refrigerated medications between 36-46 degrees Fahrenheit (F) in 1 of 5 medication refrigerators.					
	Findings include:					
	(LPN)-A verified the refrigerator tempera Review of the Januar efrigerator tempera degrees F., 3 of 3 d LPN-A confirmed that temperature log indonot kept within the adegrees F). Stored Novolog flex pen armanufacturer recombottles, cartridges, a refrigerator (between Nurse (RN)-A indicate refrigerator temperator temper	a.m. licensed practical nurse second floor west medication ature was 22 degrees F. ary log identified the ature was less than 36 lays 1/1/19, 1/2/19, 1/3/19. Ite medication refrigerator icated the temperature was allowable range (36-46 in the refrigerator were 1 and 13 Humalog flex pens with mendations to keep unused and pens of insulin in the en 36°F and 46°F). Registered ated she had just adjusted the ature and she would come echeck. At 11:55 a.m., LPN-A				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMI			SURVEY LETED	
	00238		B. WING		R-C 01/04/2019	
	PROVIDER OR SUPPLIER	STREET AD 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{21610}	was 25 degrees F. had put in a mainte refrigerator. During an interview director of nursing (replaced the thermore if it was still below 3 would be replaced. expectation to date and dispose of them. Review of the facilit policy revised April Medications requiring in a refrigerator local nurses' station or of Medications must be and must be labeled. MN Rule 4658.1418	ation refrigerator temperature and stated the nurse manager nance ticket to look at the on 1/3/19, at 1:31 p.m. the DON) stated the facility had ometer in the refrigerator and 66 degree F., the refrigerator The DON indicated it was her eye drop bottles when opened in prior to expiration. y's Storage of medication 2007, indicated "9. ng refrigeration must be stored ated in the drug room at the ther secured location. e stored separately from food d accordingly."				1/24/19
	Subp. 4. Houseke provide housekeepi necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirements by: Uncorrected based original order issued effect. Penalty asset	eping. A nursing home must ing and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on the following findings. The d on 12/27/18, will remain in essment issued.		Corrected.		
	Daseu un observall	on, interview and document				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00238	B. WING			-C 04/2019
NORTH RIDGE HEALTH AND REHAB 5430 BOO			DRESS, CITY, S DNE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{21695}	(R95, R703, R704) In addition, failed to clean for 1 of 1 resi concerns. Findings include: R95's diagnoses in weakness, profound scoliosis obtained find Data Set (MDS) data MDS indicated R95 cognition, required with transfers, one and profound mental indicated R95 used and staff propelled addition, the care prequired assist of two On 1/2/19, at 1:42 pin bed and her speciobserved parked at was observed to be and brownish multiplication. On 1/3/19, at 8:43 at all dressed for the coby the nursing static however, none acknow the cleaned.	ailed to ensure 3 of 3 residents wheelchairs were kept clean. ensure rooms were kept dent (R16) with respiratory cluded cerebral palsy, muscle d intellectual disability and rom the quarterly Minimum ted 12/1/18. In addition, the had severely impaired total dependence of two staff assist with locomotion in the hair (w/c) and had functional	{21695}			

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	(X3) DATE SURVEY COMPLETED	
00238 B. WING R-C 01/04/20		
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(21695) Continued From page 15 nurse (RN)-A assisted R95 with breakfast. During the observation R95's w/c was observed soiled. At 9.23 a.m. RN-A was observed to wheel R95 to her room. On 1/3/19, at 9:38 a.m. the director of maintenance stated wheelchair cleaning was done by the security staff at night and at times the maintenance staff cleaned them in the evening. When asked how his department was notified of soiled w/c's when it was not the scheduled time to be cleaned, the director of maintenance stated nursing staff would notify his department and when he got any notification he would pull and cleaned the wic immediately. -At 9-42 a.m. the director of maintenance reviewed the monthly wheelchair log and verified R95's w/c was last cleaned the first week in December 2018. -At 9:46 a.m. the director of maintenance verified the w/c was soiled, "it is dirty for sure. I talked to the nurse couple of times about cleaning it but don't have documentation for it because we have been having problems having access to it to be cleaned. I did not talk to [security staff] why it was not done at night as he comes at 11:00 p.m. I need to coordinate with nursing when is a good time to have it cleaned maybe when she is getting a shower. The wheelchair needs to be taken down to the machine to be cleaned because it is dirty." The undated facility Wheelchair Cleaning policy directed staff wheelchairs were to be washed monthly following the wheelchair washing schedule and as needed. In addition, the policy directed nursing staff to wipe down wheelchairs for spills and debris and for excessively soiled wheelchairs the staff was to put in "TELEs" for		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00238	B. WING		R- 01 /0	-C)4/2019
	PROVIDER OR SUPPLIER	SEHAR 5430 BOC	DRESS, CITY, S DNE AVENUE PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{21695}	Continued From particle machine.	ge 16 d on 1/2/19, at 1:19 p.m.	{21695}			
	seated in a tilt in sp rest of the chair was chair. Staff adjusted foot rest did not sta to dangle in the air. match the one on the	ace wheelchair. The left foot is hanging off to the side of the did the foot rest, however, the yin place causing R703's foot. The left foot pedal did not ne right side of the chair. was covered with food debris				
	transferred from an	ted 11/21/18, indicated R703 other unit and indicated: foot neelchair was broken.				
	R704's wheel chair	d on 1/3/19, at 11:47 a.m. and was noted to be covered in d a substance all over the				
	practical nurse (LPI wheelchairs were s night shift. She stat been cleaned on 12	1/3/19, at 11:40 a.m. licensed N)-C stated the resident upposed to be cleaned on the ed R703's chair should have 2/30/18. LPN-C further stated a work order for the broken chair.				
	schedule was poste station. RN-E stated	stated a wheelchair cleaning ed on the wall at the nurses d there had been a breakdown and felt it was on the night shift.				
		o the facility on 7/26/18, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D WING		R-	
		00238	B. WING		01/0	4/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	RFHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{21695}	respiratory failure wobstructive pulmona interview for mental (13-15 indicates into R16's room was ob The heater/radiator window sill, was full blew out cold air. TR16's room at 9:25 left the room (approwas still dirty and full R16 was interviewe said she washed 2 herself. During the blew out cold air. Doback of the closet of fan. A continuous pour (C-PAP) machine (aflow of airway press the airway stays op approximately 8 feed dust and debris on breathing problems C-PAP machine at Maintenance staff-Cat 1:43 p.m. and incoleaned and was la Maintenance staff-Cat twice a year. An environmental to maintenance direct maintenance direct schedule to be clear	with hypoxia and chronic ary disease. R16's brief I status (BIMS) score was 15 act cognition). served on 1/3/19, at 9:20. fan, located underneath the of dirt and debris. The fan the housekeeper went into a.m. after the housekeeper oximately 9:40 a.m.), the fan all of debris. d on 1/3/19, at 1:29 p.m. and of the 7 vent panels of the fan time of the interview, the fan ust debris was noted on the loor that was closest to the ositive airway pressure a machine that is a constant sure to the throat and ensures en during sleep) was et away from the fan, also had it. R16 indicated she had and used oxygen and the	{21695}			
	The housekeeping	director was interviewed on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		00238	B. WING			-C 04/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		0 1/2010
NORTH	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{21695}	1/4/19, at 11:43 a.m cleaned the top of t Housekeeping staff room each day and room each day. The unit and the housekevery 18 days each clean. Number 6 of list included: clean	n. and said housekeeping staff he heat registers/fans. If did general cleaning to a lidid a deep cleaning of one ere were 18 rooms on R16's keeping director indicated that a room would receive a deep the daily deep clean check off and wipe done heater/radiator clean and vacuum filter and	{21695}			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTA	L
PART L. TO BE COMPLETED BY THE STATE SURVEY ACEN	$\neg \mathbf{v}$

ID: WOFB Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245183 2.STATE VENDOR OR MEDICAID NO. (L2) 531716900 5. EEEECTIVE DATE CHANGE OF OWNERSHIP.	3. NAME AND ADDRESS OF FACILITY (L3) NORTH RIDGE HEALTH AND RE (L4) 5430 BOONE AVENUE NORTH (L5) NEW HOPE, MN	(L6) 55428	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2014 6. DATE OF SURVEY 11/08/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRI 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/I 04 SNF 08 OPT/SP 12 RHC	13 PTIP 22 CLIA 14 CORF IID 15 ASC	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 320 (L18) 13.Total Certified Beds 320 (L17)	A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	And/Or Approved Waivers Of The I 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B *	Collowing Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 320 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABIL	ICF IID (L42) (L43) LE SHOW LTC CANCELLATION DATE):	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Amy Charais, HFE NE II	Date: 12/21/2018 (L19)	4	rcement Specialist 12/27/2018 (L20)
PART II - TO BI 19. DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Financia	
(I 27)	DATE ENDING DATE (L25)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 29 (L28)	(L45) D. INTERMEDIARY/CARRIER NO. 00270 (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 32 (L32)	2. DETERMINATION OF APPROVAL DATE (L33)	DETERMINATION APPRO	VAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 29, 2018

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

RE: Project Number S5183030, H5183168, H5183170, H5183171, H5183172, H5183173, H5183156, H5183160, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, and H5183167

NOTE: The Life Safety Code (LSC) survey findings will be processed in a separate enforcement letter.

Dear Administrator:

On August 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 27, 2018. (42 CFR 488.422)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018. (42 CFR 488.417 (a))

Also, we notified you in our letter of August 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

On October 5, 2018, we informed you that the following enforcement remedy was recommended to the CMS Region V Office:

• Civil money penalty. (42 CFR 488.430 through 488.444)

On November 8, 2018, a standard 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. In addition, at the time of the November 8, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5183172 and H5183173 that were found to be substantiated. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby significant corrections are required. In addition, at the time of the November 8, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5183168, H5183170, and H5183171 that were

North Ridge Health And Rehab November 29, 2018 Page 2 found to be unsubstantiated.

REMEDIES

As a result of the survey findings, the previously imposed remedies of state monitoring and discretionary denial of payment (42 CFR 488.417 (a)) will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following remedy:

• Civil money penalty. (42 CFR 488.430 through 488.444)

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the standard survey completed November 8, 2018), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division North Ridge Health And Rehab November 29, 2018 Page 3

> Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the abbreviated standard surveys completed August 10, 2018, September 13, 2018, and October 18, 2018), i.e., the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us

Phone: (651) 201-4204 Fax: (651) 281-9796

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 PoC 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 if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

North Ridge Health And Rehab November 29, 2018 Page 4

Services that your provider agreement be terminated by February 10, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions.

Sincerely,

Towers Stapson

Douglas Larson, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018	
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	00			
F 000	Emergency Prepared conducted on 11/4/1 recertification survey	ance with CMS Appendix Z dness Requirements, was 8 through 11/8/18, during a 7. The facility is in compliance Emergency Preparedness	F 00	00			
	standard survey was the Minnesota Depai if your facility was in requirements of 42 C	arough November 8th ,a completed at your facility by tment of Health to determine compliance with the CFR Part 483, Subpart B, or Long Term Care Facilities.					
	as your allegation of Department's accept enrolled in ePOC, yo at the bottom of the f	correction (POC) will serve compliance upon the ance. Because you are our signature is not required first page of the CMS-2567 submission of the POC will on of compliance.					
	an on-site revisit of y	e that substantial compliance nas been attained in					
	_	ification survey, complaint also completed at the time ey.					
		omplaint, H5183168 was plaint was unsubstantiated.					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

Electronically Signed

12/07/2018

And deficiency estatement ending with an actorick (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other

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.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C / 08/2018	
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F 000	An investigation of cocompleted. The comp An investigation of cocompleted. The comp F584. An investigation of cocompleted. The comp F580, F677, F686, F6	mplaint, H5183170 was plaint was unsubstantiated. mplaint, H5183171 was plaint was unsubstantiated. mplaint, H5183172 was plaint was substantiated at mplaint, H5183173 was plaint was substantiated at 690 and F725.		000			
F 550 SS=D	S483.10(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. S483.10(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. S483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility		F	550		12/18/18	
	§483.10(a)(2) The factor access to quality care severity of condition, must establish and mand practices regarding	cility must provide equal e regardless of diagnosis,					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 550	§483.10(b) Exercises. The resident has the rights as a resident or resident of the Urights as a resident or resident can exercise interference, coerciferom the facility. §483.10(b)(2) The resident can exercise from the facility. §483.10(b)(2) The resident from the facility. This Regularies of his or he subpart. This Regularies of his or he subpart.	ess of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. acility must ensure that the se his or her rights without on, discrimination, or reprisal esident has the right to be coercion, discrimination, and cility in exercising his or her rights as required under this action, interview and document ailed to ensure 1 of 4 viewed for dignity concerns by in public areas of the failed to provide a dignified or 1 of 4 residents (R95)	F 55		r eged main te		
	from the quarterly M dated 10/5/18. In ac R175 required exter for activities of daily	ncluded depression, muscle weakness obtained finimum Data Set (MDS) ddition, the MDS indicated nsive assist of one to two staff living (ADL's) including personal hygiene. The MDS		 R175 was provided privacy to ensure dignity in public areas. R95 food is not being mixed together ensure dignity. 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245183	B. WING _			11/08/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				54	430 BOONE AVENUE NORTH			
NORTH RI	DGE HEALTH AND REH	AB		NEW HOPE, MN 55428				
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F 550	Continued From page	÷ 3	F 5	550				
	also indicated R175 h	nad not rejected cares.			Current residents that are assisted with	1		
	R175's care plan date	ed 10/9/18, identified			meals and dressing have the potential	to		
	dependence on staff	for assistance with all cares			be affected by this alleged deficiency.			
	_	eficits and directed staff to						
		clothing/blanket if [R175]			Current staff was re-educated regardin	g		
	midriff is exposed."				resident rights including maintaining			
	On 44/4/40 at 5:00 m	no D475 was absorbed			dignity when providing assistance with			
		.m. R175 was observed at the dining room table			dining and dressing.			
	_	head. R175's bare breasts			DON or designee will complete audits			
		he bra exposed to other			weekly x 4, then, monthly x 3. DON or			
	residents, staff and vi	· · · · · · · · · · · · · · · · · · ·			designee will monitor weekly for			
		ssistant (NA)-G was sitting			compliance.			
	_	tching television, but did not			·			
	cover R175 until surv	eyor questioned her. During			Results of the audits will be forwarded	to		
	the observation there	were nine residents in the			the QAPI committee for continued qual	ity		
	small dining room inc right across the table	luding two male resident's from R175.			improvement and compliance x 3 mont	hs.		
		.m. R175 was observed						
		nair by the nursing station.						
		ed over her head and her						
		posed again. At this time 75 from the front then went						
	• •	led her down the hallway						
		ed to the back nursing						
	•	proximately 200 meters. As						
		our other residents were						
	•	and looked at R175. NA-H						
	then stated to NA-I "w	ho put this on this woman.						
		you can get her ready." At						
		ached R175 and adjusted						
		d as he wheeled R175 to						
	her room.							
	At 7:09 nm when as	ked about the observation						
	•	noticed R175's breasts were						
	tri otatou no nau i	Calcoa IVII o o biodolo Wolo						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245183	B. WING			08/2018
NAME OF PF	ROVIDER OR SUPPLIER	=		STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	00/2010
NORTH RI	DGE HEALTH AND REHA	ΔR		5430 BOONE AVENUE NORTH		
NOKITIKI	DOE HEALITI AND KEIT	-D		NEW HOPE, MN 55428		
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F 550	the area to the unit. Whave covered her up I assigned to R175 and brought her back to the bed. On 11/6/18, at 2:09 p. stated he would experent and fix the problem as leave R175 in that material material first of all, resisted "first of all, resisted "first of all, resister. The staff should removed her from the dignified of staff to do Dignified dining experent R95's significant channindicated she was sevand required extensive care plan dated 10/1/1 deficit and indicated staff. Review of a facility Prindicated R95's intake excellent, however hare R95 was unable to cointake was now 0-25%. During observation or R95 was seated in the	s why he wheeled her out of when asked if he should NA-H stated he was not at that was why he had he unit for NA-I to put her to the staff to redirect, divert as this was not dignified to anner. In the director of nursing dents belong to all staff I have covered her and area. That was not that." In the director of nursing dents belong to all staff I have covered her and area. That was not that." I the covered her and area. That was not that. I when the director of nursing dents belong to all staff I have covered her and area. That was not that. I when the covered her and area. That was not tha	F	550		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			l	C
NAME OF P	ROVIDER OR SUPPLIER	243103	B. WING	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	08/2018
		A.D.			430 BOONE AVENUE NORTH		
NORTH RI	DGE HEALTH AND REH	AB		N	EW HOPE, MN 55428		
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F 550	and pureed quiche. R on the table and nursi moving items out of h NA-J assisted R95 to R95 continued to reackept placing the cup of then used a spoon to together on her plate. her juice and NA-J coher reach. NA-J fed R together food. When I a second spoonful, R94 At 12:48, NA-J moved without offering her armount of the plate of	95 was reaching for things ing assistant (NA)- J was er reach. At 12:45 p.m. drink a small sip of juice. In for the cup and NA-J but of R95's reach. NA-J mix all of R95's food R95 was still reaching for intinued to move it out of R95 a spoon full of the mixed NA-J attempted to feed R95 gets turned her head away. If R95 away from the table in the symmetry of the symmetry of the food e. RN-A stated it was good together." RN-A further we been offered more fluids	F	550			
F 558 SS=D	problem with mixing F stated she mixed up a ate. NA-J stated R95 she wanted all of her asked about the fluids her some juice." Reasonable Accommoders: 483.10(e)(3) §483.10(e)(3) The rig services in the facility accommodation of respreferences except w	sident needs and	F	558			12/18/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER		5	ETREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/06/2016
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F 558	other residents. This REQUIREMEN' by: Based on observation review, the facility fair within reach for 1 of during the initial surversides. R117's diagnoses inchistory of falling, must walking obtained from 7/12/18. In addition, R117 was at risk for impaired balance, Pair judgement. The care the call light within reuse it when he had at the call light within reuse it when he had at the call light within reuse it when he had at the call light within reuse it when he had at the call light within but R117 requested this of coffee that was on which was not within had used the call light did not have one. Within the call light the was observed with no surveyor was exiting cord were observed by the first bed which	on, interview and document illed to ensure a call light was 1 resident (R117) reviewed rey sample for call light use. Cluded Parkinson's disease, scle weakness and difficulty in the care plan revised the care plan identified falls related to history of falls, arkinson's disease and poor is plan directed staff to keep each and encourage R117 to in need.	F 558	F558 R117 call light was placed within reach Current residents have the potential to affected by this alleged deficiency. Current staff were re-educated on placicall lights within reach. DON or designee will complete call light observation audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance x 3 months.	to ity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		245183	B. WING _			11/	08/2018
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page (NA)-F came to R117	e 7 's room and verified R117	F t	558			
	` '	light on the wall mount by					
	his bed. NA-F stated	all residents were supposed					
		reach if they were able to					
		f for assistance. When					
		to connect the other call ed NA-F stated he did not					
	-	ing to have the nurse put a					
	•	intenance department to fix					
		and returned with licensed					
	. , ,	-D who stated when they					
		sting R117 the call light was ght housekeeping staff had					
		moved the call light. When					
		been in the room, LPN-D					
		LPN-D stated all residents					
	who were able to use	•					
	• •	e call lights in reach at all cance LPN-D stated R117					
	was at risk for falls.	lance LFN-D stated R 117					
		a.m. the director of nursing					
	•	ts were supposed to be					
		es when a resident was in					
	the room and was abl	le to use it.					
	The facility Answering	the Call Light policy					
	revised October 2010						
		all light is plugged in at all					
	times.	is in head on some					
		is in bed or confined to a					
	the resident"	light is within easy reach of					
F 580		jury/Decline/Room, etc.)	F 5	580			12/18/18
SS=D	CFR(s): 483.10(g)(14						
	§483.10(g)(14) Notific	cation of Changes.					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			С	
	ROVIDER OR SUPPLIER	1	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/08/2018		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 580	(i) A facility must immonsult with the resident sin injury and physician intervention (B) A significant charphysical, mental, or deterioration in health status in either life-the clinical complications (C) A need to alter the aneed to discontinual treatment due to advice commence a new for (D) A decision to trainersident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent information (2) is available and physician. (iii) The facility must resident and the	nediately inform the resident; dent's physician; and notify, or her authority, the resident en there is- living the resident which has the potential for requiring n; nge in the resident's psychosocial status (that is, a h, mental, or psychosocial preatening conditions or s); eatment significantly (that is, e an existing form of prese consequences, or to preserve or discharge the sility as specified in specified in \$483.15(c) provided upon request to the dent representative, if any, an or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and	F 58				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245183	B. WING			l	0
		245165	D. WING			11/	08/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH R	IDGE HEALTH AND REH	AB			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)		, , , , , , , , , , , , , , , , , , , 		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 580	that is a composite dia §483.5) must disclose agreement its physical the various locations distinct part, and must apply to room change locations under §483. This REQUIREMENT by: Based on observation review, the facility fail representative of a significant service. R31's diagnoses includementia, hemiplegial and anemia obtained Data Set (MDS) dated MDS indicated R31 hocognition, had both short problems and require with eating. R31's care plan revise was at increased risk "feeding" deficit, an all significant unplanned directed staff to encound identified FM-A and agent due to R31's increased risk agent due to R31's increased risk increased risk "feeding" deficit, and significant unplanned directed staff to encound identified FM-A and agent due to R31's increased risk increased risk "feeding" deficit, and significant unplanned directed staff to encound identified FM-A and agent due to R31's increased risk increased risk "feeding" deficit, and and identified FM-A and agent due to R31's increased risk increased risk "feeding" deficit, and identified FM-A and agent due to R31's increased risk increased risk "feeding" deficit, and identified FM-A and agent due to R31's increased risk increased risk "feeding" deficit, and identified FM-A and identifi	posite distinct part. A facility stinct part (as defined in a in its admission al configuration, including that comprise the composite to specify the policies that as between its different and the specify the policies that as between its different and the specify the policies that as between its different and the specify the policies that as between its different and the specific policies and document and the specific policies and document and the specific policies and the specific	F	580	F580 R31 representative has been notified regarding resident □s weight loss Current residents with significant weight loss have the potential for being affected by this alleged deficiency. Dietician staff and IDT team has been re-educated on notifying resident representative regarding significant weight loss. Dietary manager or designee will audit current residents with significant weight loss weekly x 4, then, monthly x 3 for notification. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance x 3 montiliance.	ed t to ity	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 580	FM-A also stated when members visited R31, thought when the stafijust need to be patien had noticed the weight facility staff had not refamily members to distribute nor was he aware of at the weight loss. On 11/6/18, from 8:18 was seated at a table for breakfast. At 8:32 plate of food, set it in 8:36 a.m. NA-A came to R31 and started to NA-D left the table and room area. NA-D got brought back for R31' after R31 ate a few bit the juice, NA-D wheeld room and placed him At 8:54 a.m. NA-D state approximately 25% which can be represented the significant weight family member had come at time and had for table with food in from to assist him. During review of medical revision of the significant weight and noted in progressing and noted in progressing and noted in progressing to the staff of the significant weight and noted in progressing and	n he and other family he always ate well and f told him he refused., staff t. FM-A further stated he at loss over time however eached out to him or other scuss what could be done, any interventions in place for a.m. to 8:32 a.m. R31 in the dining room waiting a.m. NA-D brought R31's front of R31 and left. At back to the table sat next assist R31. At 8:43 a.m. d went to the main dining two straws which she s beverages. At 8:53 a.m. tes of his food with sips of ed R31 out of the dining by the nursing station. ited R31 had eaten	F	580		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		245183	B. WING		<u>-</u>	11/	08/2018
	ROVIDER OR SUPPLIER IDGE HEALTH AND REH	АВ		5-	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	the significant weight nutritional supplement further review it was rediction had again noweight loss of 17.3 pc. The medical record la R31's responsible paweight loss. On 11/6/18, at 12:56 registered dietician (Contritional supplement unplanned significant 180 days and though last 90 days. When a department had obsected of the what staff were supposed to be offered when asked who was family/responsible paweight loss, CRD stated she did not eat well, she stooffer an alternate a supposed to be offered when asked who was family/responsible paweight loss, CRD state expected nursing to reparty as she did not know as involved in R31's On 11/7/18, at 8:46 at (RD) stated since the been identified R31 hutritional supplement had stabilized. When watched R31 during the fairly new and part-tire completed the assessing aide or nurse how R3	o indicated 8/14/18, due to loss in 90 and 180 days a at was ordered. During revealed on 11/1/18, the oted R31 had a unplanned ounds, 10.5% in 180 days. acked documentation of rty being informed of the p.m. the consultant CRD) stated R31 was on a at twice daily due to weight loss over the last t R31 had leveled off in the sked if anyone in the dietary rved R31 during meals, the oot think so. When asked osed to do when a resident stated staff were supposed and all residents were ed enough fluids with meals as supposed to notify rty of R31's significant ted she would have have notified the responsible anow how much the family is care. In registered dietician significant weight loss had ad been started on the trand thought the weight	F	580			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING		C 11/08/2018	
	ROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		50/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584 SS=E	At 9:42 a.m. the RD shad written the teleph supplement for weigh nurse noted the order the nurse to have upoparty about the weigh On 11/7/18, at 2:10 p. reviewed the interdisc there was no docume party being notified of RN-I stated he would the one to do the noti experts but also though done it due to the new On 11/7/18, at 2:26 p. stated she would have department to have not responsible represent when the supplement The Change in a Respolicy dated November facility staff shall promorn her attending physically staff shall promorn her attending physically staff shall promorn her attending conditions are conditionally safe/Clean/Comfortal CFR(s): 483.10(i) Safe Environther resident has a right supplement than a right shall promorn her attending physically safe shall promorn her attending physically safe/Clean/Comfortal CFR(s): 483.10(i) Safe Environther resident has a right supplement.	tes an RD would but all be doing the update. It tated at the time the RD one order for the nutritional at loss on 8/15/18, when the rit was the responsibility of lated the family/responsible at loss. In registered nurse (RN)-I ciplinary notes and verified intation of family/responsible at the significant weight loss. The have thought the RD was fication since they were goth nursing would have a vorder. In the director of nursing the expected the dietary of the weight loss was initiated. It ident's Condition or Status for 2017, directed staff "The aptly notify the resident, his idian and resident inges in the resident's tion and/or status" In the director of nursing the expected the dietary of the weight loss was initiated. It ident's Condition or Status for 2017, directed staff "The aptly notify the resident, his idian and resident inges in the resident's tion and/or status" In the a safe, clean, the like environment, including in the resident, including in the resident and its safely.		580		12/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	245183	B. WING _	STREET A	DDRESS, CITY, STATE, ZIP CODE	11/	08/2018
					ONE AVENUE NORTH		
NORTH R	DGE HEALTH AND REH	AB		NEW HO	PE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 584	homelike environmen use his or her persona possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall exthe protection of the roor theft. §483.10(i)(2) Housekes services necessary to and comfortable interior systems and comfortable interior systems and condition; §483.10(i)(3) Clean be in good condition; §483.10(i)(4) Private resident room, as specified in all areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain at 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation review, the facility fail	clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident bes not pose a safety risk. exercise reasonable care for resident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are	F	F584	4 3 missing item report was complete	ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245183	B. WING _				C /08/2018	
NAME OF PR	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2010	
				54	430 BOONE AVENUE NORTH			
NORTH RI	DGE HEALTH AND REH	АВ		N	EW HOPE, MN 55428			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 584	F 584 Continued From page 14 1 of 1 resident (R108) reviewed for personal property. In addition, failed to maintain an		F 5	84				
					for missing clothing items.			
	environment that was	clean, free from odors and			Repairs to rooms and equipment for 13	32,		
		ns 132, 282, 390, 247, 338			282, 247, and 338 have been complete	ed.		
		wheel chairs were clean and						
		ree residents (R31,R54,			R31 and R54 wheelchairs have been			
	R103) who resided in the facility. Findings include: R108, on 11/4/18, at 4:44 p.m., family member (FM)-C was asked if R108 had any missing items, and stated they had brought R108				cleaned and are free of debris			
					Room 390 has been cleaned and free from odors.			
					R103 is no longer residing at North Rid	ge		
	multiple pieces of clot	thing and all were missing.			Current residents that have reported			
		hanging on the closet door			missing clothing items have the potenti			
		ed OFF 10/15/17 to get			to be affected by the alleged deficiency	' .		
	,	d all the listed items which						
		socks, 6 sweat pants, 5			Current residents that have wheelchair			
		nnels, 1 pajama bottom and			have the potential to be affected by this	6		
		e all missing. FM-C stated			alleged deficiency.			
	•	ne about the missing items			Current residents that are care planner	ı		
	despite the facility sta	iff being aware of the issue.			Current residents that are care planned hoarders have the potential to be affect			
	On 11/6/18 at 9:40 a	.m. registered nurse (RN)-K			by the alleged deficiency.	icu		
		(NA)-E were observed			by the dileged deficiency.			
	assisting R108 to get				Current staff have been re-educated to			
		d RN-K applied a black			the location of the missing item report			
	t-shirt which had a lar				forms and the need to complete when			
		st. At 10:52 a.m. NA-E			missing items have been reported to			
	-	cal nurse (LPN)-D to assist			them. Social Services, Nurse Manager	s,		
	him to apply a light weight sweat shirt. During the		and Administration have been educated					
	observation none of t	he staff acknowledged			on policies and procedures for missing			
	R108's t-shirt was rip	ped.			items.			
	0- 44/7/40 + 0.50	un la consideración de			Current maintenance staff has been			
		.m. housekeeping/laundry			re-educated on the procedure for			
		hing needed to be labeled			wheelchair cleaning. Current			
	trie stait was suppose	ed to put the clothing in a			maintenance and housekeeping staff			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		, IDENTIFICATION AND INDED			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDIN			(С
		245183	B. WING _			11/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
NODTH DI	DGE HEALTH AND REH	AR	5430 BOONE AVENUE NORTH		130 BOONE AVENUE NORTH		
NOKIHKI	DGE REALIN AND KEN	AB		NI	EW HOPE, MN 55428		
(X4) ID PREFIX TAG			ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	e 15	F 5	584			
	bag with the resident	name and she would come			have been re-educated on the procedu	re	
	and collect them and	have them labeled. Staff			for repairs and odors in resident rooms		
	stated the resident far	mily was very good at					
	-	s of the clothing and she			Administration or designee will complete		
	•	housekeeping/laundry staff			audits of up to 4 submitted missing iten	n	
		ance the clothing was never			forms weekly x 4, then, monthly x 3.		
		looking through the lost to try to find something			Maintenance and housekeeping or designee will complete 4 resident room		
	about the clothes.	to try to find something			audits for repairs and odors weekly x 4		
	about the diothes.				then, monthly x 3. Maintenance will	,	
	At 7:38 a.m. the hous	ekeeping/laundry staff			complete 4 resident wheelchair audits	for	
	stated all the listed ite	ems at the closet door went			cleanliness weekly x 4, then, monthly x	3.	
	missing a couple of m	nonths after family had			Administration or designee will monitor		
	_	She also stated anytime she			weekly for compliance.		
		nissing item(s) she would try					
		eport to nursing and the			Results of the audits will be forwarded		
		he further stated she had			the QAPI committee for continued qual	•	
	•	r social worker several times n able to find the clothes			improvement and compliance x 3 mont	ns.	
		outcome. When surveyor					
		rn t-shirt R108 was wearing,					
		est gone through the closet					
	and room and had se	•					
	clothing and she was	going to go downstairs to					
	find some donated ite	ems to give to R108 in the					
	meantime.						
	services (DSS) stated resident's missing clo was another social we who had been followin DSS stated she was g follow up with surveyor						
	On 11/8/18, at 2:46 p. a missing item form w	.m. the administrator stated vas supposed to be					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245183	B. WING			C 11/08/2018	
	ROVIDER OR SUPPLIER	АВ		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	room, check laundry at then if the facility was to repl further stated the item through a catalog or f and a check would be administrator further searched for the item locate them they were or responsible party to item(s) progress and interview the assistant R108's missing items through October 2017 requested a copy of the she would follow up to the company of the	vere supposed to look in the and outsourced laundry in not able to find the item(s) lace them. The administrator in(s) could be replaced family could buy the items is existed to them. The stated after staff had is and were not able to exupposed to call the family indicates. During the introduced were not on the list. The administrator in the missing items and stated on the issue.	F	584			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			C 11/08/2018		
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	Ē			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE		ION	
F 584	wheelchairs. On 11/8/18, at 9:42 a. director (MD), environ (ESD), and communit administrator toured vabout the observation room 132 the mainter the heating units in the mold and mildew. The ameter to check the aheating units. The MI the room with the met. In room 282 the ESD carpet are the responkeep clean. The ESD the room to begin cleapump stand and carpet stated the rooms were repair and painting nework order had been at the MD stated when staff should have filled maintenance department completed as soon as shown R103's, R31's, and asked if there was wheelchairs. The ESD worked on, but she will clean the wheelchairs.	m. the maintenance amental services director y relations/assistant with the surveyor to interview is noted on 11/7/18. In nance director (MD) stated is rooms were checked for it MD stated the facility had air quality coming out of the D stated he would check it after the tour. I stated the stand and sibility of housekeeping to called a housekeeper to aning the feeding tube in the MD stated no completed for that room. I repairs were needed the dout a work order and the itent would get them is possible. The ESD was and R54's wheelchairs is a system for cleaning the D stated a system was being build get the housekeeper to it. Room 338 also had	F	DEFICIENCY) 584				
	make sure the walls walls walls was nown 390 there was	pain the MD stated he n of all the rooms and vere repaired and painted. s still a foul odor and the cluttering the room. The						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		<u></u>
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F 604 SS=D	because the resident leave. The ESD stated discussion with the so interdisciplinary team cleaning room 390. At 11/8/18, at 11:23 at the staff was expected request on the computation of the computation of the staff was expected request on the computation. Review of the facility produced from the staff was expected from the staff was ex	ticult to clean room 390 told the housekeepers to d she had not had a ocial worker or to come up with a plan for .m. the administrator stated d to fill out a maintenance after when there were nce needs in the building. led the staff were taught maintenance requests policy Work Orders, /2014, indicated facility staff completing a work order into maintenance for Physical Restraints , 483.12(a)(2) and Dignity. ght to be treated with including: the tobe free from any restraints imposed for e or convenience, and not esident's medical		504		12/18/18

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , ,		()	(X3) DATE SURVEY COMPLETED		
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F 604	any physical or chem treat the resident's more treat the resident's more \$483.12(a) (2) Ensure from physical or chem purposes of discipline are not required to tresymptoms. When the indicated, the facility alternative for the lead document ongoing rerestraints. This REQUIREMENT by: Based on observation review the facility failed free from physical residence (R82) reviewed for resident and required transfers, toileting and plan dated 8/4/18, indicated she impaired and required transfers, toileting and plan dated 8/4/18, ideand limited physical in directed supervision with plan further identified staff to place R95 in a day after lunch.	ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- that the resident is free nical restraints imposed for or convenience and that eat the resident's medical use of restraints is must use the least restrictive est amount of time and evaluation of the need for is not met as evidenced en, interview and document ed to ensure residents were traints for 1 of 2 residents estraint use.	F	F604 R82 is free from physical restrated facility policy. Current residents in broda/reclinated the potential to be affected alleged deficiency. Current nursing staff were reset the physical restraint policy and procedure. DON or designee will complete observation audit weekly x 4, the monthly x 3 on residents with bechairs. DON or designee will meekly for compliance.	ning chair d by the ducated of t restraint nen, roda			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			C 11/08/2018		
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, 5430 BOONE AVE NEW HOPE, MN		1 11/	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 604	leaning to her left side the armrest of the charmest of the charmest of the charmest of the charmest of the chair was observed in the reclining chair. On 11/6/18, at 7:33 at a blue reclining chair the unit. R95 appears leaning on her left side arm rest of the chair. The way back. R95 st 9:29 a.m. During interview on registered nurse (RN during the night. RN-falling a lot and had of the chair almost even on 11/6/18, at 9:56 at C stated R95 wanted to NA-C stated R95 from getting up the standard wheel cand walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk. NA-C stated R95 ros longer wanted to and walk.	wing in a reclining chair, le with her head resting on air. R95 appeared to be a.m. R95 was asleep in a television room outside the unit. A standard wheel in R95's room. R95 remained until 9:26 a.m. a.m. R95 was again lying in in the television room on ed to be asleep. She was de with her head lying on the The chair was reclined all till remained in the chair at 11/6/18, at 9:37 a.m. 11/6/18, at 9:37 a.m.	F	Results of the QAPI co	he audits will be forwarded ommittee for continued qua nt and compliance x 3 mor	ality		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE	11100/2010	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 604	Continued From page 21		F	604			
	getting up from the reher in the recliner charstaff did not attempt of in the chair. During interview on 1 stated R95 transferre ordered her a reclinin had not fallen in a few to fall quite a bit, esperate thought the nurse the chair for positionir unable to say how oft reclining chair or how chair. She further state often R95 was up at resulting the recliner of the resulting that the resulting chair or how chair.	tated when R95 started gular wheel chair, staff put hir. NA-K further stated the other things but just put her 1/6/18, at 1:34 p.m. RN-K d herself a lot so they g chair. She stated R95 weeks but stated she used exially at night, RN-K stated a practitioner had ordered hg. RN-K stated she was en staff were using the they were utilizing the sed she did not know how hight in the chair but stated tting her up to sleep in the					
	a huge fall risk. LPN-washed R95 up and a then put her in the received because she was a high she thought R95 had recliner chair after lur stated she thought the but R95 would try to greclining chair. At 2:10 p.m. the direct should be using R95's	se (LPN)-B stated R95 was B stated the p.m. shift and dressed her for bed cliner chair to sleep igh fall risk. LPN-B stated an order to sit in the ach but not for bed. LPN-B e night shift put her in bed get up so they put her in the tor of nursing stated staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018	
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	06/2016
NORTH RI	DGE HEALTH AND REH	AB			3430 BOONE AVENUE NORTH		
	OUR MAN DV OT				NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From page	22	F	604			
	dated September 201 only be used for the s resident. Restraints si the residents medical discipline or staff convprevention of falls. Ex be considered a restraints	amples of devices that can					
F 656 SS=D	-	comprehensive Care Plan	F	656			12/18/18
	implement a compreh care plan for each respectives and timefra medical, nursing, and needs that are identificated assessment. The completives that are identificated assessment. The complete the following (i) The services that a or maintain the resident physical, mental, and required under §483.2 and (ii) Any services that a complete the following that the residence of the following that the residence of the following that the residence of the following that the following the following the following that the following th	cility must develop and tensive person-centered sident, consistent with the chat §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fed in the comprehensive apprehensive care plan must					
	provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized se	esident's exercise of rights ling the right to refuse .10(c)(6).					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	(X3)	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	<u> </u>	11/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	findings of the PASA rationale in the reside (iv)In consultation wiresident's representation (A) The resident's godesired outcomes. (B) The resident's profuture discharge. Fact whether the resident's community was asselucal contact agencial entities, for this purporation (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation review the facility fail interventions on the for 1 of 1 resident (R concerns, and 1 of 1 lift. Findings include: R160's admission M dated 9/30/18, indicated 9/30/18, indicated section in the plant of the plant	a facility disagrees with the RR, it must indicate its ent's medical record. The the resident and the tive(s)-als for admission and eference and potential for cilities must document is desire to return to the ssed and any referrals to es and/or other appropriate one. In the comprehensive care in accordance with the hin paragraph (c) of this in paragraph (c) of this in the comprehensive care in accordance with the hin paragraph (c) of this in paragraph (c) of this in paragraph (document end to develop and implement person centered care plan and the following in the comprehensive to the second that is not met as evidenced in the comprehensive activities of daily living	F 6	F656 R160 behavior care plan review updated. R11 ADL care plan reviewed and updated. Current residents with behaviors concerns have the potential to be by this deficiency. Current residents with full lifts ha potential to be affected by this deficiency cCC (clinical care coordinator), managers, and CRC (clinical	d al ee affected ave the eficiency.		

		(X3) DATE COMP	SURVEY LETED				
		245183	B. WING _			l	C 08/2018
	ROVIDER OR SUPPLIER	АВ		5430	EET ADDRESS, CITY, STATE, ZIP CODE BOONE AVENUE NORTH V HOPE, MN 55428		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	(stroke) affecting unsign of ability to understand apraxia (inability to personal apraxia (inability to personal apraxia), and compression indicated R160 was not as needed (PRN) pantipsychotic, antianal medications. Review assessments dated 1 indicated R160 exhibits of R160's plan of care behaviors. Review of R160's Profollowing entries: 9/20/18, 10:42 p.m. N. R160 was alert, and cout the Peg and pulle cc balloon. The Cathemissing part was seen abdominal binder, clorefusing cares. 9/21/18, 6:03 a.m. Nudid not sleep through the G tube and clothin note further indicated mattress for fall preven 9/21/18, 2:12 p.m. Nuhad been lethargic, sleep when she was given pagitated, trying to put to roll over the bed. Fiseemed to suggest ". 9/24/18, 5:31 a. m. Nik R160 was restless all	cerebrovascular disease pecified side, aphasia (loss dor express speech), erform particular purposive sion of brain. The MDS not receiving any scheduled pain medications or any siety or antidepressant of subsequent MDS 0/7/18 and 10/21/18 sited no behaviors. Review e, did not address any egress Notes indicated the dursing: Note indicated confused. She was pulling dout the Catheter with 10 eter was intact and no en. R160 was pulling out the thing, falling out of bed and ersing: Note indicated R160 the night, was pulling out ing through the shift. The R160 had a floor bed and ention. Irsing Note indicated R160 eepy from around 8:00 a.m.	F 6	r r k li C a c r r	reimbursement coordinator) were re-educated on updating care plans for pehavior concerns/interventions and furifts. CRC or designee will complete care plandits on residents with behavior concerns and full lifts weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded the QAPI committee for continued qual mprovement and compliance x 3 months.	II an to ity	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			1, ,	(X3) DATE SURVEY COMPLETED		
		245183	B. WING			C
	ROVIDER OR SUPPLIER DGE HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	l	11/08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
F 656	and placement check 9/24/18, 9:16 p.m.: Nowas being monitored was resistive with carwhen giving cares. Stand assessed skin du 10/8/18, 9:53 p.m. Nowas a bit agitated on feeding tube and also G-tube out with her had 10/23/18, 6:29 a.m. Nowas a wake most a.m. writer and NAR worder saw resident's conflated. 10/23/18, 3:19 p.m. Nowas awake most a.m. writer and NAR worder saw resident's conflated. 10/23/18, 3:19 p.m. Nowas awake most a.m. writer saw resident's conflated. 10/23/18, 3:19 p.m. Nowas awake most a.m. writer saw resident's conflated. 10/23/18, 3:19 p.m. Nowas awake most a.m. writer saw resident's conflated. 10/23/18, 3:19 p.m. Nowas awake most a.m. writer saw resident's conflated. 10/23/18, 3:19 p.m. Nowas awake most a.m. Nowa	Will continue to monitor. Ursing Note indicated R160 for readmission this shift, es, attempted to slap staff aff unable to change tubing e to resistance. Ursing:Note indicated R160 shift, disconnected the attempted to pull the ands. Ursing Note indicated et hours of the night, at 3:44 went to assist her to bed, eatheter lying on the floor Ursing: Note indicated w writer to re-insert her very resistive. 160 started pulling apers, pulling G- tube, and D was fighting with the staff ing inappropriate words. Ursing Note indicated staff	F	656		
	Interview on 11/6/18, therapist (ST)-A indic	at 8:00 a.m. speech ated on days R160 is				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	fatigued she does not to be fed. ST-A indicated staff, but would put when the staff attemp During interview on 1. Registered Nurse (Rhindicated she reviewed specific MDS items, a exhibit the specific bear esident started exhibit the same stated and same started exhibit the specific bear ex	eat well, and does not like ated R160 would take food bush the staff's hands away ted to feed her. 1/7/18, at 9:00 a.m., with N)-G, who complete MDS's, and progress notes for very and indicated R160 did not haviors. RN -G indicated if ibiting behaviors between the nurse manager is ng the care plan. m., RN-B verified R160 did are identified on the plan of 60 did exhibit behaviors. m., Social Service (SS)-A would add the specific of care. of lymphedema and a left attation of the left leg and order sheet. A quarterly indicated R11 had intact in o/26/18 indicated R11 had ity and directed staff to use all lift device), however, the indicated. n. 11/5/18, at 9:09 a.m. a full was under R11 while hair. R11 stated the staff lost	F	356			

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED			
		245183	B. WING		,	C I1/08/2018
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	I	11/06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	side when she was to legged sling. During instruction sheet for the sling was observed processed for the sling was observed processed for the sling was observed processed for the should be used for Rordered for her. He was care sheet (undated) transfers but did not also verified the commindicate the type of some sheet (undated) transfers but did not also verified the commindicate the type of some sheet (undated) transfers but did not also verified the commindicate the type of some sheet (undated) transfers but did not also verified the commindicate the type of some sheet (undated) transfers but did not satisfied the staff was indicated the staff was (amputee)sling and listen the staff was interview was to be trained not to use a computee residents and decided by a nurse to cross legged sling has wednesday. On 11/6/18, at 9:12 and was interviewed and should not be used for with an above the known the resident was sure the resident was single to the resident was sure the resident was single to the should determined to the same should determined to the should not be used for with an above the known the resident was sure the resident was single to the same should determined to the same shou	cansferred in the cross the observation an he multipurpose (amputee) osted in the resident's room. a.m. the nurse manager ipurpose (amputee) sling 11 and this sling was erified that the aide group 5 noted for R11 "hoyer" for specify the type of sling. He prehensive care plan did not ling to be used. Seessment dated 10/19/18, as to use the multipurpose ft posted information for the scroom. With NA-A on 11/6/18, at she was told the sling for laundry and the other cross e used. She stated she was cross legged sling for and did not know if it was to use it. She verified the ind been used since last .m. the director of nursing verified a cross legged sling or a full lift with a resident ee amputation. She stated the ermine the type of sling and was safely transferred in the e care plan should reflect	F 65	56		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		245183	B. WING				C 11/08/2018	
	ROVIDER OR SUPPLIER	AB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 130 BOONE AVENUE NORTH EW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656 F 677 SS=D	review the resident ca and to use the needer transfer the resident. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resident out activities of daily I	ed 10/2010, directed staff to are plan for special needs, dequipment to safely or Dependent Residents ent who is unable to carry iving receives the necessary		656			12/18/18	
	and personal and ora This REQUIREMENT by: Based on observation review, the facility fail grooming was provide who was dependent of living (ADL's). Findings include: R31's diagnoses include hemiplegia obtained f Data Set (MDS) dated MDS indicated R31 h cognition, had both sh problems and require assistance of one to the dressing and personal dated 11/2/18, identifiting related to right hemiple decreased mobility. To provide assistance hygiene.	is not met as evidenced in interview and document ed to ensure adequate ed to 1 of 5 residents (R31) on staff for activities of daily aded aphasia, dementia and from the quarterly Minimum d 8/8/18. In addition the ead severely impaired fort and long term memory d physical extensive wo staff to completed il hygiene. R31's care plan ed an self care deficit			R31 has had adequate grooming. Current residents have the potential to affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on the ADL polic and procedure. DON or designee will complete groomin audits weekly x 4, then, monthly x 3. Do or designee will monitor weekly for compliance. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance x 3 months.	ng ON to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED			
		245183	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER DGE HEALTH AND REH	АВ	,	STREET ADDRESS, CITY, STATE, ZIP COE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428)E	11100/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA	DATE	
F 677		e 29 dining room and was noted hair. When greeted, R31 did	F 6	577			
	on 11/5/18, at 9:53 a outside the front nurs	ed away. .m. R31 was observed					
	interview family mem not make sure R31 h was not shaved daily	•					
	standing beside R31 area. R31 still had so food around his mout dried and wet food d had just arrived at the and was frustrated w sure R31 was well gr clothing. FM-A stated shaver but did not kn	.m. FM-A was observed in the television lounge cruffy facial hair and dried th. R31's shirt had both ebris on it. FM-A stated he facility to find R31 that way ith the staff for not making comed and had clean the family had brought in a low where it was and if and las R31 was not well kept					
	verified R31 was uns mouth and the shirt of dried and wet yellow would have R31 clea further stated all residuassisted with cares a	.m. registered nurse (RN)-K haved, had food around his in the front left side had food on it. RN-K stated she ned up right away. RN-K dents were supposed to be nd staff were to make sure ed properly after meals and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245183	B. WING			1	08/2018
	ROVIDER OR SUPPLIER	АВ		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	On 11/7/18, at 2:26 p. stated residents were cares as directed by t were supposed to be	e 30 s she reminded staff all the m. the director of nursing supposed to be provided he care plan and residents well groomed and have	F	677			
F 679 SS=D	CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The factor the comprehensive as and the preferences of program to support reactivities, both facility individual activities are designed to meet the physical, mental, and each resident, encour and interaction in the This REQUIREMENT by: Based on observation review the facility failed.	is not met as evidenced n, interview and document ed to provide activity	F	679	F679		12/18/18
	engagement for 1 of 2 during the survey. Findings include: R82's Activity Assessi indicated it was very i participate in her favo assessment identified included: religious sel	I resident (R82) reviewed ment dated 8/5/18, mportant to her that she			R82 will be provided with activity engagement that meets her interest / needs. Current residents have the potential to affected by this alleged deficiency. Activity or TR Staff will review attendant records for current residents to assess that interest needs are being met.	ice	

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245183	B. WING _			l	C 08/2018
	ROVIDER OR SUPPLIER	AB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428	<u>,</u>	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	animals. R82's quarterly minimindicated she was sevand required extensivitoileting and bed mob 8/4/18, indicated she activities. The care plan in kind of music. R82 to activities and in nail care, special eventime. The care plan in kind of music. R82's activity participa and included the followard included include	aum data set dated 8/31/18, verely cognitively impaired e assistance for transfers, ility. R82's care plan dated was dependent on staff for an directed staff to escort dentified her preferences as ints, church and toddler dicated R82 enjoyed any action logs were reviewed wing activites: 2 participated in 2 one to programs and one self 2 participated in 2 one to oup activity and one selevision. 2 nad no documented activity 2 was requested through vided after 10/9/18. attendance lacked evidence	F	679	TR Director or designee provided re-education to Activity staff to review resident⊡s activity attendance for engagement of leisure to meet their interest / needs. TR Director or designee will complete activity attendance audits weekly x 4, then, monthly x 3. Administrator or designee will monitor weekly for compliance. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement x 3 months.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		C	2040
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/08/	2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUNDER OF THE APPREDED TO	JLD BE C	(X5) OMPLETION DATE
F 679	Continued From pag	e 32	F 679	9		
	nurses station on the reclining chair until 9	unit. R82 remained in the :26 a.m.				
	in the hallway outsid	as asleep in her wheel chair e the nurses station. At 1:29 in a wheel chair in her				
	a blue reclining chair the unit. R82 appear leaning on her left si arm rest of the chair.	a.m. R82 was again lying in in the television room on ed to be asleep. She was de with her head lying on the The chair was reclined all till remained in the chair at				
	At 1:09 p.m. R82 aga nurses station alone	ain was seated outside the				
	R82 to remain seate "I've ben sitting here	a.m. a staff member directed d in her chair. R82 replied, ever since I got up." The "I know but I don't want you				
	wheel chair in the co	a.m. R82 was seated in a mmon area outside the stated, "I'll probably still be supper time."				
	participate in activities She stated she usua R82 used to have a used it to stand so the	11/6/18, at 1:11 p.m. I)-M stated R82 did not really es unless it involved kids. Ily just sits. RN-M stated table in her room but she bey got rid of it. She stated er hair and do her makeup				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C
	ROVIDER OR SUPPLIER DGE HEALTH AND REH		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/	08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	on it. During interview on 1 licensed practical number didn't really do anything about activities R82 wonce in a while she withink they don't take hone to one." LPN-B store brown box in her roomused to comb her hair one to comb her hair one to one it all day. RN-K table in front of her. Richard know if R82's niece how Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a further facility residents. Base assessment of a resident residents receive accordance with profession practice, the comprehencare plan, and the residents receive with the residents received accordance with profession and the residents received accordance wit	are Indamental principle that and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. In the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. In the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. In the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices. In the facility must ensure densive person-centered sidents' choices.	F			12/18/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/00/2010	
NODTH DI	DGE HEALTH AND REH	A D		5430 BOONE AVENUE NORTH			
NOKIRKI	DGE REALIN AND REN	AD		NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	34	F 68	34			
	of motion.			Current residents having limitation	ns in		
	Findings include:			range of motion have the potentia affected by this alleged deficiency			
	contracture, hemipleg	luded left hand and wrist jia, muscle weakness and om the quarterly Minimum d 9/7/18. In addition, the		Current licensed and certified nurs staff were re-educated on providir during ADLs.	_		
	range motion of one s extremity.	had functional limitation in side on his upper and lower		DON or designee will complete Reaudits weekly x 4, then, monthly x or designee will monitor weekly for compliance.	3. DON		
	had limited physical n cerebrovascular accid hemiplegia. The care provide gentle ROM a The care plan also increfused but staff were ROM to the left upper The care plan further a palm protector in the indicated it was okay	dent (CVA) with left plan directed staff to as tolerated with daily care. dicated R108 frequently to attempt to provide the extremity, hand and wrist. indicated R108 was to wear he left hand as tolerated and		Results of the audits will be forwa the QAPI committee for continued improvement and compliance x 3	quality		
	left arm rested agains fingers of his left hand closed fist. There was cloth in place in R108 was asked if he could out his fingers he stat						
	left arm was observed	00 a.m. to 1:20 p.m. R108's d resting on a armrest chair. His left hand was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			C 11/08/2018		
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11/33/23 10		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	rolled wash cloth in plduring the observation On 11/6/18, from 9:40 nursing assistant (NA (RN)-K provided R100 not offer or provide R protector applied to the From 10:03 a.m. to 10 licensed practical nur to R108's body, shaws sweat shirt but neithe palm protector for the offered passive ROM On 11/6/18, at 1:50 p. hand palm protector in applied to R108. LPN signed it off on the tre record as she though LPN-D then stated she palm protector to R108' p.m. NA-E approached palm protector and R -At 1:59 p.m. NA-E state to have the palm protector to because he had a lot acknowledged he had ROM that shift. -At 2:00 p.m. LPN-D state of the palm protector and R	in fist. There was no splint or ace in R108's left hand in. 2 a.m. to 10:03 a.m. 3)-E and registered nurse is morning care. They did it is contracted hand. 20:55 a.m. NA-E and it is see (LPN)-D applied cream it is ed him and applied a light it is of them offered the hand it left contracted hand nor it is is incompleted. 2 a.m. LPN-D verified the left in and not been offered or it is incompleted. 3 a.m. LPN-D verified the left in and not been offered or it is incompleted. 3 a.m. to 10:03 a.m. 3 a.m. 4 b.d. 5 a.m. NA-E and 5 a.m. NA-E hand 6 alight in fired the hand 7 a.m. LPN-D verified the left in and not been offered or in a policy it is a policy in a policy in a policy in a policy in the and applied the in a policy in the and applied the in a policy in the and applied in a policy in that morning it to do. NA-E further in and offered or completed in at least offer and if R108 in a policy in the and if R108 in a policy in the and if R108 in a policy in the and if R108 in and if R108 in a policy in the and if R108 in the and in th	F	584				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245183	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	HAB	5	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 684 F 686 SS=G	were supposed to copalm protector as dir the assignment sheet copy of the ROM docopy of the Roman doco	p.m. RN-I stated the NA's emplete ROM and apply the rected by the care plan and et. Surveyor requested a cumentation/charting. D.m. no ROM provided. D.m. no ROM provided. D.m. the type of ROM and how long the exercise revent/Heal Pressure Ulcer (i)(i)(ii) Grity (ii) Grity (iii) Grity (iii) Grity (iii) Grity (iiii) Grity (iiii) Grity (iiiii) Grity (iiiiii) Grity (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	F 684		12/18/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _				C 08/2018
NAME OF PR	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
NODTH DI	DGE HEALTH AND REH	A R		54	430 BOONE AVENUE NORTH		
NOKIHKI	DGE HEALTH AND KEN	AB		N	IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	6 Continued From page 37		F	686			
	turning and positionin actual harm, when R8	31 acquired three (3) new rs (partial-thickness loss of			Current residents at risk for pressure ulcers (Braden <18) have the potential be affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on turning and repositioning.	to	
	new, stage II, pressur R81's quarterly minim assessment dated 8/3 including: dementia w Alzheimer's disease, i neuromuscular dysfur peripheral vascular di R31 had severely imp required physical assi toileting, bed mobility	e hours and acquired three e ulcers. num data set (MDS) 80/18, identified diagnoses ith Lewy bodies, muscle weakness nction of bladder, and sease. The MDS indicated			DON or designee will complete repositioning audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance x 3 mont	ity	
	of cares, and had no of R81's care plan dated for impaired skin integrand incontinence. The had a history of a presand had a potential for development related to incontinence. The care had a stage 2 pressure left buttocks. The care assess and complete areas on the coccyx aplan directed staff to present the care of the coccyx appared to the coccyx app	refusal of care behaviors. I 9/12/18, identified a risk grity related to fragile skin e care plan indicated R81 ssure ulcer on the coccyx or pressure ulcer co immobility and e plan further indicated R81 re ulcer to the coccyx and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE S	ETED
		245183	B. WING _			11/0) 08/2018
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		1170	0012010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 686	any pressure ulcers, stated "yes." FM-B a "sores" were on the changed often enough sit on her buttocks "f During continuous of 6:25 a.m. to 9:54 a.m. were made: R81 was backside in bed slee assistant (NA)-F wernot offer repositionin remained asleep on attempts by staff to minutes), at which tili and alerted licensed Nursing assistant (N 11/7/18 at 9:44 a.m. know the last time R he had come in late NA-F approached Rigoing to check, chang:54 a.m. (3 hours a repositioning), NA-F left side. R81's incorwith urine and three noted on R81's left kareas on the right budressing was observed.	a.m. when asked if R81 had family member (FM)-B also stated the pressure outtocks, that R81 was not gh, and that R81 was left to or a long time." Deservations on 11/7/18, from n., the following observations observed to lay on the ping. At 7:50 a.m. nursing at past R81's room but did g. At 9:40 a.m. R81 the backside with no eposition (3 hours and 15 me the surveyor intervened practical nurse (LPN)-E. A)-F was interviewed on NA-F stated he did not 81 had been repositioned as that morning. At 9:52 a.m., 31 and cued her they were ge and reposition her. At and 29 minutes after last and NA-M turned R81 to the tinent pad was saturated open bleeding areas were ower buttock, with two other ttock. In addition, a foam ed around the coccyx.	F 6	86			
	to remove the old dre	7/18, LPN-E was observed essing revealing an open PN-E measured the three					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING		C	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/08/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 686	bleeding wounds and the nurse manager kersaid in the meantime foam dressing until the contacted to obtain a open areas. At 10:05 would have expected and repositioned accessid if the NAs were repositioning in a time supposed to let her kersaid proposed to	d stated she was going to let know about them. LPN-E e, she was going to apply a he physician could be a treatment for the other of a.m. LPN-E stated she d R81 to have been turned cording to the care plan. She not able to complete lely manner, they were know. Iterview with NA-F at 10:30 of stated he did not know he down the surveyor had here not able to complete lely manner, they were know. Iterview with NA-F at 10:30 of stated he did not know he down the surveyor had here no corn was brought to the rogress note dated 11/7/18, down the following:: In three new small stage 2 of the coccyx" The areas were in (centimeter) by 0.5 cm by 0.4 cm by 0.1 cm; and 1.1 cm; and one stage 2 of the coccy of th	F 68	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING		l l	C
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/	08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 686	11/1/18, and 10/31/18 four dates the coccyx an open area. On 11/indicated there was a buttock. The documed drainage color, odor a pain if present, nor die the wound bed to inclusive/character and a edges and surroundir. On 11/7/18, at 10:24 wound documentation stated for the past few had been doing the wistated they were suppled documentation. RN-K lacked documentation drainage color, odor a pain if present, wound and type of tissue/chawound edges and surroundir with R81 how care plan he stated it was R81 would be reas she was at risk for had a current pressur. On 11/7/18, at 2:02 pinctual working schedule assigned to NA-beginning of the shift.	It was revealed that on all had been identified to have 1/18, the assessment had in open area on the left intation lacked staging, size, and approximate amount, id it include assessment of ude the color and type of a description of wounding tissue. It was the floor nurses found rounds for her. RN-K to seed to complete the experiment of a description of wound rounds for her. RN-K to seed to complete the experiment of a description of a related to staging, size, and approximate amount, if bed including the color aracter and a description of a rounding tissue. In RN-I stated he was not ever, after reviewing the me minimum expectation positioned every two hours pressure ulcers and already in the ulcer. In RN-I reviewed the ule and verified R81 had in RN-I stated there was no have been confused about	F 68	6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11/06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	On 11/8/18, at 2:02 p. (DON) stated she had than two months and working on various castated wound assessic clinical coordinators whaving the whole interior in the DON further state risk for pressure ulcer repositioned at least edirected by the care positioned at least edirected by	m. the director of nursing a been at the facility for less was in the process of the concerns. The DON ments were something the vere working on as well as redisciplinary team round. The desire of the concerns who were at the series were supposed to be every two hours or as alan. The difference of the concerns of the	F	686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245183	B. WING		·	11/	08/2018
	ROVIDER OR SUPPLIER IDGE HEALTH AND REH	АВ		5	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	for skin breakdown duincontinence, cognitive mobility. The care plate repositioning every two on 11/7/18, R31 was from 6:25 a.m. unit 11 minutes). At 7:50 a.m. approached R31, tilter left R31 in the televisity registered dietician (Fidining room table. R4 directly to the main discontined where he remained unsurveyor intervened. When he came to the noticed R31 in the televited the wheelchair behad uncrossed R31's was an appropriate for stated it was and indictionable positions. NA when R31 had been might shift had gotten NA-F and NA-I were comechanical lift to get brief was observed to on 11/7/18, at 2:02 p. stated a resident had least two minutes for repositioning, which moff-loaded from the swas on an every two	In 11/2/18, identified a risk are to bladder and bowel be loss and decreased in directed staff to offer to hours and as needed. Continuously observed 1:34 a.m. (5 hours and 9 in nursing assistant (NA)-Fied the wheelchair back and on lounge. At 8:41 a.m. the RD) wheeled R31 to the 1 ate and was assisted in ning room for an activity in til 11:20 a.m., NA-F stated unit at 7:50 a.m., he had evision lounge and had back and at the same time alegs. When asked if that form of repositioning, NA-Fied the him up. At 11:40 a.m., observed to use a R31 onto the bed. R31's be wet from urine.	F	686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245183	B. WING			11/	08/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH RI	DGE HEALTH AND REH	AB			430 BOONE AVENUE NORTH		
		-		N	EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 SS=E	were supposed to be two hours or as direct asked what she consi repositioning, the DO to be off- loaded from Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(2)(1)(3)(1)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	m. the DON stated t risk for pressure ulcers repositioned at least every led by the care plan. When dered to be appropriate N stated a resident needed the surface. ards/Supervision/Devices (2) . Ire that - sident environment remains leards as is possible; and sident receives adequate stance devices to prevent is not met as evidenced an, interview and document and to provide therapeutic lea physician for 2 of 4 b) reviewed for dining. In ailed to utilize the leal lift sling for 1 of 2 lead to a continued mum data set (MDS) dated least moderately cognitively dispervision while eating		689	F689 R11 has been provided with the appropriate mechanical lift slings. R115 and R83 have been provided the therapeutic diets as ordered by the physician. Current residents requiring mechanical slings have the potential to be affected this alleged deficiency. Current residents with therapeutic diets	lift by	12/18/18
	10/2/18, indicated a p	otential nutrition/hydration nechanically altered diet, and weight loss. R115's			have the potential to be affected by the alleged deficiency.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		C 11/08/201	18	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	133,20	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMP	X5) PLETION ATE	
F 689	order dated 9/19/18, figround texture diet with R115, during observation. R115, during observation. R115 was in the evening meal. R115, residents on a mechal pureed food. During interview at 5: stated she was not sumechanical soft diet of them all pureed food. At 5:56 p.m. R115 rectioned food even though his mechanical soft diet. R83's quarterly MDS was severely cognitive supervision and physical conduction of the condu	or t identified a physican's for a mechanical soft, th nectar thick liquids. Ition on 11/4/18, at 5:24 dining room during the along with all other nical soft diet were served 33 p.m. Dietary aide (DA)-A are what the residents on a could eat so she served Relived a meal of pureed diet slip identified a R115 did not eat his meal. Idated 6/31/18, indicated he ely impaired and required ical assistance to eat. R83's out identified a physican's for a mechanical soft, The order indicated R83 exture meals and directed small pieces. R83's care entified a dysphagia g) diagnosis and a diet of	F 689	Current licensed and certified nursing staff were re-educated on using appropriate mechanical lift slings. Dietary staff were re-educated on the Resident Rights Nutritional Care, po and procedure. DON or designee will complete sling audits weekly x 4, then, monthly x 3. D or designee will monitor for compliance weekly. Dietary manager or designee will audit resident trays weekly x 4, then monthly 3. Dietary manager or designee will monitor for compliance. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance x 3 months.	ON 60 x to		
	chopped up as directe	ed by R83's diet. Nursing rned the plate to DA-B and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		245183	B. WING			C 11/08/2018
	ROVIDER OR SUPPLIER	НАВ	,	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	I	11100/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	DATE
F 689	and requested two we R83 would "get mad food. NA-C served the and left the table. During interview at 1 gave R83 the right in give him whole corn asked. At 12:38 p.m. NA-C the chopped up food offered it to him. She offered it, "it would he stated she thought the stated she thought the stated the wrong distance the NA's were upgrade a residents be following the diet the incorrect food contresistents diet. RD-A and stated staff were chewing and swallow plan did not contain diet and did not c	ot eat the chopped up food whole corn dogs. She stated "if she served the chopped he whole corn dogs to R83 12:37 p.m. DA-B stated she heal but NA-C told her to dogs so she did what NA-B stated R83 would not take the even though she had not e stated if she would have he dietician knew about it. ered nurse (RN)-K was et had been served. RN-K "absolutely" not allowed to diet. She stated staff should slip. RN-K did not remove	F 68	39		

■ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			l .	08/2018
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	a.m., was served egg toast. In addition, R11 milk and juice. R115 hand drank some of the and was observed co. At 8:50 a.m. RN-I veribeen served to R115. remaining thin liquids dining room should be and were responsible was served. During interview on 1'stated the aides tell hiserve and stated, "the asked about the toast diet, DA-B stated, "puhere somewhere. May dietician." During interview on 1'director of dietary senheard about the diet of The DDS stated staff food safety and diet at to serve. She stated tigive food that was no stated she rounded in meal service but did raudits to ensure meal by the physicians order.	tion on 11/7/18, at 8:44 gs with cheese and regular 5 was served thin liquids of had eaten all of the toast e milk and all of the juice, ughing at the table. If the incorrect diet had RN-I removed the RN-I stated all staff in the e aware of the residents diet to ensure the correct food 1/7/18, at 9:09 a.m. DA-B er what they want her to ht;s what i give." When for a mechanical ground reed, I think. It's written hybe you should ask the 1/8/18, at 10:28 a.m. the vices (DDS) stated she had concerns on the third floor. received training related to he dietary aide should not ton the diet order. The DDS he dining rooms during hot conduct any formal s were provided as directed er.	F	689			
	On 11/8/18, at 1:36 p.	m. the director of nursing					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING		C 11/08/2018		
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11/06/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDE DEFICIENCY)	D BE COMPLETION		
F 689	(DON) stated she had incorrect diets. The Idietary staff were rescorrect diet was served. A facility policy titled Investigating and Resindicated all accident residents, etc shalt be to the administrator. Supervisor shall prorinvestigation of the attent and a diagnosis above the knee ampower of the supervisor shall prorinvestigation of the attent and the supervisor shall proring the supervisor shall provide the supervisor shall provide and the su	Accidents and Incidents - porting dated April 2010, ts or incidents involving the investigated and reported The nurse manager or inptly initiate and document accident or incident. of lymphedema and a left tutation on the left leg. data assessment (MDS) ated a brief inventory of) of 15 which indicated R11 at for memory. The care plan ated R11 had limited didirected staff to use a hoyer evice), the type of sling was on 11/5/18, at 9:09 a.m. a full g was under R11 while thair. R11 stated the staff lost inputee) sling last 8) and were not able to find ated she feels scared and the te back of her leg on the right ransferred in the cross ruction sheet for the tree) sling was observed	F 689				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11100/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDESICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	On 11/5/18, at 11:20 at (RN-A) stated the mushould be used for Randred for her. RN-A legged sling was in useross-legged sling was in useross-legged sling was not sure if the changed the sling. He care sheet (undated transfers but did not sometimes assessment for the ty was done by the theration of the staff to follow in the computer of sometimes assistants (NA)'s were legged sling and not assistants (NA)'s were leg	a.m. the nurse manager Itipurpose (amputee) sling I1 and this sling was was not aware that a cross see. RN-A verified that a could not be used with a above the knee amputation, e aides or a nurse had everified that the aide group II noted for R11 "hoyer" for specify the type of sling. In 11/6/18. at 8:15 a.m., ing did not do an pe of sling to be used, that apy department. Sessment dated 10/19/18, as to use the multipurpose eft posted information for the resident's room.	F	589			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING				C 08/2018	
	ROVIDER OR SUPPLIER	AB		5430	EET ADDRESS, CITY, STATE, ZIP CODE D BOONE AVENUE NORTH N HOPE, MN 55428		00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page		F	689				
	= -	off center and leaning to straps were in 2 different d R11 complained of						
	7:10 a.m., she stated for R11 had gone to the cross legged sling wanthat she was trained r sling for amputee resi was decided by a nur-	ith NA- A on 11/6/18, at she was told that the sling ne laundry and the other is to be used. She stated not to use a cross legged dents and didn't know if it se to use it. She verified sling had been in use since						
	revealed that R11 was the day before and RI	_						
	reassessment or notice and benefits for the use	note on change of sling, ce to resident of the risks se of a cross legged sling. and benefits of refusing the						
	was interviewed and valing should not be us resident with an above	e the knee amputation. She ld determine the type of esident was safely						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			l	C 08/2018
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	, 11/	06/2016
NORTH RI	DGE HEALTH AND REH	AB			430 BOONE AVENUE NORTH EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	÷ 50	F	689			
	slings for amputee res multipurpose or hourg	ecommendations for use of sidents included a glass sling. A multipurpose tween the resident's legs.					
		ed 10/2010, directed staff to are plan for special needs, d equipment to safely					
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)-		F	690			12/18/18
	admission receives se maintain continence u	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is					
	§483.25(e)(2)For a reincontinence, based of comprehensive assessensure that-	-					
	indwelling catheter is resident's clinical con- catheterization was n	-					
	indwelling catheter or is assessed for removas possible unless the	ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary;					
	(iii) A resident who is	incontinent of bladder treatment and services to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245183	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 690	superior solutions of the extension of t	t infections and to restore keent possible. resident with fecal don the resident's essment, the facility must ent who is incontinent of bowel extreatment and services to small bowel function as the interview and document in interview and document in item of the interview and document in item of the interview and document in item of the interview and in item of the interview and in item of the interview and item of the interview a	F 690	F690 R31, R81, and R224 care plans and B assessments were reviewed and upd for current status. R31 and R81 were toileted timely per plan. Current residents who are assessed a incontinent have the potential to be affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on timely toileting/incontinent care per care plan. Current licensed nursing staff were re-educated on the use of the 3 day voiding diary upon admission to determine continence pattern of new admissions. IDT were re-educated on the complet of the bladder assessment and resulting the same and the same an	ated care as

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		•	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING				C 08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		117	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	Review of the Nursing movement evaluation "based upon the 3 day continent. with the ansbased upon the voidir candidate for: no retr. Bladder Incontinence indicated R224 had unot of recent onset. During interview on 1' indicated she was conwith a small pad but a removed in the facility her diaper" R224 indicoffered the commode bathroom and would to the bathroom in "he On 11/7/18, at 10:00 at (RN)-B indicated she who had told her to "gwhen a urinary cathet three day assessment retraining should have verified R224 lacked in catheter was removed. R31's diagnoses included the severely impaired and long term memor dependent on two stather the MDS further iden.	g 3 day voiding/ bowel dated 9/4/18, indicated y trial, is the resident swer of yes," and that ag diary, is the resident a aining. Review of the Evaluation dated 10/8/18, rinary frequency that was 1/05/18, at 1:30 p.m., R224 at a timent of bladder at home of the staff told her to "go in cated she had never been or assistance into the cell the staff after she went er diaper." a.m., registered nurse would talk to R224 to see to in her diaper" and stated er was discontinued, at twas completed and expenditude the urinary	F	590	tasks for certified staff. DON or designee will complete turning and repositioning/toileting audits weekly 4, then monthly x 3. DON or designee will complete B&B audits weekly x 4, then, monthly x 3. DO or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	will ON to ity	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		245183	B. WING _			C 11/08/2018
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11700/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	DATE
F 690	Continued From pag		F6	90		
	hemiplegia, dementi The care plan directe down via a mechanic	der and bowel related to a and decreased mobility. ed staff to assist R31 to lay cal lift to check and change upon rising, after meals,				
	from 6:25 a.m. unit 1 minutes). At 7:50 a.m approached R31 from wheelchair back and lounge. At 8:41 a.m. wheeled R31 in his was table. R31 remained 10:00 a.m. when standining room for an activity until 11:20 a. intervened. At 11:20 came to the unit at 7 R31 in the television wheelchair back and uncrossed R31's leg not checked and chart at 1:40 a.m. NA-F thand with assistance	left R31 in the television the registered dietician (RD) wheelchair to the dining room in the dining room until ff wheeled him to the main ctivity. R31 remained in the m. when surveyor a.m. NA-F stated when he :50 a.m., he had noticed lounge and had tilted the at the same time he s. NA-F confirmed he had inged R31 after breakfast. brought R31 into the room, from NA-I, used a R31 onto the bed. R31's				
	bodies, Alzheimer's and neuromuscular obtained from the qu	uded dementia with Lewy disease, muscle weakness dysfunction of bladder, arterly MDS dated 8/30/18. indicated R31 had severely				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245183	B. WING		C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 690	impaired cognition are assistance of two stars and transfers. The Monot refuse cares and of bladder and bower R81's care plan date was incontinent of bloom immobility, obesity, of dementia. The care on rising, after meals needed. On 11/7/18, R81 was from 6:25 a.m. to 9:5 minutes). During the R81's room until at 9 approached licensed indicated R81 had not changed since 6:25. At 9:44 a.m. nursing did not know the last checked and changed that morning. At 9:52 R81 and cued her the change and reposition At 9:54 a.m. which wo for continuous observaturned R81 to the left was saturated with unwet. At 10:05 a.m. LPN-E expected the NA's to R81 according to the	and required physical aff with toileting, bed mobility and substituting and provided the substitution of t	F 690		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245183	B. WING		1	C 08/2018
	ROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 725 SS=E	was assigned to R81 it. On 11/7/18, at 2:02 p. actual working schedula assigned to NA-F's teethe shift. RN-I stated was confused if he was confused residents were directed by the care p. (DON) stated all residence and changed provided cares as directed and changed provided cares as directed if the sufficient in the facility must have the appropriate composition provide nursing and resident safety and at practicable physical, it well-being of each resident assessments care and considering diagnoses of the facility accordance with the fat §483.70(e).	m. RN-I reviewed the ule and verified R81 was am from the beginning of there was no reason NA-F as assigned to assist R81. m. registered nurse (RN)-I supposed to be toileted as olan. m. the director of nursing lent's who required to be divere supposed to be ected by the care plan.		725		12/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245183	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11100/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 725	types of personnel or nursing care to all respective this section, licensed (ii) Other nursing persimited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation review, the facility fair staffing was available assistance with meal assistance with personal assistance with personal residents who respectively. The fadequate grooming we residents (R31) who activities of daily living Refer to F684: The fade of motion services in or maintain range of	s of each of the following in a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not is. It when waived under section, the facility must nurse to serve as a charge of duty. It is not met as evidenced on, interview and document led to ensure sufficient en order to implement is, and provide timely onal cares according to the need and as directed by the ce had the potential to affect sided in the facility. In accility failed to ensure was provided to 1 of 5 was dependent on staff for	F 72	F725: Sufficient Nursing Staff R31 was assisted with grooming a R108 was assisted with ROM duri ADLs. R31 and R81 has been turn repositioned per facility policy. Current residents have the potenti affected by this alleged deficiency R224 care plans involving urinary continence/incontinence and B&B assessments have been reviewed updated. Current staff were re-educated reg facility expectations for meeting re needs, range of motion, the facility policy on repositioning and the us 3 day voiding diary upon admission was re-educated on the completion bladder assessment and resulting	ing ned and ial to be dial to be dial and garding desidents y se of the on. IDT on of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING _				C 08/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				5	430 BOONE AVENUE NORTH			
NORTHR	DGE HEALTH AND RE	нав		١	NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From pag	ge 57	F 7	725				
	Refer to F686: The residents (R81, R31	facility failed to ensure 2 of 5) identified at risk for			for certified staff.			
		eived timely repositioning. The			DON or designee will complete			
	-	to consistently implement a			observation audits for grooming, range	of		
		ing program resulted in			motion, turning and repositioning, and			
		R81 acquired three (3) new			B&B weekly x 4, then, monthly x 3. DC	νN		
		cers (partial-thickness loss of			or designee will monitor weekly for			
	skin with exposed d	erriis).			compliance.			
Refer to F690: The facility failed to provide timely toileting for 2 of 7 residents (R31, R81) reviewed				Staffing patterns are determined by				
					resident assessments and individual p	lan		
	for bowel and bladder. In addition, failed to				of care, as well as the consideration of			
	ensure 1 of 7 reside	nts (R224) received services			current census, acuity, and diagnoses	of		
	and assistance to m	aintain bladder continence.			residents residing in the facility, in			
					accordance with the facility assessmer			
	Resident interviews:				Staffing fluctuations and adjustments v			
					be completed by the administrator, DO	νN,		
		on 11/05/18, at 9:11 a.m.			and scheduler each day as needed to			
		staffing R9 stated there was			provide competent and skilled staff in t	he		
		t takes a long time to get			facility.			
		go, a couple of months ago, 3:00 a.m. I had a bowel			Current purging staff have been			
	_	t changed at 8:00 a.m. The			Current nursing staff have been re-educated regarding facility			
	_	ht had not come on. I put			expectations for meeting resident need	de		
	_	y 15 minutes, they come in			Current staff has been re-educated to	15.		
	_	iting beyond 30 minutes is			notify the unit manager or supervisor for	or		
	_	it to get help. I think they			any needs that require licensed nursing			
		When I first got here I was				J-		
	dizzy and needed m				An audit of call light response times we	ere		
	assistance to go to t				performed for the following residents: F			
					R219, R11, R184, R227, R149, R242,			
	R219 was interviewe	ed on 11/5/18, at 09:58 a.m.			R697, R202, R151, R173, R170, R215			
		hey are short on aides." They			R40, R61, and R93 to ensure that eacl			
		des on the floor. One night			unit had the necessary call light			
	there was one aide	on the floor until someone			equipment for all licensed beds. Identif	ied		
	could come in. Aide	s are working double shifts.			concerns regarding working equipmen	t		
	Lots of aides have q	uit. They can't get me			were forwarded to maintenance and fix	(ed		
			1		I .			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			l	C
NAME OF D	DOVIDED OD CUDDUED	245103	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/	/08/2018
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
NORTH R	DGE HEALTH AND REH	AB			430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	repositioned as frequencare of 12 people by a nurses on this floor and I was here. People from and they do not care as who left in the middle said they have to go, complained to the nurnow gone. My light withey come in to turn in Staffing is a big proble R11 and family member at 2:00 p.m. and state answered timely, espronly 2 aides and would help and at times staff the call light off and significant to the call light off and significant to the staff to three aides on the R184 was interviewed and stated the rewest to 4 hours to have a constant of the nurse manager. On 11/4/18, at 12:57 of the staff to three manager.	ently as I need. They take themselves. They put new and 4 nurses have quit since om Florida bought this place about us. I have had people of cares because they have their shift was done. I have raing supervisor and she is all be on for 2 hours before the or bring me water. There were interviewed 11/4/18 and the call lights are not ecially at night there are all dwait up to 2 hours for a forme into the room turned that they would be back a follow up interview with 00 a.m., R11 stated she had 100 a.m. to have a bath. R11 asions she had brought and not improved. R11 fing levels were decreased unit about 3 months ago. If on 11/4/18 at 6:30 p.m. a concerns about waiting up the concerns abou	F	725	immediately. DON or designee will complete call light observation audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance x 3 months.	to ity	
	facility was very short	staffed. R451 stated he had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING				08/ 2018	
	ROVIDER OR SUPPLIER	AB		5430	EET ADDRESS, CITY, STATE, ZIP CODE O BOONE AVENUE NORTH W HOPE, MN 55428	1	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	1 0		F	725				
	incontinence product	e sitting in stool, to get his changed.						
		m. R227 stated her two hours late at times, why, she was told staff were						
	was bad. R149 stated	m. R149 stated staffing "I have had to wait two to be changed because I nt in my brief."						
	On 11/4/18, at 2:35 p.m. R242 stated "I do not want to wait 30 minutes for assistance to walk to bathroom. They placed my walker across the room, so I would not go to the bathroom without help. I was not incontinent prior to admission."							
	with oxygen on by a to opening in the neck to There was a suction r R697 stated it was diffrequested to write her wrote, "They take too! I have waited up to two someone to respond to call light]. This just do	answers. R697 ong to answer my call light. o and a half hours for o my button [pointed at the esn't happen once, it R697 wrote, "I could die if I						
	put the call light on it will minutes to come and	ed he could do it himself but						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING			l	C	
	ROVIDER OR SUPPLIER DGE HEALTH AND REH			5430	EET ADDRESS, CITY, STATE, ZIP CODE D BOONE AVENUE NORTH N HOPE, MN 55428	<u> 11/</u>	08/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	because he recently hamputated. On 11/4/18, at 4:20 p. getting the care and a R151 stated "they are have cut the hours of to either leave an hour one wants to stay and aide for one to two he supposed to be up at bed and no one has dwhat is going on. Son and people here have and they never come. On 11/4/18, at 4:30 p. have too many patient stated "I have had to my call light to be ans and want a pain pill." On 11/4/18, at 4:38 p. "Sometimes I have to there is no help anyw people but they walk at toilet with their help. The same and want had been supposed to the same and want a pain pill."	m. when asked if he was assistance he required, a short of help here. They the staff here and tell them are early or come late. So no a work here. You wait for an ours sometimes. Like I was 4 p.m. and look am still in some to even let me know the nights it's only one aide to wait for that one person." m. R173 stated the staff tts, they are so busy. R173 wait 30 to 45 minutes for wered. I have been in pain. m. R170 stated hold to go poop because there. There are a lot of around. I need to use the frat's the only thing I got to need to train people on.	F	725				
	13 residents, said the	m. nursing assistant es on the unit are assigned re was not enough staff and red 4 aides to meet the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION	' '	DATE SURVEY COMPLETED
		245183	B. WING			C
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	l	11/08/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	needs of the resident when asked to assist were needed to use transfers and she wayet for the afternoon. On 11/4/18, at 6:50 p (LPN)-F stated she wand had been floate about staffing LPN-F work done at times to NA's. When asked he the resident correctly medication LPN-F stated the 70 point out the CN 11/4/18, at 4:18 p (RN)-L stated the 70 properties of the three nurses. RN-L stated the 70 point out the CN 11/6/18, at 8:03 after morning cares showed srveyor the loud he had 13 residences. NA-C stated I and at times he had come in and assist he transfer residents. We want to state the state of the cares of the care of	atts in the unit. At 2:40 p.m. It R11, NA-A stated 2 aides the lift which R11 used for as the only aide on the unit shift. D.m. licensed practical nurse worked on a different floor d to the floor. When asked stated it was hard to get the because she had to help the low she was able to identify when administering tated she depended on the residents. D.m. registered nurse nurse for nurse did not come in so the entire 700 hall between stated there was one nursing to 500 hall and one on the lat floated between the two she was responsible for the worked at his own pace to wait for another NA to whim when he used the lift to when asked if he thought the lift staff he just "laughed"	F 72	25		
		a.m. NA-L stated "you can ." When you get home you				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		245183	B. WING			C 11/08/2018
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		11/00/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 725	Continued From pag	je 62	F 72	25		
	whole day from room management was an done and yet the resident can and transfers. On 11/7/18, at 1:30 pindicated "It is about about the resident care. They know but management and the residents are so know what to do or wattempt to fix the process."	e you will be running the in to room." NA-L stated ware and nothing had been sident's in the unit needed direquired two staff for cares o.m. anonymous staff in profit here. They don't care are. We seriously need the the residents with quality it it's not a priority for the cooperation. Sometimes helpless that you just don't where to begin. You can oblems but they continue to hough help around here				
	staff according to the work okay and some be difficult when we done because you hassistants and the retimes resident would get the assistance b nobody to help esperequired two staff as Resident observation					
	calling out "Hello cha observed down the I state to nursing assi When LPN-D return	a.m. R215 was overneard ange my diaper." LPN-D was nallway and was overheard stant (NA)-L "he needs help. ed to the nursing station n cart was parked surveyor				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		245183	B. WING			C 11/08/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE	11/00/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 725	indicated R215 was "I have told the aide -At 7:01 a.m. R215 of time registered nurs and R215 stated "ch stated to R215 "some the came out of the LPN-D stated "I have-At 7:06 a.m. to 7:11 out "help me change RN-N and LPN-D we medication carts who nursing station across -At 7:12 a.m. to 7:45 no staff went into the -At 7:45 a.m. to 7:45 R215's room to give she left R215 stated RN-N turned around R215 was overheard strained voice "chan "change what" but R mind" as RN-N left ti -At 7:49 a.m. survey asking staff to change stated she did not un as he was heard to was going to find he -At 7:50 a.m. survey LPN-D when R215 whad been 50 minute LPN-D stated she was -At 7:53 a.m. as RN-R215 he stated "whad-At 7:58 a.m. as NA-R215	calling out and LPN-D stated "continued calling out at this e (RN)-K went into the room lange my diaper." RN-K then leone is coming" as she left room at the nursing station e told [NA-L]." a.m. R215 started calling e my diaper" at this time lere both standing at the lich were located outside the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich standing at the lich were located outside the lich stand asked lich stand approached lich standing at the lich were located outside lich were located outside lich were located outside lich were located outside lich we	F	725		
	R215 yelled out "cha	E and NA-L approached ange my f****** diaper." was observed wipe stool off				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			l	C 08/2018
	ROVIDER OR SUPPLIER	AB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725		ated R215's pad was dry. .m. RN-K stated "if help is ' RN-K stated "when	F	725			
	past 3 months revealed the council notified the nursing concerns, and concerns form. The concern form was call lights were not be manner. The respons	nt council minutes for the ed on September 17, 2018 e new director of nursing of d they would be filed on a s dated 10/8/18, indicated sing answered in a timely se from nursing was that e re-educated on using the on expectations.					
	11/6/18 from 10:30 to attended by seven resombudsman. R11 star submitted three grievabeen discussed in the meetings and not resoresponse by nursing sand it had been an on the staff come in and turn off the light and son't come back." R4 hours, and hearing of for help. R61 stated the light on three times be was common practices.	sidents and the ted the council had ances because they had					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER	IAB	,	STREET ADDRESS, CITY, STATE, ZIP COI 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DE	1110012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	DATE	ION
F 725	residents had waited previous night on the reported wound treat completed as ordere R93 reported passin always done becauss aides on duty. During the resident of members in attendant that comments they meetings about staff into the minutes, and to the council on efforts (Call light audits for the were reviewed for the the audit was for 14 episodes of the call I minutes or more. The interviewed on 11/7/1 they had audited a fet the past 3 months. Sinvestigate call light for resident issues be assigned. She stated track instances where light and return later. She stated she was concerns about staff but offered no written.	R93 stated he and other a long time again the enight shift. R93 further atments were not always d. In additon, R61, R40, and g bedtime snacks was not e there were not enough council meeting the not expressed a concern were bring up in the council ing issues did not get written d a response was not given writs to solve the problem. The second floor north unit emonth of October 2018, residents and included 47 ights being on for 60 er assistant adminstrator was 18 at 1:06 p.m., and stated aw residents on 2 north for the stated she did not times greater than an hour aut did see which aide was defined the audit was not able to the an aide would turn off the to meet the resident's need. It is a long and had talked to them the response. She stated the ides carry a pager with them	F 7				
	but offered no written new policy to have a to indicate a call ligh	n response. She stated the ides carry a pager with them					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING				C 08/2018
	ROVIDER OR SUPPLIER	AB		,	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	11/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	at 2:33 p.m. if staff can need and if not will maned an	ffing coordinator on 11/7/18 Ill in will attempt to fill the ake administration aware. Sing staff to carry pagers amo dated 9/7/18 which a to sign out and carry a the call lights. The current a banner on the unit which a sof call lights activated and sound to alert staff. For the second floor for 1/18, and 11/6 18 had none out for the evening and aed out on the day shift. The day and evening shifts them. In. during an interview with director of nursing and the he administrator stated the fed by acuity and transfers. The eobservations of staff not so not toileting residents the services and care needs the staff who were involved been let go as this was not	F	725			
F 757 SS=D	the needs of residents and determined they Drug Regimen is Free CFR(s): 483.45(d)(1)-		F	757			12/18/18
	§483.45(d) Unnecess Each resident's drug	ary Drugs-General. regimen must be free from					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		245183	B. WING				08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 17	00/2010
NORTH R	DGE HEALTH AND REH	AB			430 BOONE AVENUE NORTH		
				N	IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	drug when used- §483.45(d)(1) In excee duplicate drug therapy §483.45(d)(2) For excee §483.45(d)(3) Without §483.45(d)(4) Without its use; or §483.45(d)(5) In the processed processed which reduced or discontinut §483.45(d)(6) Any constated in paragraphs as section. This REQUIREMENT by: Based on observation review, the facility fails monitor bruising for 1 reviewed who was red (blood thinner). Findings include: R215's diagnoses income dementia and atrial fits quarterly Minimum Da 10/12/18. In addition,	essive dose (including y); or cessive duration; or t adequate monitoring; or t adequate indications for cresence of adverse indicate the dose should be led; or mbinations of the reasons (d)(1) through (5) of this cis not met as evidenced in, interview and document ed to identify, assess and of 1 resident (R56) ceiving an anticoagulant eluded heart failure, brillation obtained from the lata Set (MDS) dated the MDS indicated R215 docognition and used an	F	757	F757 R215 has been assessed and monitore for bruising. Current residents receiving an anticoagulant have the potential to be affected by this alleged deficiency. Orders and care plans have been reviewed for current residents on anticoagulation therapy. Care plans have been updated for current residents on care plans have been updated for current residents.		
	assessment period.				residents on anticoagulation therapy.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245183	B. WING				C /08/2018	
NAME OF DE	ROVIDER OR SUPPLIER		1	9	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> 11/</u>	100/2010	
NAME OF T	TOVIDER OR SOLT LIER							
NORTH RI	DGE HEALTH AND REHA	AB		5430 BOONE AVENUE NORTH NEW HOPE, MN 55428				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 757	Continued From page	68	F	757				
	R215's care plan date	ed 7/31/18, identified a risk			Current licensed and certified nursing			
	•	ited to decreased mobility,			staff were re-educated on monitoring			
		e loss and diabetes. The			residents on coagulation therapy for			
		ff to assess/record/monitor			bruising.			
	•	ng, however the care plan						
	did not identify use of				CRC or designee will complete			
	monitoring of side effe	9			anticoagulation audits weekly x 4, then	,		
	, , ,				monthly x 3. DON or designee will			
	R215's Physician orde	ers dated 7/7/18, and			monitor weekly for compliance.			
	11/2/18, revealed R21	5 was receiving						
	Prednisone 5 mg one	time daily for polymyalgia			Results of the audits will be forward to	the		
	rheumatica, Coumadi	n 2 milligram (mg)			QAPI committee for continued quality			
	(Sunday, Monday, We	ednesday, Thursday and			improvement and compliance x 3 mont	hs.		
	Saturday) and Couma	adin 1.5 mg (Tuesday and						
	Friday) for atrial fibrilla	ation. A review of the						
		ition record (MAR's) and						
		on records (TAR's) for						
		er 2018 lacked evidence of						
	_	erse reactions/effects of the						
	two medications, ever medications daily.	n though R215 received the						
	•	. R215 was observed lying						
		is hands and revealed						
		g from dark to light on the vand in the left inner elbow.						
		got the bruises R215 stated						
	he did not know, after	-						
		m. family member (FM)-D						
		5's room assisting with						
		ched and asked about the						
	bruises FM-D stated hand thought R215 did	ne had also noticed them bruise easy.						
	On 11/5/18, at 9:30 a.	m. and on 11/6/18, at 8:00						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245492				С		
NAME OF PE	ROVIDER OR SUPPLIER	245183	B. WING	STREET ADDRESS	CITY, STATE, ZIP CODE	11/0	8/2018	
	DGE HEALTH AND REHA	AB		5430 BOONE AVEN NEW HOPE, MN	NUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	Continued From page	: 69	F	' 57				
	a.m. R215's brusing redocumentation in the							
	revealed the consulta R215's medical chart in progress note, "No On 11/6/18, following Progress Note dated "Discolored bruises no hands this shift. When know." Staff assessed noted and which mea 2.3 cm Right hand, 2. and 0.3 x 1.1 cm Left	surveyor inquiry, a 11/6/18, indicated oted on Resident's both n asked states "I don't d,dark discolored bruises sured 2.7 cm [centimeter] x 8 cm x 2.8 cm Right elbow inner elbow. In addition, inti-coagulant care plan was a nursing order to g and bleeding due to						
	thinner were suppose identify they bruised of In addition RN-K and documentation of the record including the w Both RN's also verifie in place for staff to mobruising and bleeding thinners. RN-I stated observe for skin chan concerns to the nurse investigate the cause.	dents who were on a blood d to have a care plan to easy "It was an oversight." RN-I verified there was no bruises in the medical veekly skin assessments. d there was no monitoring onitor and observe R215 for due to anticoagulant/blood all staff were supposed to ges and were to report any is so they could assess and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	240100		S7	FREET ADDRESS, CITY, STATE, ZIP CODE	11/	08/2018
NORTH R	IDGE HEALTH AND REH	ΔR	5430 BOONE AVENUE NORTH		30 BOONE AVENUE NORTH		
NOKIHKI	DGE HEALTH AND KEH	AD		NI	EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757 F 761 SS=E	nurse and then the nu incident report for the was to be initiated. Label/Store Drugs and	o report the bruises to the urse was to complete an bruises and monitoring d Biologicals		757 761			12/18/18
33-E	§483.45(g) Labeling of Drugs and biologicals	of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary					
	§483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls,	ordance with State and compartments under proper and permit only authorized					
	locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 at abuse, except when the package drug distributed quantity stored is minican be readily detected. This REQUIREMENT by: Based on observation review, the facility failure.	cility must provide separately affixed compartments for drugs listed in Schedule II of Orug Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose			F761 Expired stock medications have been		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245183	B. WING _				C 11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTH R	DGE HEALTH AND REHA	AB			430 BOONE AVENUE NORTH			
				N	NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 761	761 Continued From page 71		F	761				
	(F) in 1 of 5 medication the facility failed to real	on refrigerators. Additionally, move expired stock			removed from the medication carts.			
		dication storage on 4 of 9			Current licensed nursing staff were			
		ch had the potential to affect			re-educated on removing expired			
	(TCU), first floor south	the transitional care unit			medications from the medication carts.			
	second floor north we				DON or designee will complete expired	i		
					medication audits weekly x 4, then,			
	Findings include: On 11/8/18 at 9:00 a.m., registered nurse (RN)-				monthly x 3. DON or designee will			
					monitor weekly for compliance.			
	E verified the first sou	- , ,			Results of the audits will be forwarded	to		
	refrigerator temperatu				the QAPI committee for continued qual			
	temperature was not I	kept within the allowable			improvement and compliance x 3 mont	hs.		
	_ ,	es F). Review of the log						
	_	tor temperature was less						
	_	5 times in the last 26 days. Itor were 17 vials of Lantus						
	_	Levemir flex pens and 11						
	Novolog flex pens for							
	influenza vaccine. RN	l-E indicated maintenance						
	would be called to adj	ust the temperatures						
	During medication storage review of the TCU 600 wing medication cart on 11/5/18, at 10:32 a.m.							
	with licensed practical	•						
	-	10 tablet bottle, one fourth						
		, 24 caplet bottle, 9 tabs in						
		8. LPN-C indicated these						
	wing medication cart	age review of the TCU 500 on 11/5/18 at 10:55 a.m. (RN) - D, the following						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	١ , ,	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		1	C 1/08/2018
	ROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	8/18Optic-vits with lutein expired 6/18.	nd to be expired: softgel, 3/4 full expired 36 tabs bottle, 1/2 full	F 7	61		
	1/2 full, expired 10/18 -Magnesium oxide 50 full expired 10/18Aspirin 325 mg, 100 expired 1/18Calcium 600 mg +40 bottle, 3/4 full, expired	0 mg, 100 tablet bottle, 3/4 tablet bottle, 3/4 full, 0 iu vitamin D, 60 tablet				
	medication cart on 11 LPN-B, the following be expired: -Calcium 600 mg, 150 expired 10/18 -Magnesium oxide 50 full expired 6/18 -Zinc sulfate 220 mg, expired 9/18 -Vitamin D 400 iu, 10 expired 8/18 -Vitamin D3-2000 iu, expired 5/18 -Naproxen 220 mg 10 expired 6/18 All medications were stock medications.	orage review of 3 north near /8/18 at 8:44 a.m., with medications were found to 0 tablet bottle, full bottle, 0 mg, 100 tablet bottle, 1/2 full, 100 softgel bottle, full bottle, 1/0 softgel bottle, full bottle, 1/0 tablet bottle, 1/4 full, 100 tabl				
	_	orage review of 2 west far on 11/8/18, at 9:14 a.m.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING			1	C /08/2018
	ROVIDER OR SUPPLIER	AB		54	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH EW HOPE, MN 55428		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 808 SS=D	found to be expired: -Magnesium oxide 50 expired 10/18. All medications were stock medications. Review of facility's dismedication policy date 12. Expired medication state or contract phank review of the facility's policy dated 2007 ind 9. Medications requires stored in a refrigeration at the nurses; station Medication must be sand must be labeled at Therapeutic Diet Preschen (S): 483.60(e)(1) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	ving medications were 10 mg, 100 tablets, 1/2 full, verified by LPN-C as being scarding and destroying ed 2012: ons will be disposed of per macy guidelines. s storage of medication icated: ring refrigeration must be r located in the drug room or other secured location. tored separately from food according. scribed by Physician (2) tic Diets eutic diets must be		761	F808 R109, R115, R168, R83 have been provided with prescribed diets as order	red.	12/18/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С
		245183	B. WING		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
NORTH RI	DGE HEALTH AND REH	ΔB	5	430 BOONE AVENUE NORTH	
			1	NEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 808	Continued From page during dining.	: 74	F 808		
	Findings include:			Current residents with therapeutic diets have the potential to be affected by this alleged deficiency.	
	was to receive a glute being offered. She sh 11/4/18, which includ whole wheat toast for that she would ask for facility was out of oats dietician had talked to During interview on 1 Registered Dietician staff communicated w residents had issues. had informed her that concerns. On 11/8/18 indicated she had me going to work on som Review of R109's me was admitted on 6/7/2 including, tibia fracture.	breakfast. R109 indicated roatmeal, and was told the meal. R109 indicated no her. 1/8/18, at 9:30 a.m., (RD)-A indicated nursing with the dietary staff when RD-A indicated no staff R109 was having issues or at 10:20 a.m. RD-A twith R109 and "they were things." dical record indicated R109 l8, with diagnosis e, multiple sclerosis, gastro-esophageal reflux		Dietary Manager and Licensed Dietitial were re-educated on the Diet Orders & Other Resident Information policy and procedure and Resident Food Preferences policy and procedure. Current dietary staff were re-educated the process for offering residents preferences. Dietary manager or designee will audit resident trays weekly x4, then, monthly 3. Dietary manager or designee will monitor for compliance weekly. Results of the audits will be forwarded the QAPI committee for continued qual improvement and compliance for 3 months.	on 60 7 x
	an order for gluten resof 6/12/18. Review of R109's plate 6/13/18, indicated "professional Column (Gluten restricted, Reresident prefers to ear	ovide, serve diet as ordered gular Texture, thin Liquids)", t meals in room, honor food and RD to evaluate and			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(c
		245183	B. WING		<u></u>	11/	08/2018
	ROVIDER OR SUPPLIER	АВ		5	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 BOONE AVENUE NORTH NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 808	Continued From page needed." Review of Progress N		F	808			
	indicated the following complained of food, v regular diet with glute	g:Nutrition Note - R109 isited with resdient on					
	bread available for too as gluten free muffins Resident reports enjo	· ·					
	place. Reviewed alwa	ood dislikes. Select menu in nys available foods for place of main entrees when n resident acknowledged.					
	with resident for food seems to be very part	who also report have visited preferences. Resident ticular with foods, states may include avocados and					
	sardines; items not av Resident declined wa cereal, does consume	vailable in community. nting gluten free cold e oatmeal and eggs though					
	Continue to encourage additional items as ab	s she would eat at home. e resident to request ble to honor food preference en free. Nursing and food					
	indicated she did not	n 11/08/18, 10:52 a.m. she think anything was going to be the facility a chance.					
	9/4/18, indicated he wimpaired and required after meal set up. R1	mum data set (MDS) dated vas moderately cognitively d supervision while eating 15's care plan dated otential nutrition/hydration					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING _			C 11/08	3/2018
	ROVIDER OR SUPPLIER DGE HEALTH AND REH	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 808	coughing with meals a Order Summary Reporder dated 9/19/18, figround texture diet with During observation or R115 was in the dinin meal. R115, along with mechanical soft diet with At 5:56 p.m. R115 record even though his mechanical soft diet. R115 was upset with not eating his food. His meal of pureed quicher also refused to eat. A asking for a peanut by "how long does it take 6:57 p.m. R115 told at a sandwich around quit."	nechanically altered diet, and weight loss. R115's ort identified a physican's for a mechanical soft, th nectar thick liquids. In 11/4/18, at 5:24 p.m. g room during the evening h all other residents on a were served pureed food. R115 did not eat his meal. the meal choices and was e was served an alternate e and spinach which he to 6:56 p.m. R115 was autter sandwich and asked, e to make a sandwich?" At staff member, "I asked for parter to six, I still don't have	F 8				
	the bread which prese blob. R115 did not ea At 12:06 p.m. R115 re pie and mashed potat bowl that contained a of the food on his plat During observation or R115 was served egg	eceived a chopped up pot coes and gravy along with a brown mixture. R115 ate all					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			С	
NAME OF PI	ROVIDER OR SUPPLIER	245103	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/08/2018	
	IDGE HEALTH AND REH	АВ		5430 BOONE AVENUE NORTH NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 808	milk and juice. R115 I and drank some of th and was observed co R168's annual Minimi indicated he was mode and required supervision or R168 and indicated R168's mea 100% and indicated R168's mea 100% and indicated and indicated R168's mea 100% and indicated R168's mea 100% and indicated R168 was served puring observation or R168 was in the dining meal. R168 was served puring and was served puring to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad. A NA removed then returned and remain to a served a plate with salad.	and eaten all of the toast e milk and all of the juice, ughing at the table. The milk and all of the juice, ughing at the table. The milk and all of the juice, ughing at the table. The milk and Set dated 10/1/18, derately cognitively impaired sion during meals. R168's port identified a physican's for a mechanical soft, with an ok for regular bread. The milk and th	F8	08			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245183	B. WING _			C 11/08/2018
	ROVIDER OR SUPPLIER	AB	•	STREET ADDRESS, CITY, STATE, ZIF 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE
F 808	may request regular to staff to cut meat into soplan dated 9/1/18, ided (difficulty in swallowin mechanical soft food.) During observations of R83 was seated at a sawaiting his noon merequested a corn dog chopped up as directed assistant (NA)-C return and stated R83 would food and requested to stated R83 would "ge chopped food. NA-C sto R83 and left the table During interview at 12 gave R83 the right megive him whole corn of asked. At 12:38 p.m. NA-C sto the chopped up food, offered it to him. She offered it, "it would hastated she thought the At 12:40 p.m. register	The order indicated R83 exture meals and directed small pieces. R83's care intified a dysphagia g) diagnosis and a diet of on 11/6/18, at 12:29 p.m. table in the dining room al. At 12:30 p.m. R83. DA-B served a corn dog, and by R83's diet. Nursing red the plate to to DA-B I not eat the chopped up wo whole corn dogs. She that mad" if she served the served the whole corn dogs ole. 2:37 p.m. DA-B stated she heal but NA-C told her to logs so she did what NA-B tated R83 would not take even though she had not stated if she would have ve been a problem." She dietician knew about it. 2:46 nurse (RN)-K stated the red	F	308		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				OATE SURVEY COMPLETED		
		245183	B. WING			C 11/08/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	- 1	11/06/2016
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 808	assistants were not a residents diet. RD-A and stated staff were chewing and swallow plan did not contain diet and did not contrelated to not following asked about the difference of ground diets, RD-A seground diet they could see the served diet and stated served. During interview on aide (DA)-A stated served them all buring interview on stated the aides tell serve and stated, "the asked about the toast diet, DA-B stated, "phere somewhere. Madietician." During interview on director of dietary see heard about the diet. The DDS stated staffood safety and diet to serve. She stated give food that was not stated to serve. She stated give food that was not stated that was not served.	allowed to upgrade a reviewed R83's care plan at to monitor for difficulty with wing. RD-A stated the care any modifications to R83's ain any risks and benefits and his prescribed diet. When be exerces in the chopped and stated if a resident was on a lid only have pureed bread. Attended all staff in the dining are of the residents diet and bensure the correct food was a lid only have pureed bread.	F 80	08		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245183	B. WING			1	08/2018
	ROVIDER OR SUPPLIER	AB		5-	TREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 808	audits to ensure meal by the physicians ord 11/4/18, during the eversident on a mechan pureed food. She stat any mechanical soft for she realized it, it was On 11/8/18, at 1:36 p. (DON) stated she had incorrect diets. The Didietary staff were responded in the physician in conjudietician. Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procurapproved or consider state or local authoriti (i) This may include for from local producers, and local laws or regulii) This provision doe facilities from using processing the state of the physician of the form local producers, and local laws or reguliing the physician of the physician in conjudietician.	not conduct any formal is were provided as directed er. The DDS stated on rening meal all of the ical diet were served ed the cook had not made bood and stated by the time too late to make more food. In the director of nursing is heard staff were giving ON stated nursing and consible for ensuring the ed. Therapeutic Diets dated is residents on therapeutic extra or reduced portions is diet unless approved by inction with the registered core/Prepare/Serve-Sanitary (2) The food from sources is destricted as a stisfactory by federal, it is not prohibit or prevent roduce grown in facility ompliance with applicable		808			12/18/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245183	B. WING			l	00/0040
	ROVIDER OR SUPPLIER			5430	EET ADDRESS, CITY, STATE, ZIP CODE D BOONE AVENUE NORTH N HOPE, MN 55428	11/	08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S			(X5) COMPLETION DATE
F 812	(iii) This provision doe from consuming foods facility. §483.60(i)(2) - Store, serve food in accorda standards for food set This REQUIREMENT by: Based on observation review the facility failer refrigerators was proported for effigerators and refrigerators, 1 of 1 from 1 fr	prepare, distribute and noce with professional rvice safety. Is not met as evidenced in the interview and document and ensure food stored in the prepare, 1 of 2 microwaves, 2 orage cabinets, and 1 of 2	F		F812 Food stored in refrigerators has been properly dated and labeled. Refrigerators, freezer, microwaves, stainless steel storage cabinets, and cereal carts have been cleaned. Current dietary staff were re-educated the Food Supply and Storage policy an procedure and the Food Handling Guidelines policy and procedure. Dietary manager or designee will audit times weekly x 4, then, monthly x 3. Dietary manager or designee will monit for compliance weekly. Results of the audits will be forwarded the QAPI committee for continued qualimprovement and compliance for 3 months.	d 15 or to	
	i i	itchen staff member stated p and mop it twice a week. d walk in freezer was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245183	B. WING			C
	ROVIDER OR SUPPLIER		Ze	STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DDE	11/08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 812	inspected and the flood In the kitchen there we cabinets for kitchen enutensils. Both cabine shelves and smears of substance on the outstance on the sexposed to the air. The with the date it was plundated Magic Cup Noin the refrigerator. The Cup could only be kep There was no date on when it was removed in the refrigerator. The was covered with a rette dry cereal dispension pieces of cereal arour shelf. On the second dust. At 12:36 p.m. the kitchinspected. There was Raisins that were not interior bottom of the spills. At 12:45 p.m. the Brid was inspected. A cart thick supplement drin	or of that freezer was dirty. ere two metal storage quipment, bowls, and ts had debris on all of the of grease and/or a white side of the doors. The tender of	F	812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018		
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CO 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	DDE	11/0	5072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE	
F 812	kitchenette refrigerat third shelf in the bac not dated. C-A put to The inside of the refrigure spills. C-A state responsible for clear On 11/06/18, at 10:00 kitchen and kitchened dietary director (DD) freezer there were from the plastic flap has freezer there was an smeared on the plastic flap has needed to be cleane of the freezer and was swept and washed cooler was still dirty. The two metal cabin front and had debris stated all food going freezer needs to be marked with the date. The DD added the smaking sure the food appropriately. The kin after the kitchen. The refrigerator still had just and debris. The refrigerator was still dust and debris. The refrigerator was still inside. The refrigerator as still inside. The refrigerator and the cart of the still contained just and still still still and still still and still still still and still still still and still still and still still still still still and still sti	ok (C)-A the Bridgeway back for was inspected. On the k was a dish of fruit that was he dish in the dirty dish rack. rigerator was also dirty with ed housekeeping was ning the refrigerators. 8 a.m. a second tour of the attes was conducted with the line that in the main kitchen walk in we tator tots on the floor and anging in the door of the arrange brown substance tic. The DD stated the food doff the plastic and the floor alking coolers should be laily. The floor of the walk-in and had paper scraps on it. Lets still had smears on the lon the shelves. The DD into the refrigerator or covered appropriately and the open or expiration date. Laff were responsible for downs labeled and dated tchenettes were inspected to 2 west kitchenette luice spills on the inside with the dry cereal covered with cereal crumbs, and west witchenette dirty with juice spills on the tors on Bridgeway Front and	F8	12				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245183	B. WING			C 11/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	CODE	1170	JO/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 812	kitchen staff were res the refrigerators. She schedule for that prod been following it. The were responsible for t areas and refrigerator kitchen staff were res open food got marked opened or used by da	ponsible for the cleaning of stated there was a less, but the staff had not a DD stated the kitchen staff the cleaning of the kitchen as. The DD also stated the ponsible for making sure all d with the date it was atte.	F	312			

Printed: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245183

B. WING

11/29/2018

NAME OF PROVIDER OR SUPPLIER

NORTH RIDGE HEALTH AND REHAR

STREET ADDRESS, CITY, STATE, ZIP CODE

5430 BOONE AVENUE NORTH

NORTH		BOONE AV W HOPE, MN	ENUE NORTH 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)	ID ORY PREFIX TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000			
	FIRE SAFETY				
	An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 29, 2018. At the time of this survey North Ridge Health and Rehab Building 01 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.	ne			
	North Ridge Care Center is a 3-story building on basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type I(332) construction. In 1978 an addition was constructed and was determined to be of Type I(332) construction. In 1981 an addition was constructed and was determined to be of Type I(332) construction. In 1998 an addition was constructed and was determined to be of Type I(332) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection the corridors and spaces open to the corridor that is monitored for automatic fire department.	ed m ion rs,			
	In 2018 a remodel was conducted on the 800 Wing. Because the original building and the 4 additions are of existing construction, the new remodel will be surveyed as a separate buildin	g.			
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE	'S SIGNATURE	TITL	E	(X6) DATE

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.

Printed: 12/05/2018

DEPART CENTER	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEMEN		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SU COMPLE		
		245183		B WING_			11/2	9/2018	
1	PROVIDER OR SUPPLIER				STATE, ZIP CODE		121		
NORTH	RIDGE HEALTH AN	D REHAB	I	OONE AVI OPE, MN	ENUE NORTH 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) COMPLE DATI			(X5) COMPLETION DATE	
K 000		apacity of 320 beds a	and had a	K 000		Ę *		T (1)	
	The requirement at MET.	42 CFR, Subpart 48	33.70(a) is						
	а	я			B	s			
	1 2							= "	

Printed: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A: BUILDING 04 - 800 WING COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION B. WING 245183 11/29/2018

NAME OF PROVIDER OR SUPPLIER

NORTH DIDGE HEALTH AND REHAR

STREET ADDRESS, CITY, STATE, ZIP CODE

5430 BOONE AVENUE NORTH

(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
K 000	INITIAL COMMENTS	K 000		
	FIRE SAFETY			
	An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 29, 2018. At the time of this survey, North Ridge Health and Rehab Building 04 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC); Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.			
	North Ridge Care Center is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification.			
	In 2018 a remodel was conducted on the 800 Wing. Because the original building and the 4 additions are of existing construction, the new remodel will be surveyed as a separate building.		н 8	

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.

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Printed: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUI		A. BUILDING 04 - 800 WING			COMPLETED	
		245183		B. WING			11/29/2018	
	ROVIDER OR SUPPLIER RIDGE HEALTH AN	D REHAB	5430 B		STATE, ZIP CODE ENUE NORTH 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECT TIVE ACTION SHOL CED TO THE APPRO EFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	·	apacity of 320 beds a	and had a	K 000	o.			
	The requirement at MET.	42 CFR, Subpart 48	33.70(a) is					
	e ·			-				
				9		ē:		×
				:				
				a:	*			0
-								3

(X2) MULTIPLE CONSTRUCTION



Protecting, Maintaining and Improving the Health of All Minnes ot ans

Electronically delivered December 27, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5183030, H5183172, H5183173

Dear Administrator:

The above facility was surveyed on November 4, 2018 through November 8, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5183168, H5183170, H5183171, H5183172, and H5183173. H5183168, H5183170, and H5183171 were found to be unsubstantiated. 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 <u>only a suggestion</u> 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

North Ridge Health And Rehab December 27, 2018 Page 2

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:

Susanne Reuss, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

(X6) DATE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		C 11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	11/00/2010	
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO E, MN 55428	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 000	00 Initial Comments		2 000			
	*****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of whe corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessmit.	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.				
	Department's staff vis the following correction Please indicate in you	1/8/17, surveyors of this ited the above provider and on orders are issued.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/07/18 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 76 WOFB11

winnesou	a Department of Healtr	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					l c
		00238	B. WING		11/08/2018
NAME OF D	ROVIDER OR SUPPLIER	STDEET ADI	DRESS, CITY, STA	TE ZIR CODE	
NAME OF FI	ROVIDER OR SUFFLIER		NE AVENUE N		
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE N E, MN 55428	ORIH	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	` '
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
2 000	Continued From page	e 1	2 000		
	and identify the date	when they will be			
	and identify the date to completed.	when they will be			
	compicted.				
	You have agreed to p	articipate in the electronic			
	•	sure orders consistent with			
	the Minnesota Depart	tment of Health			
	Informational Bulletin	14-01, available at			
	•	te.mn.us/divs/fpc/profinfo/inf			
	obul.htm The State I	•			
	delineated on the atta				
	•	orders being submitted to though no plan of correction			
		e Statutes/Rules, please			
		cted" in the box available for			
		idicate in the electronic			
	State licensure proce	ss, under the heading			
	T	date your orders will be			
	-	ctronically submitting to the			
	Minnesota Departme	nt of Health.			
	Duning the ne contition	tion our an 44/4/40			
	•	ition survey on 11/4/18, plaint investigations were			
	conducted time of the	·			
	An investigation of co	mplaint, H5183168 was			
	completed. The comp	olaint was unsubstantiated.			
	· ·	mplaint, H5183170 was			
	completed. The comp	plaint was unsubstantiated.			
	An investigation of	mploint UE199174			
		mplaint, H5183171 was plaint was unsubstantiated.			
	completed. The comp	ภลแน พลร นทรนมรเสทแสเซน.			
	An investigation of co	mplaint, H5183172 was			
		plaint was substantiated at			
	MN Rule 4658.1415				

Minnesota Department of Health

An investigation of complaint, H5183173 was

STATE FORM 6899 WOFB11 If continuation sheet 2 of 76

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00238	B. WING		1 1	1/08/2018
	ROVIDER OR SUPPLIER	5430 BC	ADDRESS, CITY, STATE DONE AVENUE NOF DPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 000	MN Rule 4658.0085, 2D, MN Rule 4658.05	olaint was substantiated at MN Rule 4658.0520 Subp	2 000			
2 265	policies to guide staff physicians, physicians practitioners, and if ki legal representative of member of a resident accident, or death. A nursing services, and attending physician meteories development of these have criteria which acappropriate notification. A. an accident in results in injury and herequiring physician in B. a significant of physical, mental, or pexample, a deterioration.	develop and implement decisions to consult assistants, and nurse nown, notify the resident's or an interested family 's acute illness, serious t a minimum, the director of the medical director or an nust be involved in the expolicies. The policies must diress at least the on times for: volving the resident which as the potential for tervention; mange in the resident's psychosocial status, for ion in health, mental, or in either life-threatening	2 265			12/18/18
	example, a need to d of treatment due to a begin a new form of t					
	D. a decision to	transfer or discharge the				

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B WING		С
		00238	B. WING	· · · · · · · · · · · · · · · · · · ·	11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
NORTH R	IDGE HEALTH AND REH	5430 BOO	NE AVENUE N	ORTH	
		NEW HOP	E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 265	Continued From page	3	2 265		
	resident from the nurs	sing home; or			
	E. expected and unexpected resident deaths.				
	by:	t is not met as evidenced			
	review, the facility fail	n, interview and document ed to notify a resident gnificant weight loss for 1 of viewed for nutrition.		Corrected.	
	Findings include:				
	R31's diagnoses included dysphasia, aphasia, dementia, hemiplegia, diabetes mellitus type II and anemia obtained from the quarterly Minimum Data Set (MDS) dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required total dependence on staff with eating.				
	R31's care plan revise was at increased risk "feeding" deficit, an a significant unplanned directed staff to encount identified FM-A a agent due to R31's in make decisions for hi On 11/5/18, at 10:15 had lost weight, family "they don't feed him a	weight loss. The care plan urage family involvement s the appointed health care ability to communicate and			
	with it because he is in FM-A also stated when	not physically able to do it." In the and other family In the always ate well and			

Minnesota Department of Health

STATE FORM 6899 WOFB11 If continuation sheet 4 of 76

Minnesot	<u>a Department of Healtl</u>	h				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					l c	
		00238	B. WING		11/08/2018	
		00230			11/06/20	10
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5430 BOO	NE AVENUE N	ORTH		
NORTHR	IDGE HEALTH AND REH	NEW HOP	PE, MN 55428			
(V4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ı.	PROVIDER'S PLAN OF CORRECTION	1	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	IATE I	DATE
				DEFICIENCY)		
2 265	Continued From page	e 4	2 265			
	thought whon the stat	ff told him he refused staff				
	•	ff told him he refused., staff				
	· ·	nt. FM-A further stated he				
	-	nt loss over time however				
	_	eached out to him or other				
	•	scuss what could be done,				
		any interventions in place for				
	the weight loss.					
		3 a.m. to 8:32 a.m. R31				
		in the dining room waiting				
	for breakfast. At 8:32	a.m. NA-D brought R31's				
	plate of food, set it in	front of R31 and left. At				
	8:36 a.m. NA-A came	back to the table sat next				
	to R31 and started to	assist R31. At 8:43 a.m.				
	NA-D left the table an	nd went to the main dining				
	room area. NA-D got	two straws which she				
	brought back for R31	's beverages. At 8:53 a.m.				
	after R31 ate a few bi	ites of his food with sips of				
	the juice, NA-D whee	led R31 out of the dining				
	room and placed him	by the nursing station.				
	At 8:54 a.m. NA-D sta	ated R31 had eaten				
	approximately 25% w	rith 10 milliliters of the				
	cranberry juice. NA-D	acknowledged she had not				
	offered R31 anything	else, as he did not want to				
	eat.					
	On 11/06/18, at 1:20	p.m. during a follow up				
	interview FM-A stated	he had not been notified of				
	the significant weight	loss. FM-A stated another				
	-	ome to visit R31 during				
	•	und R31 was seated at the				
		it of him and no staff present				
	to assist him.					
		ical record it was revealed				
	•	that loss had been identified				
	-	s notes by the dietician on				
	. •	7/18, 9/4/18, and 11/1/18.				
		o indicated 8/14/18, due to				
	-	loss in 90 and 180 days a				
	nutritional supplemen	it was ordered. During				

Minnesota Department of Health

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Minnesot	a Department of Health	า			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		00238	B. WING		11/08/2018
		1 00-00			11/100/2010
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
NORTH R	IDGE HEALTH AND REH	5430 BO	ONE AVENUE N	ORTH	
		NEW HO	PE, MN 55428		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ , ,
PREFIX	7	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MATE
		_	 		
2 265	Continued From page	5	2 265		
	further review it was r	revealed on 11/1/18, the			
		oted R31 had a unplanned			
	_	ounds, 10.5% in 180 days.			
	The medical record la	acked documentation of			
	R31's responsible par	rty being informed of the			
	weight loss.	, ,			
	On 11/6/18, at 12:56	p.m. the consultant			
	· ·	CRD) stated R31 was on a			
	nutritional supplemen	•			
	• •	weight loss over the last			
	•	t R31 had leveled off in the			
		sked if anyone in the dietary			
	_	rved R31 during meals, the			
	CRD stated she did n	ot think so. When asked			
	what staff were suppo	osed to do when a resident			
	did not eat well, she s	stated staff were supposed			
	to offer an alternate a	nd all residents were			
	supposed to be offered	ed enough fluids with meals.			
	When asked who was	s supposed to notify			
		rty of R31's significant			
	weight loss, CRD stat				
		ave notified the responsible			
		now how much the family			
	was involved in R31's				
		.m. registered dietician			
	` '	significant weight loss had			
		ad been started on the			
	• •	t and thought the weight			
	had stabilized. When				
	•	meals, RD stated "No I'm			
		ne." RD stated when he			
		sments he would ask the			
		1 ate. When asked who			
		sible party, RD thought			
	during care conference				
	-	uld be doing the update.			
	At 9:42 a.m. the RD s	stated at the time the RD			

Minnesota Department of Health

had written the telephone order for the nutritional

STATE FORM 6899 WOFB11 If continuation sheet 6 of 76

Minnesota Department of Health

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00238		B. WING		C 11/08/2018	
	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STANE AVENUE NO E, MN 55428		<u>,</u>	0.2010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 265	nurse noted the order the nurse to have upon party about the weight On 11/7/18, at 2:10 previewed the interdisc there was no docume party being notified of RN-I stated he would the one to do the notic experts but also though done it due to the new On 11/7/18, at 2:26 pstated she would have department to have not responsible represent when the supplement The Change in a Respolicy dated Novembracility staff shall promorn her attending phys representative of charmedical/mental conditions SUGGESTED METH. The Director of Nursing develop policies and president's representation treatments. The DON all appropriate staff of and monitor to ensure	t loss on 8/15/18, when the it was the responsibility of lated the family/responsible at loss. Im. registered nurse (RN)-I ciplinary notes and verified entation of family/responsible if the significant weight loss. have thought the RD was fication since they were ght nursing would have worder. Im. the director of nursing e expected the dietary otified the family or tative of the weight loss was initiated. ident's Condition or Status er 2017, directed staff "The aptly notify the resident, his ician and resident nges in the resident's tion and/or status" OD OF CORRECTION: Ing (DON) or designee could procedures to ensure each tive is promptly notified of all	2 265			
2 505	MN Rule 4658.0300 S	Subp. 1 A-E Use of	2 505			12/18/18

Minnesota Department of Health

STATE FORM 6899 WOFB11 If continuation sheet 7 of 76

Minnesota Department of Health

` '		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	A. BUILDING:		COMPLETED	
						С	
		00238	B. WING		11/	/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE			
			ONE AVENUE N				
NORTH R	IDGE HEALTH AND REH	AB	PE, MN 55428				
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORREC		(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHO		(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	ROPRIATE	DATE	
				DEFICIENCY)			
2 505	Continued From page	e 7	2 505				
	Subpart 1 Definitions	s. For purposes of this					
		ms have the meanings					
	given.	me nave the meaninge					
	9.70						
	A. "Physical restr	aints" means any manual					
	method or physical or						
		nt attached or adjacent to					
		at the individual cannot					
	remove easily which r	restricts freedom of					
	movement or normal	access to one's body.					
	Physical restraints inc	clude, but are not limited to,					
	leg restraints, arm res	straints, hand mitts, soft					
	ties or vests, and whe	eelchair safety bars.					
	Physical restraints als	so include practices which					
	meet the definition of	a restraint, such as tucking					
		nat a resident confined to					
		d rails; chairs that prevent					
		sident in a wheelchair so					
		e wall prevents the resident					
	_	are considered a restraint if					
	-	of movement. If the bed					
		ssist the resident in turning t get out of bed, then the					
	•	s a restraint. Wrist bands or					
		nat trigger electronic alarms					
		sident is leaving a room or					
	area do not, in and of	G					
	freedom of movemen						
	considered restraints.						
	B. "Chemical rest	traints" means any					
	psychopharmacologic	•					
		ence and is not required to					
	treat medical symptor	•					
		eans any action taken by					
	the nursing home for	the purpose of punishing or					
	penalizing a resident.	-					
		" means any action taken					

Minnesota Department of Health

STATE FORM 6899 WOFB11 If continuation sheet 8 of 76

Minnesota Department of Health

00238 B. WING C	3/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 505 Continued From page 8 solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were free from physical restraints for 1 of 2 residents (R82) reviewed for restraint use. Findings include: R82's quarterly Minimum Data Set dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance for transfers, toileting and bed mobility. R82's care plan dated 8/4/18, identified a self care deficit and limited physical mobility. The care plan directed supervision with ambulation. The care plan further identified a risk for falls and directed staff to place R95 in a geri-chair four hours per day after lunch. During observation on 11/4/18, from 1:30 p.m. to 4:30 p.m. R95 was lying in a reclining chair, leaning to her left side with her head resting on the armrest of the chair. R95 appeared to be asleep. On 11/5/18, at 8:21 a.m. R95 was asleep in a reclining chair in the television room outside the	

Minnesota Department of Health

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Minnesota Department of Health

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MIN 55428 PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREGULATORY OR LSC IDENTIFYING INFORMATION PREGULATORY OR LSC IDENTIFYING INFORMATION TAG CONTINUED FROM THE APPROPRIATE		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY PILL. TAG CROSS-HEPERIX (CACH DEFICIENCY MUST BE PRECEDED BY PILL. TAG CROSS-HEPERIX (CACH DEFICIENCY MUST BE PRECEDED BY PILL. TAG CROSS-HEPERIX (CACH DEFICIENCY MUST BE PRECEDED BY PILL. TAG CROSS-HEPERIX (CACH CORRECTIVE ACTION SHOULD BE CORRECTION BY CORRECTIVE ACTION SHOULD BE CORRECTION SHOULD BE CORRECTIVE ACTION SHOULD BE CORRECTION SHOULD BE CORRECTIVE ACTION		00228		B. WING		1	
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SUMMARY STATEMENT OF DEFICIENCIES PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG SUMMARY STATEMENT OF DEFICENCY PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG SUMMARY STATEMENT OF DEFICENCE DEFICIENCY PREFIX TAG SUMMARY STATEMENT OF DEFICENCE DEFICIENCY TAG SUMMARY STATEMENT OF DE	NORTH R	IDGE HEALTH AND REH	AB		ORTH		
chair was observed in R95's room. R95 remained in the reclining chair until 9:26 a.m. On 11/6/18, at 7:33 a.m. R95 was again lying in a blue reclining chair in the television room on the unit. R95 appeared to be asleep. She was leaning on her left side with her head lying on the arm rest of the chair. The chair was reclined all the way back. R95 still remained in the chair at 9:29 a.m. During interview on 11/6/18, at 9:37 a.m. registered nurse (RN)-M stated R95 was up a lot during the night. RN-M stated R95 had been falling a lot and had gotten the reclining chair a few months ago. RN-M stated staff put her in her bed at night but if she woke up they would place her in the reclining chair. She stated R95 slept in the chair almost every night, On 11/6/18, at 9:56 a.m. nursing assistant (NA)-C stated R95 wanted to get up by herself. NA-C stated R95 no longer walked with staff but still wanted to. NA-C stated the reclining chair kept R95 from getting up and stated if staff put her in the standard wheel chair she would try to get up and walk. NA-C stated R95 could get up from the regular chair but not the reclinier, she stated "that's why we put her in it." At 10:03 a.m. NA-K stated when R95 started getting up from the regular wheel chair, staff put	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
staff did not attempt other things but just put her in the chair. During interview on 11/6/18, at 1:34 p.m. RN-K	2 505	chair was observed in in the reclining chair to On 11/6/18, at 7:33 at a blue reclining chair the unit. R95 appeare leaning on her left sid arm rest of the chair. the way back. R95 stig. 9:29 a.m. During interview on 1 registered nurse (RN) during the night. RN-I falling a lot and had go few months ago. RN-bed at night but if she her in the reclining chair the chair almost event on 11/6/18, at 9:56 at C stated R95 wanted stated R95 no longer wanted to. NA-C stated R95 from getting up at the standard wheel chair almost even wanted to and walk. NA-C state regular chair but not to "that's why we put he at 10:03 a.m. NA-K so getting up from the reher in the recliner chair staff did not attempt of in the chair.	in R95's room. R95 remained until 9:26 a.m. Im. R95 was again lying in in the television room on ad to be asleep. She was the with her head lying on the The chair was reclined all lill remained in the chair at 1/6/18, at 9:37 a.m. 1/6/18,	2 505	DELICITION ()		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00238	B. WING		C 11/08/2018	
					11/00/2010	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO PE, MN 55428	ORTH		
0/0.15	CLIMMA DV CT		1	DROVIDER'S DI AN OF CORRECTION	0/5)	_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ΓE
2 505	Continued From page	2 10	2 505			
	ordered her a reclinin	g chair. She stated R95				
		weeks but stated she used				
	to fall quite a bit, espe	ecially at night, RN-K stated				
	she thought the nurse	practitioner had ordered				
	the chair for positioning	ng. RN-K stated she was				
	_	en staff were using the				
	_	they were utilizing the				
		ted she did not know how				
	I	night in the chair but stated tting her up to sleep in the				
	chair at night.	itting her up to sleep in the				
	Gran at riight.					
	During interview on 1	1/6/18, at 2:27 p.m.				
	•	se (LPN)-B stated R95 was				
		B stated the p.m. shift				
	· · · · · · · · · · · · · · · · · · ·	and dressed her for bed				
	then put her in the red	•				
	she thought R95 had	igh fall risk. LPN-B stated				
	•	an order to sit in the ich but not for bed. LPN-B				
		e night shift put her in bed				
	_	get up so they put her in the				
	reclining chair.					
	At 2:10 p.m. the direct	tor of nursing stated staff				
	should be using R95's	_				
	_	hould not be sleeping in the				
	chair at night.					
	A facility policy titled I	Jse of Physical Restraints				
	dated September 2017, indicated restraints shall					
	·	afety and well-being of the				
	_	hall only be used to treat				
		symptoms and never for				
	discipline or staff con					
	-	amples of devices that can				
	be considered a restr	·				
	resident in a recliner t	that prevents them from	1			

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Minnesota Department of Health

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING:		
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		00238	B. WING		11/0	8/2018
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NORTH R	IDGE HEALTH AND REH	AB	PE, MN 55428			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 505	Continued From page	2 11	2 505			
	rising.					
2 555	The director of nursin develop, review, and/procedures to ensure monitoring and release. The director of nursin educate all appropriate procedures. The director of nursin develop monitoring sycompliance. TIME PERIOD FOR 0 (21) Days MN Rule 4658.0405 SPlan of Care; Develop must develop a compleach resident within a completion of the	there was a system of se of the restraint. g (DON) or designee could te staff on the policies and g (DON) or designee could ystems to ensure ongoing CORRECTION: Twenty-one Subp. 1 Comprehensive or care for seven days after the prehensive plan of care for seven days after the prehensive resident ed in part 4658.0400. The of care must be developed or team that includes the a registered nurse with resident, and other sciplines as determined by and, to the extent participation of the resident,	2 555			12/18/18

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018	
NAME OF PROVIDER O	OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 1110	0/2010
NORTH RIDGE HEA	ALTH AND REH	AB	NE AVENUE NO E, MN 55428	ORTH		
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
This MI by: Based of review interver for 1 of concern lift. Finding R160's dated 9 cognitive behavior assistant (ADL's) (paralyst and her following (stroke) of ability apraxial actions indicate or as not antipsylmedical assessing indicate of R160 behavior Review following 9/20/18 R160 w	on observation the facility failed intions on the profession of th	t is not met as evidenced a, interview and document ad to develop and implement berson centered care plan about 160) reviewed for behavioral resident (R11) using a full animum Data Set (MDS) animum Data Set (MDS) animum Data Set (MDS) and R160 was moderately demonstrated no mood or and required extensive activities of daily living actuded hemiplegia just one side of the body) acrebrovascular disease activities of daily living actuded hemiplegia just one side of the body) acrebrovascular disease activities on half of the body) acrebrovascular disease activities of daily living activities of activities ac	2 555	Corrected.		

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Minnesot	a Department of Health	h .				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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NORTH RIDGE HEALTH AND REHAB						
		NEW HOF	PE, MN 55428			
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0.555			1			
2 555	Continued From page	e 13	2 555			
	cc balloon. The Cathe	eter was intact and no				
	missing part was see	n. R160 was pulling out the				
	abdominal binder, clo	thing, falling out of bed and				
	refusing cares.					
	9/21/18, 6:03 a.m. Nu	ursing: Note indicated R160				
	did not sleep through	the night,was pulling out				
	the G tube and clothing	ng through the shift. The				
	note further indicated	R160 had a floor bed and				
	mattress for fall preve	ention.				
	9/21/18, 2:12 p.m. Nu	rsing Note indicated R160				
	had been lethargic, sl	leepy from around 8:00 a.m.				
	when she was given	prn Zyprexa. She was				
	agitated , trying to pu	ll off her G-tube and wanted				
	to roll over the bed. F	amily was present and				
	seemed to suggest ".	mom needed a rest"."				
	9/24/18, 5:31 a. m. N	ursing: Note indicated				
	R160 was restless all	nigh, rolling on the floor				
	mat and pulling on he	er G-tube. G-Tube intact				
	•	Will continue to monitor.				
	•	ursing Note indicated R160				
	-	for readmission this shift,				
		es, attempted to slap staff				
	• •	taff unable to change tubing				
	and assessed skin du					
	•	ursing:Note indicated R160				
	_	shift, disconnected the				
	-	attempted to pull the				
	G-tube out with her h					
		lursing Note indicated				
		st hours of the night, at 3:44				
		went to assist her to bed,				
	writer saw resident's inflated.	catheter lying on the floor				
		Jurging: Note indicated				
		lursing: Note indicated				
		w writer to re-insert her				
	Foley catheter. Was v	-				
	11/4/18, 10:50 p.m. R	· · · · · · · · · · · · · · · · · · ·				
	cameter, taking out d	iapers, pulling G- tube, and				

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Minnesot	a Department of Healtr	1					
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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		00238	B. WING		11/08/2018		
			•				
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
NODTH D	DOE HEALTH AND BEH	5430 BOO	NE AVENUE N	ORTH			
NUKIHK	DGE HEALTH AND REH	NEW HOP	E, MN 55428				
(VA) ID	STIMMADV ST	ATEMENT OF DEFICIENCIES	ID.	DROVIDER'S BLAN OF CORRECTION	(VE)		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	` ,		
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR			
		,		DEFICIENCY)			
2 555	Continued From page	e 14	2 555				
	massing barself D16	O was fighting with the stoff					
	•	0 was fighting with the staff					
	while cleaning and us	ing inappropriate words.					
		lursing Note indicated staff					
	attempted foley cathe	ter change but were					
	unsuccessful due to p	patient being combative.					
	During interview on 1	1/7/18, at 9:00 a.m.,with					
	-	N)-G, who complete MDS's,					
	- '	ed progress notes for very					
		and indicated R160 did not					
	·						
	•	haviors. RN -G indicated if					
		nibiting behaviors between					
		nen the nurse manager is					
	responsible for updati	ing the care plan.					
	On 11/7/18, at 9:15 a.	.m., RN-B verified R160 did					
	not have any behavio	rs identified on the plan of					
	•	60 did exhibit behaviors.					
		m., Social Service (SS)-A					
		would add the specific					
	behaviors to the plan	of care.					
		18, at 1:30 p.m., R160 was					
	lying naked on the be	d in her room, yelling at the					
	nursing assistant to le	eave the door open.					
	Surveyor asked the s	taff if R160 required 1:1					
		taff stated "not always but					
		_					
	right now because she was trying to take out her tubing."						
	tubing.						
	Internieus en 44/0/40	at 0.00 a va ana a - la					
	Interview on 11/6/18,						
	therapist (ST)-A indic						
	fatigued she does not	eat well, and does not like					
	to be fed. ST-A indica	ated R160 would take food					
	from staff, but would a	oush the staff's hands away					
	when the staff attemp	-					
	P11 had a diagnosis	of lymphedema and a left					
	above the knee ampu	itation of the left leg	1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	X3) DATE SURVEY COMPLETED	
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			B. WING		C		
		00238	B. WING		11/0	8/2018	
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NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO	ORTH			
		NEW HOP	E, MN 55428		ı		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
2 555	Continued From page	: 15	2 555				
		ent order sheet. A quarterly indicated R11 had intact					
	The care plan dated 10/26/18 indicated R11 had limited physical mobility and directed staff to use a hoyer lift (mechanical lift device), however, the type of sling was not indicated.						
	During observation on 11/5/18, at 9:09 a.m. a full lift cross legged sling was under R11 while seated in the wheelchair. R11 stated the staff lost the multipurpose (amputee) sling last Wednesday (10/31/18) and were not able to find another one. She stated she felt scared and the sling hurts her on the back of her leg on the right side when she was transferred in the cross legged sling. During the observation an instruction sheet for the multipurpose (amputee)						
	On 11/5/18, at 11:20 a RN-A stated the multi should be used for R ordered for her. He ve care sheet (undated) transfers but did not s	erified that the aide group 5 noted for R11 "hoyer" for specify the type of sling. He prehensive care plan did not					
	indicated the staff wa (amputee)sling and lif staff to follow in R11's	sessment dated 10/19/18, s to use the multipurpose it posted information for the room.					
	7:10 a.m., she stated	she was told the sling for aundry and the other cross					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
00238		B. WING			C I/ 08/2018	
	5430 BO	ONE AVENUE NOR				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE	
ng was to be of to use a corresidents and by a nurse to ged sling had ay. 8, at 9:12 and viewed and with the used for should determine the stated the sed type of a type of the resident. TED METHOMETHOMETHOMETHOMETHOMETHOMETHOMETHO	e used. She stated she was ross legged sling for id did not know if it was use it. She verified the id been used since last. m. the director of nursing verified a cross legged sling in a full lift with a resident reamputation. She stated within the type of sling and as safely transferred in the recare plan should reflect sling. ed 10/2010, directed staff to are plan for special needs, id equipment to safely OD OF CORRECTION: g or designee could direct replan to include appropriate rentified care needs. A could be established in order id effective care plan inse to resident care needs.	2 555				
equirements . Staffing re	equirements. A nursing	2 800			12/18/18	
	SUMMARY STACH DEFICIENCY GULATORY OR LE de From page and was to be of to use a corresidents and ay. 8, at 9:12 and wiewed and was a should determ a should determ a resident was asset type of a state of the resident case the needed are resident. STED METHOM to on should program of a corresponding and ons in responsions	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) If From page 16 Ing was to be used. She stated she was be to use a cross legged sling for residents and did not know if it was by a nurse to use it. She verified the ged sling had been used since last aay. 8, at 9:12 a.m. the director of nursing viewed and verified a cross legged sling be used for a full lift with a resident cove the knee amputation. She stated should determine the type of sling and the resident was safely transferred in the stated the care plan should reflect used type of sling. If y policy dated 10/2010, directed staff to be resident care plan for special needs, the needed equipment to safely the resident. IFED METHOD OF CORRECTION: tor of nursing or designee could direct evelop a care plan to include appropriate tons for all identified care needs. A g program could be established in order ongoing and effective care plan to include appropriate ons for all identified care needs. RIOD FOR CORRECTION: Twenty One	SUPPLIER STREET ADDRESS, CITY, STATE 5430 BOONE AVENUE NOR NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) DEFINITION ID PREFIX TAG ID ID PREFIX TAG ID PREFIX TAG ID	SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$430 BOONE AVENUE NORTH NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES COLD DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY IT From page 16 Ing was to be used. She stated she was to to use a cross legged sling for residents and did not know if it was by a nurse to use it. She verified the god sling had been used since last ay. 8, at 9:12 a.m. the director of nursing viewed and verified a cross legged sling on the used for a full lift with a resident pove the knee amputation. She stated should determine the type of sling and the resident was safely transferred in the he stated the care plan should reflect used type of sling. In y policy dated 10/2010, directed staff to be resident care plan for special needs, the the needed equipment to safely the resident. TED METHOD OF CORRECTION: tor of nursing or designee could direct evelop a care plan to include appropriate pons for all identified care needs. A go program could be established in order ongoing and effective care plan ons in response to resident care needs. RIOD FOR CORRECTION: Twenty One 4658.0510 Subp. 1 Nursing Personnel; equirements Staffing requirements. A nursing st have on duty at all times a sufficient	SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5439 BOONE AVENUE NORTH NEW HOPE, INN 55428 SUMMARY STATEMENT OF DEFICIENCIES OF DEFICIENCY MUST SE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE ALLATORY OR LSC IDENTIFYING INFORMATION) If From page 16 If From page 16 If From page 16 If From page 16 If year and id not know if if was year and id not know if if was year aruse to use it. She verified the ged sling had been used since last ay. If year and we are a cross legged sling or residents and did not know if it was year aruse to use it. She verified the ged sling had been used since last ay. If year and the stated the care plan should reflect used type of sling. If ye policy dated 10/2010, directed staff to a resident care plan for special needs, ee the needed equipment to safely he resident. If ED METHOD OF CORRECTION: tor of nursing or designee could direct verlop a care plan to include appropriate ones for all identified care needs. A g program could be established in order ongoing and effective care plan sons in response to resident care needs. RIOD FOR CORRECTION: Twenty One 4658.0510 Subp. 1 Nursing Personnel; equirements Staffing requirements. A nursing st have on duty at all times a sufficient	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
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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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 800	Continued From page	e 17	2 800		
	nursing assistants to residents at all nurses in all buildings if more	es relief duty, weekends,			
	by: Based on observation review, the facility fail staffing was available assistance with meals assistance with person residents' assessed in care plan. This practicall residents who residents	nal cares according to the need and as directed by the ce had the potential to affect		Corrected.	
	Refer to F677: The fa adequate grooming w residents (R31) who activities of daily living	vas provided to 1 of 5 was dependent on staff for			
	of motion services in or maintain range of r	cility failed to provide range order to prevent a decrease notion (ROM) for 1 of 1 wed for limitations in range			
	residents (R81, R31) pressure ulcers receifailure of the facility to turning and positionin	cility failed to ensure 2 of 5 identified at risk for yed timely repositioning. The consistently implement a g program resulted in 31 acquired three (3) new			

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STATEMENT		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		00238	B. WING		C 11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
NORTH R	DGE HEALTH AND REH	5430 BOO	NE AVENUE NO	ORTH	
	DOL HEALTH AND REIL	NEW HOP	E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 800	Continued From page	e 18	2 800		
	stage II pressure ulce skin with exposed de	ers (partial-thickness loss of rmis).			
	toileting for 2 of 7 resi for bowel and bladder ensure 1 of 7 residen	cility failed to provide timely idents (R31, R81) reviewed r. In addition, failed to ts (R224) received services intain bladder continence.			
	Resident interviews:	intam bladder continence.			
	R9 was interviewed on 11/05/18, at 9:11 a.m. When asked about staffing R9 stated there was not enough aides. "It takes a long time to get help. Not too long ago, a couple of months ago, on the night shift at 3:00 a.m. I had a bowel movement and I got changed at 8:00 a.m. The aide said the call light had not come on. I put the call light on every 15 minutes, they come in turn off the light. Waiting beyond 30 minutes is too much time to wait to get help. I think they need a float person. When I first got here I was dizzy and needed more help. I still need assistance to go to the bathroom."				
	and indicated that "thused to have 5-6 aid there was one aide or could come in. Aides Lots of aides have querepositioned as frequecare of 12 people by nurses on this floor at I was here. People from and they do not care who left in the middle	d on 11/5/18, at 09:58 a.m. ey are short on aides." They es on the floor. One night in the floor until someone are working double shifts. it. They can't get me ently as I need. They take themselves. They put new and 4 nurses have quit since om Florida bought this place about us. I have had people of cares because they have their shift was done. I have			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00238		B. WING		C 11/08/2018	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
NORTH RIDGE HEALTH AND REHAL	В	NE AVENUE NO	ORTH		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
complained to the nursi now gone. My light will they come in to turn me Staffing is a big problem. R11 and family membe at 2:00 p.m. and stated answered timely, especionly 2 aides and would help and at times staff of the call light off and state but never did. During a R11 on 11/5/18 at 9:00 been waiting since 5:00 stated on several occass complaints to registered the nurse manager, about and long call lights but if further stated the staffing to three aides on the urea of the total the staffing to the aides on the urea of the total the staffing to the nurse manager. On 11/4/18, at 12:57 p.1 facility was very short so wait two hours while incontinence product of the complete of the total total the total the staffing total the staffing to the staffing to the staffing total the sta	ing supervisor and she is be on for 2 hours before e or bring me water. In were interviewed 11/4/18 If the call lights are not cially at night there are wait up to 2 hours for come into the room turned ted they would be back follow up interview with a.m., R11 stated she had 0 a.m. to have a bath. R11 sions she had brought d nurse (RN)-A), who was out staffing complaints it had not improved. R11 ng levels were decreased in about 3 months ago. In R451 stated the staffed. R451 stated he had sitting in stool, to get his hanged. In R227 stated her	2 800			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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		00238	B. WING		11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO	DRTH		
	Г		PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 800	Continued From page	e 20	2 800			
	was bad. R149 stated hours when I needed had a bowel moveme. On 11/4/18, at 2:35 p want to wait 30 minut bathroom. They place room, so I would not ghelp. I was not incont. On 11/4/18, at 3:07 p with oxygen on by a topening in the neck to There was a suction r R697 stated it was differed requested to write her wrote, "They take too I have waited up to two someone to respondicall light]. This just do	.m. R242 stated "I do not es for assistance to walk to ed my walker across the go to the bathroom without inent prior to admission." .m. R697 was lying in bed racheostomy (an artificial or allow a patient to breath). machine next to the window. Efficult to speak and ranswers. R697 long to answer my call light. I wo and a half hours for to my button [pointed at the besn't happen once, it ' R697 wrote, "I could die if I				
	put the call light on it minutes to come and commode. R202 state the staff wanted him to because he recently hamputated. On 11/4/18, at 4:20 pigetting the care and a R151 stated "they are have cut the hours of	ed he could do it himself but to wait for assistance				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NORTH R	IDGE HEALTH AND REH	AB	PE, MN 55428	OKIH		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 800	Continued From page	e 21	2 800			
	aide for one to two hosupposed to be up at bed and no one has owhat is going on. Son and people here have and they never come. On 11/4/18, at 4:30 p have too many patient stated "I have had to my call light to be ansand want a pain pill." On 11/4/18, at 4:38 p "Sometimes I have to there is no help anyw people but they walk toilet with their help. The walk is to be up at the control of the co	ours sometimes. Like I was 4 p.m. and look am still in come to even let me know me nights it's only one aide to wait for that one person." .m. R173 stated the staff ats, they are so busy. R173 wait 30 to 45 minutes for swered. I have been in pain .m. R170 stated to hold to go poop because there. There are a lot of around. I need to use the frat's the only thing I got to the need to train people on				
	Staff Interviews:					
	13 residents, said the thought the unit requineeds of the resident when asked to assist were needed to use the said of the transfer of the tra	es on the unit are assigned ere was not enough staff and red 4 aides to meet the s in the unit. At 2:40 p.m. R11, NA-A stated 2 aides he lift which R11 used for s the only aide on the unit				
	(LPN)-F stated she wand had been floated	.m. licensed practical nurse orked on a different floor to the floor. When asked stated it was hard to get the				

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STATEMENT	TOF DEFICIENCIES DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
00238		B. WING		C 11/08/2018	
NORTH RIDGE HEALTH AND REHAB 5430 BOOK			DDRESS, CITY, STATE ONE AVENUE NO PE, MN 55428	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 800	NA's. When asked ho the resident correctly medication LPN-F stated NA's to point out the resident correctly medication LPN-F stated NA's to point out the resident correctly medicated the room the resident cares. RN-L stated the room they were splitting the three nurses. RN-L stated the room the food hall and a NA that halls. On 11/6/18, at 8:03 and after morning cares we showed srveyor the welloud he had 13 residencares. NA-C stated he and at times he had to come in and assist his transfer residents. When the residents were so tired because you whole day from room management was away done and yet the resident care assistance and and transfers. On 11/7/18, at 1:30 puindicated "It is about pabout the resident care."	ecause she had to help the w she was able to identify when administering ted she depended on the esidents. m. registered nurse nurse did not come in so entire 700 hall between ated there was one nursing 500 hall and one on the tolerated between the two. m. NA-C was interviewed ere done for R78. NA-C ork sheet and counted out not she was responsible for eworked at his own pace of wait for another NA to me when he used the lift to be neaked if he thought the estaff he just "laughed" ent. m. NA-L stated "you can When you get home you you will be running the to room." NA-L stated are and nothing had been dent's in the unit needed required two staff for cares	2 800	DELI MIENOT)	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	FE, ZIP CODE	1 00. 20.10
		5430 BO	ONE AVENUE NO		
NORTH R	IDGE HEALTH AND REH	AB NEW HO	PE, MN 55428		
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2 800	Continued From page	e 23	2 800		
	the residents are so he know what to do or we attempt to fix the production and just not energeriod." On 11/8/18, at 10:26 staff according to the work okay and somethe difficult when we we done because you have assistants and the restimes resident would	cooperation. Sometimes nelpless that you just don't here to begin. You can olems but they continue to ough help around here a.m. LPN-G stated "they census and sometimes we imes we work short. It can work short to get the work to help the nursing sidents." LPN-G stated at have to wait for a while to			
	get the assistance be nobody to help espec required two staff ass	ially when a resident			
	required two staff assistance with cares. Resident observation: On 11/6/18, at 6:58 a.m. R215 was overheard calling out "Hello change my diaper." LPN-D was observed down the hallway and was overheard state to nursing assistant (NA)-L "he needs help. When LPN-D returned to the nursing station where the medication cart was parked surveyor indicated R215 was calling out and LPN-D stated "I have told the aide." -At 7:01 a.m. R215 continued calling out at this time registered nurse (RN)-K went into the room and R215 stated "change my diaper." RN-K then stated to R215 "someone is coming" as she left the came out of the room at the nursing station LPN-D stated "I have told [NA-L]." -At 7:06 a.m. to 7:11 a.m. R215 started calling out "help me change my diaper" at this time RN-N and LPN-D were both standing at the medication carts which were located outside the				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE ### STREET ADDRESS, CITY, STATE, 2IP CODE ### S439 BOONE AVENUE NORTH NEW HOPE, MN 55428 CALL DEPTICE HEALTH AND REHAB SA9 BOONE AVENUE NORTH NEW HOPE, MN 55428 CALL DEPTICE HEALTH AND REHAB SA9 BOONE AVENUE NORTH NEW HOPE, MN 55428 CALL DEPTICE HEALTH AND REHAB SA9 BOONE AVENUE NORTH NEW HOPE, MN 55428 D	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (PA) 10 (SALIP SECRET AND RESS. CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 PROVIDERS PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 24 nursing station across from R215's room. -A1 7:12 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room. -A4 7:45 a.m. to 7:48 a.m. RN-N went into R215's room to give R215 medications and as she left R215 stated to her "fill don't run away." RN-N turned around and approached R215 and R215 was overheard state in a loud voice strained voice "change my diaper." RN-N stated "change what" but R215 then stated "never mind" as RN-N left the room. -A1 7:49 a.m. surveyor told RN-N R215 was asking staff to change his incontinent pad. RN-N stated she did not understand what R215 wanted as he was heard to understand what R215 wanted as he was peard to understand. RN-N stated she was going to find help. -A1 7:50 a.m. surveyor intervened and asked LPN-D when R215 was going to be assisted as it had been 50 minutes since R215's had asked. LPN-D stated she was going to find help. -A1 7:53 a.m. as RN-K and RN-N approached R215 pelded out 'change my firm' diaper." -A1 7:59 a.m. NA-E was observed wipe stool off R215's bottom and stated R215's pad was dry.						C	
SUMMARY STATEMENT OF DEFICIENCIES D	00238		B. WING		1	018	
NORTH RIDGE HEALTH AND REHAB NEW HOPE, MN 55428 (A) D PROVIDER'S PLAN OF CORRECTION (A) COMPLETE CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 2 800 Continued From page 24 2 800 Invising station across from R215's room. -At 7:12 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room. -At 7:45 a.m. to 7:48 a.m. RN-N went into R215's room to give R215 medications and as she left R215 stated to her "Hi don't run away." RN-N turned around and approached R215 and R215 was overheard state in a loud voice strained voice "change my diaper." RN-N stated "change what" but R215 then stated "never mind" as RN-N left the room. -At 7:49 a.m. surveyor told RN-N R215 was asking staff to change his incontinent pad. RN-N stated she did not understand what R215 wanted as he was heard to understand. RN-N stated she was going to find help. -At 7:50 a.m. surveyor intervened and asked LPN-D when R215 was going to find help. -At 7:53 a.m. as RN-K and RN-N approached R215 he stated "what took so long." -At 7:58 a.m. as RN-E and NA-L approached R215 he stated "what took so long." -At 7:59 a.m. NA-E was observed wipe stool off R215's bottom and stated R215's pad was dry.	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NEW HOPE, MN 55428 CALL DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PRECINCATOR SHOULD BE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NORTH D	IDOE HEALTH AND DEH	5430 BOC	NE AVENUE NO	ORTH		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 24 nursing station across from R215's room. -At 7:12 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room. -At 7:45 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room. -At 7:45 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room. -At 7:45 a.m. to 7:48 a.m. RN-N went into R215's room to give R215 medications and as she left R215 stated to her "Hi don't run away." RN-N turned around and approached R215 and R215 was overheard state in a loud voice strained voice "change my diaper." RN-N stated "change what" but R215 then stated "never mind" as RN-N left the room. -At 7:49 a.m. surveyor told RN-N R215 was asking staff to change his incontinent pad. RN-N stated she did not understand what R215 wanted as he was heard to understand. RN-N stated she was going to find help. -At 7:50 a.m. surveyor intervened and asked LPN-D when R215 was going to find help. -At 7:53 a.m. as RN-K and RN-N approached R215 had been 50 minutes since R215's had asked. LPN-D stated she was going to find help. -At 7:58 a.m. as NA-E and NA-L approached R215 yelled out "change my f***********************************	NORTHR	IDGE HEALTH AND REH	NEM HOL	E, MN 55428			
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needed it's provided." RN-K stated "when someone has to go he has to go." Resident Council: Review of the Resident council minutes for the past 3 months revealed on September 17, 2018	2 800	nursing station across -At 7:12 a.m. to 7:45 a no staff went into the -At 7:45 a.m. to 7:48 a R215's room to give F she left R215 stated to RN-N turned around a R215 was overheard strained voice "change "change what" but R2 mind" as RN-N left the -At 7:49 a.m. surveyo asking staff to change stated she did not und as he was heard to unwas going to find help -At 7:50 a.m. surveyo LPN-D when R215 was had been 50 minutes LPN-D stated she war -At 7:53 a.m. as RN-K R215 he stated "what -At 7:58 a.m. as NA-E R215 yelled out "char -At 7:59 a.m. NA-E was R215's bottom and stated it's provided." someone has to go her Resident Council:	a.m. R215's room. a.m. R215 was quiet and room. a.m. RN-N went into R215 medications and as o her "Hi don't run away." and approached R215 and state in a loud voice e my diaper." RN-N stated 15 then stated "never e room. It told RN-N R215 was his incontinent pad. RN-N derstand what R215 wanted nderstand. RN-N stated she of the stated as going to be assisted as it since R215's had asked as going to find help. If and RN-N approached took so long." If and NA-L approached took so long." If and RN-L approached took so long. If and RN-L approached took so long." If and RN-L approached took so long. If and RN-L approach	2 800			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		00238	B. WING		
		00238			11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		5430 BO	ONE AVENUE NO	ORTH	
NORTH R	IDGE HEALTH AND REH	AB	PE, MN 55428		
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				DEFICIENCY)	
2 900	Cantinuad Francisco	- 05	2 800		
2 800	Continued From page	25	2 000		
	concerns form.				
		s dated 10/8/18, indicated			
		eing answered in a timely			
	_	se from nursing was that			
	-	e re-educated on using the			
	call light pagers and o	_			
	call light pagers and c	оп ехрестанопа.			
	During the regident of	ouncil mosting hold on			
	_	ouncil meeting held on			
	11/6/18 from 10:30 to				
	attended by seven re				
	ombudsman. R11 sta				
	•	ances because they had			
	been discussed in the				
		olved. The call light time			
		staff was the main grievance			
		ngoing issue. R40 stated			
	the staff come in and	ask what was needed, then			
	turn off the light and s	said they will return "but they			
	don't come back." R4	0 reported waiting two			
	hours, and hearing ot	thers on the unit calling out			
	for help. R61 stated the	hey would have to turn the			
	light on three times be	efore getting help and this			
	was common practice	e. R93 reported having the			
	call light taken from re	esidents when it was used			
	to call for assistance.	R93 stated he and other			
	residents had waited	a long time again the			
		night shift. R93 further			
	-	tments were not always			
	•	-			
	completed as ordered. In additon, R61, R40, and R93 reported passing bedtime snacks was not				
		e there were not enough			
	aides on duty.	word flot dribugit			
	aides on duty.				
	During the resident co	ouncil meeting the			
	•	ce expressed a concern			
	-	vere bring up in the council			
	_	ng issues did not get written			
	into the minutes, and	a response was not given			

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Minnesot	a Department of Health	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
NORTH R	DGE HEALTH AND REH	AB	ONE AVENUE NO	DRIH		
			PE, MN 55428			
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				DEFICIENCY)		
2 800	Continued From page	26	2 800			
	to the council on effor	ts to solve the problem.				
	0					
	System:	a accord floor porth unit				
	-	e second floor north unit month of October 2018,				
		esidents and included 47				
	episodes of the call lig					
	•	assistant adminstrator was				
		8 at 1:06 p.m., and stated				
		w residents on 2 north for				
	the past 3 months. Sh					
	•	mes greater than an hour				
		t did see which aide was				
	assigned. She stated	the audit was not able to				
	track instances when	an aide would turn off the				
	light and return later t	o meet the resident's need.				
		ware of the resident council				
		ng and had talked to them				
		response. She stated the				
	•	des carry a pager with them				
	to indicate a call light	was on started in				
	September 2018.					
	Interview with the stat	ffing coordinator on 11/7/18				
		all in will attempt to fill the				
	•	ake administration aware.				
	The policy for the nur	sing staff to carry pagers				
		emo dated 9/7/18 which				
	indicated all staff were	e to sign out and carry a				
	pager to be aware of	the call lights. The current				
	call light system had a	a banner on the unit which				
		s of call lights activated and				
	the pager would also					
	-	or the second floor for				
		5/18, and 11/6 18 had none				
	of the pagers signed	out for the evening and				

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night shift, and 3 signed out on the day shift. The

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SUI COMPLET	
00000		B. WING		C 11/08/2018		
NAME OF P	ROVIDER OR SUPPLIER	00238 STREET ADD	RESS, CITY, STA	TE. ZIP CODE	1 11/00/	72016
NORTH R	IDGE HEALTH AND REH	AB	IE AVENUE NO	DRTH		
		NEW HOPE	, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 800	Continued From page	27	2 800			
	RN-A verified that the would have 6 staff on	day and evening shifts them.				
	the administrator, the	m. during an interview with director of nursing and the				
	facility was being staff	ne administrator stated the fed by acuity and transfers.				
	When asked about the observations of staff not repositioning residents, not toileting residents timely and providing the services and care needs					
	both stated some of the staff who were involved in the situations had been let go as this was not acceptable standards.					
	•	nt dated 7/23/18 indicated s, past survey performance, nad sufficient staffing.				
	SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement					
		further recommendations				
	TIME PERIOD FOR 0 (21) days.	CORRECTION: Twenty-one				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ((X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		11/00/2010	
NORTH R	DGE HEALTH AND REH	AB	NE AVENUE NO E, MN 55428	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
2 830	Continued From page	28	2 830			
2 830	MN Rule 4658.0520 S Proper Nursing Care;		2 830		12/18/18	
	receive nursing care a custodial care, and su individual needs and the comprehensive re plan of care as descr and 4658.0405. A nube out of bed as much	and treatment, personal and upervision based on preferences as identified in esident assessment and libed in parts 4658.0400 rsing home resident must in as possible unless there in the attending physician at remain in bed or the				
	by: Based on observation review the facility faile diets as ordered by the) reviewed for dining. In ailed to utilize the al lift sling for 1 of 2		Corrected.		
	Findings include:					
	9/4/18, indicated he wimpaired and required after meal set up. R11 10/2/18, indicated a problem related to a ricoughing with meals a	mum data set (MDS) dated vas moderately cognitively d supervision while eating 15's care plan dated otential nutrition/hydration nechanically altered diet, and weight loss. R115's ort identified a physican's				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
	00238 B. WING 11		11/0	, 8/2018		
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO UNIC OT TH	to vibert of tool i eleft		ONE AVENUE NO	,		
NORTH R	DGE HEALTH AND REH	AB	PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	29	2 830			
	-	for a mechanical soft, ith nectar thick liquids. dated 6/31/18, indicated he				
	was severely cognitively impaired and required supervision and physical assistance to eat. R83's Order Summary Report identified a physican's					
	order dated 12/13/17, for a mechanical soft, chopped texture diet. The order indicated R83 may request regular texture meals and directed staff to cut meat into small pieces. R83's care					
	plan dated 9/1/18, identified a dysphagia (difficulty in swallowing) diagnosis and a diet of mechanical soft food.					
	R115 was in the dinin meal. R115, along with	n 11/4/18, at 5:24 p.m. g room during the evening th all other residents on a vere served pureed food.				
	stated she was not su	33 p.m. Dietary aide (DA)-A ure what the residents on a could eat so she served				
	food even though his	ceived a meal of pureed diet slip identified a R115 did not eat his meal.				
	R83 was seated at a awaiting his noon me requested a corn dog chopped up as directe assistant (NA)-C return stated R83 would not and requested two who was a seated at a awaiting his noon are seated at a awaiting his noon me	n 11/6/18, at 12:29 p.m. table in the dining room al. At 12:30 p.m. R83. DA-B served a corn dog, ed by R83's diet. Nursing rned the plate to DA-B and eat the chopped up food nole corn dogs. She stated if she served the chopped				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		c	
		00238	B. WING		11/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NORTH R	DGE HEALTH AND REH	5430 BOC	NE AVENUE N	ORTH		
		NEW HOP	PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 830	Continued From page	e 30	2 830			
	and left the table.	e whole corn dogs to R83				
	gave R83 the right me	2:37 p.m. DA-B stated she eal but NA-C told her to logs so she did what NA-B				
	the chopped up food, offered it to him. She offered it, "it would ha	tated R83 would not take even though she had not stated if she would have we been a problem." She e dietician knew about it.				
	state the NA's were "a upgrade a residents of	t had been served. RN-K absolutely" not allowed to liet. She stated staff should slip. RN-K did not remove				
	and stated staff were chewing and swallow plan did not contain a diet and did not contair related to not followin made no attempt to ta R83. When asked abordhopped and ground resident was on a grohave pureed bread.	RD)-A stated nursing allowed to upgrade a reviewed R83's care plan to monitor for difficulty with ing. RD-A stated the care my modifications to R83's in any risks and benefits g his prescribed diet. RD-A take the incorrect food from the differences in the diets, RD-A stated if a mund diet they could only				
		n 11/7/18, at 8:44 a.m.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00238	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	5430 BOON	RESS, CITY, STA IE AVENUE NO I, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 830	milk and juice. R115 hand drank some of the and was observed co. At 8:50 a.m. RN-I veribeen served to R115. remaining thin liquids. dining room should be and were responsible was served. During interview on 1 stated the aides tell his serve and stated, "the asked about the toast diet, DA-B stated, "puhere somewhere. Madietician." During interview on 1 director of dietary senheard about the diet of The DDS stated staff food safety and diet at to serve. She stated the give food that was no stated she rounded in meal service but did raudits to ensure meal by the physicians order. On 11/8/18, at 1:36 p. (DON) stated she had incorrect diets. The D	5 was served thin liquids of had eaten all of the toast e milk and all of the juice, ughing at the table. fied the incorrect diet had RN-I removed the RN-I stated all staff in the e aware of the residents diet to ensure the correct food 1/7/18, at 9:09 a.m. DA-B er what they want her to hat; what i give." When for a mechanical ground reed, I think. It's written ybe you should ask the 1/8/18, at 10:28 a.m. the vices (DDS) stated she had concerns on the third floor. The received training related to hat should know what food the dietary aide should not at on the diet order. The DDS at the dining rooms during not conduct any formal is were provided as directed er. In the director of nursing is heard staff were giving ON stated nursing and consible for ensuring the	2 830		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00000	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	00238	RESS, CITY, STA	TE ZIP CODE	11/08/2018
	IDGE HEALTH AND REH	5430 BOOI	NE AVENUE NO		
NEW HOP			E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
	Investigating and Repindicated all accidents residents, etc shalt be to the administrator. I supervisor shall prominvestigation of the administration of t	of lymphedema and a left			
	dated 10/26/18 indica mental status (BIMS) was cognitively intact dated 10/26/18 indica physical mobility and	ted a brief inventory of of 15 which indicated R11 for memory. The care plan			
	lift cross legged sling seated in the wheelch the multipurpose (am Wednesday (10/31/18 another one. She stat sling hurts her on the side when she was tralegged sling. An instrumultipurpose (ampute posted in the resident	pair. R11 stated the staff lost putee) sling last and were not able to find sed she feels scared and the back of her leg on the right ansferred in the cross action sheet for the see) sling was observed			
	(RN-A) stated the mu should be used for Ro ordered for her. RN-A legged sling was in us	ltipurpose (amputee) sling			

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
					c	
		00238	B. WING			3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO	ORTH		
			E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	÷ 33	2 830			
	resident that had an a and was not sure if the changed the sling. He so care sheet (undated transfers but did not so During an interview on RN-A stated that nurse assessment for the tywas done by the there. A physical therapy as indicated the staff was (amputee)sling and less taff to follow in the result of the education nurse, assistants (NA)'s were legged sling and not a She stated no training about which sling was the nurse's decision. During an observation cradle full body sling of R11 was transferred by	above the knee amputation, e aides or a nurse had e verified that the aide group d) noted for R11 "hoyer" for specify the type of sling. In 11/6/18. at 8:15 a.m., sing did not do an appe of sling to be used, that apy department. Sessment dated 10/19/18, as to use the multipurpose of posted information for the esident's room. In during an interview with she stated nursing e trained with the cross a cradle or amputee sling. In a full on 11/5/18, at 2:38 p.m. a was observed in the room. In on 11/5/18, at 2:38 p.m. a was observed in the room.				
	under R11 in the whe from the wheelchair to up in the lift, R11 was the left. The cross leg	d sling which had been elchair. R11 was transferred to the bed as R11 was raised off center and leaning to a straps were in 2 different				
	-	R11 complained of with NA- A on 11/6/18, at she was told that the sling				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00238	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	·	11100/2010
		NEW HOP	E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 34	2 830		
	for R11 had gone to the cross legged sling was that she was trained in sling for amputee resi was decided by a nur that the cross legged last Wednesday. An interview with RN-revealed that R11 was the day before and R1 transferred R11 safely	the laundry and the other as to be used. She stated not to use a cross legged idents and didn't know if it se to use it. She verified sling had been in use since A on 11/6/18, at 8:48 a.m. s brought a cradle lift sling N-A observed that the staff y. RN-A was aware R11 that gged sling and it had been			
	reassessment or notice and benefits for the u	onote on change of sling, ce to resident of the risks se of a cross legged sling. and benefits of refusing the			
	was interviewed and sling should not be us resident with an abov	e the knee amputation. She ald determine the type of resident was safely			
	slings for amputee re- multipurpose or hourg sling did not cross be The facility policy date	ecommendations for use of sidents included a glass sling. A multipurpose tween the resident's legs. ed 10/2010, directed staff to are plan for special needs,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SUR COMPLETE		
					С	
		00238	B. WING	·	11/08/	2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
NORTH R	IDGE HEALTH AND REH	AB	ONE AVENUE N PE, MN 55428	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	The director of nursin review and revise as procedures related to and therapeutic diets. could provide training these policies and proassessment and assurandom audits of train and complete dining reproper delivery of pre	OD FOR CORRECTION: g (DON) or designee could necessary the policies and mechanical lift transfers The DON or designee for all appropriate staff on ocedures. The quality urance committee could do sfers to ensure compliance oom audits to ensure	2 830			
2 850	Proper Nursing Care; Subp. 2. Criteria for oproper care. The crit adequate and proper D. Assistance wit of all residents as ne and well-groomed. This MN Requirement by: Based on observation review, the facility fail clean clothing was proper care.	determining adequate and eria for determining	2 850	Corrected.	1:	2/18/18

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С		
		00238	B. WING		11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NORTH R	IDGE HEALTH AND REHA	AB	ONE AVENUE NO	ORTH		
	_	NEW HOR	PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
2 850	Continued From page	36	2 850			
	hemiplegia obtained find Data Set (MDS) dated MDS indicated R31 has cognition, had both ship problems and required assistance of one to the dressed and personal R31's care plan dated had an ADL deficit reladementia and decreased directed staff to provide with personal hygienes. On 11/4/18, 5:37 p.m. on the wheelchair in the noted to have scruffy	nort and long term memory d physical extensive wo staff with getting I hygiene. I 11/2/18, identified R31 ated to right hemiplegia, sed mobility. The care plan de assistance of one staff				
		.m. R31 was observed by on dressed up and the ained.				
	interview when asked with ADL's family mer not make sure R31 hawas not shaved daily. was able to take care and took pride in mak	a.m. during a telephone I if R31 received assistance mber (FM)-A stated staff did ad clean clothes and R31 FM-A stated when R31 of himself he shaved daily cing sure he was well self respected himself."				
	standing beside R31 i	.m. FM-A was observed in the television lounge ned R31 was observed still				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE A/ENUE NORTH NEW HOPE, MN 55428 (X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC DENTIFYING INFORMATION) 2 850 Continued From page 37 with scruffy facial hair and around his mouth was dried food and the shirt had both dried and wet spills of food. When approached FM-A stated he had just arrived at the facility to find R31 that way and was rrustrated with the staff with not making sure R31 was well groomed and had clean clothing. FM-A stated the family had brought in a shaver but did not know where it was and if and when they shaved R31 as R31 was not well kept most of the time. On 11/6/18, at 2:29 p.m. registered nurse (RN)-K verified R31 was unshaved, had food around his mouth and the shirt on the front left side had dried and wet yellow food spills. RN-K stated she would have R31 cleaned right away. RN-K further stated all residents were supposed to be assisted with cares and staff were to make sure residents were cleaned properly after meals and were well groomed as she reminded staff all the time. On 11/7/18, at 2:26 p.m. the director of nursing stated residents were supposed to be provided cares as directed by the care plan and residents were supposed to be well groomed and have clean clothing.	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428 CALL DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LOC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LOC IDENTIFYING INFORMATION			00000					
NORTH RIDGE HEALTH AND REHAB S430 BOONE AVENUE NORTH NEW HOPE, MN 55428 (X4) 10			00238	B. WING		11/08/2	018	
NORTH RIDGE HEALTH AND REHAB NEW HOPE, MN 55428 (A4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 850 Continued From page 37 with scruffy facial hair and around his mouth was dried food and the shirt had both dried and wet spills of food. When approached FM-A stated he had just arrived at the facility to find R31 that way and was frustrated with the staff with not making sure R31 was well groomed and had clean clothing. FM-A stated the family had brought in a shaver but did not know where it was and if and when they shaved R31 as R31 was not well kept most of the time. On 11/6/18, at 2:29 p.m. registered nurse (RN)-K verified R31 was unshaved, had food around his mouth and the shirt on the front left side had dried and wet yellow food spills. RN-K stated she would have R31 cleaned right away. RN-K further stated all residents were supposed to be assisted with cares and staff were to make sure residents were cleaned properly after meals and were well groomed as she reminded staff all the time. On 11/7/18, at 2:26 p.m. the director of nursing stated residents were supposed to be provided cares as directed by the care plan and residents were supposed to be well groomed and have	NAME OF PE	ROVIDER OR SUPPLIER						
CX4) ID REFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PRE	NORTH RI	DGE HEALTH AND REH	AB		ORTH			
with scruffy facial hair and around his mouth was dried food and the shirt had both dried and wet spills of food. When approached FM-A stated he had just arrived at the facility to find R31 that way and was frustrated with the staff with not making sure R31 was well groomed and had clean clothing. FM-A stated the family had brought in a shaver but did not know where it was and if and when they shaved R31 as R31 was not well kept most of the time. On 11/6/18, at 2:29 p.m. registered nurse (RN)-K verified R31 was unshaved, had food around his mouth and the shirt on the front left side had dried and wet yellow food spills. RN-K stated she would have R31 cleaned right away. RN-K further stated all residents were supposed to be assisted with cares and staff were to make sure residents were cleaned properly after meals and were well groomed as she reminded staff all the time. On 11/7/18, at 2:26 p.m. the director of nursing stated residents were supposed to be provided cares as directed by the care plan and residents were supposed to be well groomed and have	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	O BE	COMPLETE	
SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one	2 850	with scruffy facial hair dried food and the sh spills of food. When a had just arrived at the and was frustrated wi sure R31 was well gro clothing. FM-A stated shaver but did not knowhen they shaved R3 most of the time. On 11/6/18, at 2:29 powerified R31 was unsumouth and the shirt of dried and wet yellow the would have R31 clear stated all residents were cares as directed by the were supposed to be clean clothing. SUGGESTED METH The director of nursine educate responsible stresidents' dependant residents' comprehent DON or designee could be dependent resident compressonal hygiene needs.	and around his mouth was inthad both dried and wet approached FM-A stated her afacility to find R31 that way the the staff with not making borned and had clean the family had brought in a cow where it was and if and the family had so well kept the staff with not well kept the staff with not making borned and had clean the family had brought in a cow where it was and if and the family had food around his in the front left side had food spills. RN-K stated she had food spills. RN-K stated she had rere to make sure residents by after meals and were well inded staff all the time. I.m. the director of nursing the supposed to be provided the care plan and residents well groomed and have OD OF CORRECTION: g and/or designee could staff to provide care to on facility staff, based on sively assessed needs. The ald conduct audits of ares to ensure their distance in the staff was are met consistently.	2 850	DEFICIENCI)			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE	
NORTH R	IDGE HEALTH AND REH	AB	OONE AVENUE N OPE, MN 55428	ORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 850	Continued From page	: 38	2 850		
	(21) days.				
2 895	MN Rule 4658.0525 S of Motion	Subp. 2.B Rehab - Range	2 895		12/18/18
	deformities through p motion must be imple Based on the compre assessment, the direct	ed toward prevention of ositioning and range of mented and maintained. hensive resident of nursing services levelopment of a nursing			
	receives appropriate t	a limited range of motion treatment and services to tion and to prevent further motion.			
	by: Based on observation review, the facility fail motion services in ordinal maintain range of motions.	t is not met as evidenced n, interview and document ed to provide range of der to prevent a decrease or tion (ROM) for 1 of 1 wed for limitations in range		Corrected.	
	Findings include:				
	contracture, hemipleg dementia obtained fro Data Set (MDS) dated MDS indicated R108	luded left hand and wrist gia, muscle weakness and om the quarterly Minimum d 9/7/18. In addition, the had functional limitation in side on his upper and lower			

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winnesou	<u>a Department of Healtl</u>	<u>n</u>			-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		00228	B. WING		
		00238	B. WING		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		5430 BO	ONE AVENUE NO	ORTH	
NORTH R	IDGE HEALTH AND REH	AB	PE, MN 55428		
			1 L, WIN 33420		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
		,		DEFICIENCY)	
0.005			0.005		
2 895	Continued From page	e 39	2 895		
	P108's care plan date	ed 9/1/18, indicated R108			
	had limited physical r				
		<u> </u>			
	cerebrovascular accid	` ,			
	hemiplegia. The care	-			
		as tolerated with daily care.			
		dicated R108 frequently			
		e to attempt to provide the			
		r extremity, hand and wrist.			
	-	indicated R108 was to wear			
	a palm protector in the	ne left hand as tolerated and			
	indicated it was okay	to remove the palm			
	protector for skin care	e, bathing and per R108's			
	request.				
	On 11/4/16, from 4:42	2 p.m. to 7:09 p.m. R108's			
		st his abdomen with the			
	_	d tightly clenched into a			
	_	s no splint or rolled wash			
		8's left hand. When R108			
	· ·	d open his hand and stretch			
	out his fingers he stat				
	out his lingers he star	ted it fidits.			
	On 11/5/19 from 10:0	00 a.m. to 1:20 p.m. R108's			
	· ·	d resting on a armrest			
		Ichair. His left hand was			
		a fist. There was no splint or			
	-	lace in R108's left hand			
	during the observatio	n.			
	On 11/6/18, from 9:40				
	,	A)-E and registered nurse			
	(RN)-K provided R10	8 morning care. They did			
	not offer or provide R	OM, nor was the palm			
	protector applied to the	ne left contracted hand.			
	From 10:03 a.m. to 1				
		se (LPN)-D applied cream			
	T	ed him and applied a light			

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STATE FORM 6899 WOFB11 If continuation sheet 40 of 76

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I DAN OF CONNECTION		A. BUILDING: _		COMPLETED		
			B. WING		C	
		00238	B. WING		11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
NORTH R	IDGE HEALTH AND REH	AB	ONE AVENUE NO	DRTH		
040.5	CLIMMA DV CT		PE, MN 55428	DROVIDERIC DI ANI OF CORRECTION	1 075	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
2 895	Continued From page	e 40	2 895			
	sweat shirt but neither of them offered the hand palm protector for the left contracted hand nor offered passive ROM.					
	hand palm protector happlied to R108. LPN signed it off on the tre record as she though LPN-D then stated shalm proctor to R108'	ne was going to apply the 's left contracture. At 1:58 ed R108 and applied the				
	-At 1:59 p.m. NA-E stated R108 was supposed to have the palm protector on the left contracted hand but he forgot to apply it that morning because he had a lot to do. NA-E further acknowledged he had not offered or completed ROM that shift.					
	-At 2:00 p.m. LPN-D stated NA-E was supposed to do passive ROM or at least offer and if R108 refused he was supposed to let her know. On 11/8/18, at 12:35 p.m. RN-I stated the NA's were supposed to complete ROM and apply the palm protector as directed by the care plan and the assignment sheet. Surveyor requested a copy of the ROM documentation/charting.					
	On 11/8/18, at 4:30 p.m. no ROM documentation was provided.					
	October 2010, directed medical record the date	Exercise policy revised ed staff to document in the ate, time, the type of ROM and how long the exercise				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING:		
		A. BOILDING.			
		00238	B. WING		C 11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
NORTH R	IDGE HEALTH AND REH	AB	ONE AVENUE NO	DRTH	
			PE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 895	Continued From page	e 41	2 895		
	was conducted.				
	The director of nursin all residents at risk fo they are receiving the treatment/services to director of nursing or random audits of the appropriate care and to reduce the risk for	OD OF CORRECTION: g or designee, could review r contractures to assure e necessary prevent contractures. The designee, could conduct delivery of care; to ensure services are implemented; contracture development. CORRECTION: Twenty-one			
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	2 900		12/18/18
	of nursing services m development of a nur provides that:	ent assessment, the director ust coordinate the sing care plan which enters the nursing home			
	pressure sores unles condition demonstrate	s the individual's clinical			
	receives necessary t	o has pressure sores reatment and services to vent infection, and prevent loping.			
	This MN Requiremen	t is not met as evidenced			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			-			
		00238	B. WING		11/0	8/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORTH R	DGE HEALTH AND REH	5430 BOOI	NE AVENUE N	ORTH		
NOKITIK	DOE HEAETH AND REIN	NEW HOPI	E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 900	Continued From page	: 42	2 900			
2 900	Based on observation review, the facility fail residents (R81, R31) pressure ulcers received failure of the facility to turning and positionin actual harm, when R8 stage II pressure ulces skin with exposed der Findings include: R81 did not receive a 11/7/18, for over three new, stage II, pressure R81's quarterly minimassessment dated 8/3 including: dementia was Alzheimer's disease, neuromuscular dysfur	n, interview and document ed to ensure 2 of 5 identified at risk for yed timely repositioning. The o consistently implement a g program resulted in 81 acquired three (3) new ers (partial-thickness loss of emis). position change on e hours and acquired three ee ulcers. num data set (MDS) 80/18, identified diagnoses rith Lewy bodies, muscle weakness	2 900	Corrected.		
	toileting, bed mobility	paired cognition and istance of two staff with and transfers. The MDS was frequently incontinent				
ı		refusal of care behaviors.				
	for impaired skin integ and incontinence. The had a history of a pre- and had a potential for development related to incontinence. The car- had a stage 2 pressur- left buttocks. The care	-				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00238	B. WING		11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		5430 BO	ONE AVENUE N			
NORTH R	IDGE HEALTH AND REH	AB	PE, MN 55428			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
2 900	Continued From page	e 43	2 900			
	arasa an the assayıv	and left buttacks. The care				
	-	and left buttocks. The care provide assistance with				
		ning at least every 2 hours				
	and more often as ne	-				
	On 11/5/18 at 9:58 a	.m. when asked if R81 had				
	,	family member (FM)-B				
		lso stated the pressure				
		outtocks, that R81 was not				
		h, and that R81 was left to				
	sit on her buttocks "fo					
	During continuous ob	servation on 11/7/18, from				
	_	., the following observations				
		observed to lay on the				
		ping. At 7:50 a.m. nursing				
		t past R81's room but did				
	not offer repositioning					
	remained asleep on t					
	attempts by staff to re	eposition (3 hours and 15				
	minutes), at which tim	ne the surveyor intervened				
	and alerted licensed p	oractical nurse (LPN)-E.				
	Nursing assistant (NA	A)-F was interviewed on				
	<u></u>	NA-F stated he did not				
		31 had been repositioned as				
		hat morning. At 9:52 a.m.,				
		1 and cued her they were				
	going to check, chang	ge and reposition her. At				
	9:54 a.m. (3 hours an	id 29 minutes after last				
	repositioning), NA-F	and NA-M turned R81 to the				
	left side. R81's incont	tinent pad was saturated				
	with urine and three o	ppen bleeding areas were				
		wer buttock, with two other				
	areas on the right but	tock. In addition, a foam				
	dressing was observe	ed around the coccyx.				
	At 10:02 a.m. on 11/7	7/18, LPN-E was observed				

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
		00238	B. WING		11/08/2	2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORTH R	IDGE HEALTH AND REH	AB	IE AVENUE NO	ORTH		
	- I	NEW HOPE	, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE 0	(X5) COMPLETE DATE
2 900	Continued From page	2 44	2 900			
	to remove the old dre area to the coccyx. Lf bleeding wounds and the nurse manager kr said in the meantime, foam dressing until th contacted to obtain a open areas. At 10:05 would have expected and repositioned accessid if the NAs were repositioning in a time supposed to let her kn During a follow up into a.m. on 11/7/18, NA-F	ssing revealing an open PN-E measured the three stated she was going to let now about them. LPN-E she was going to apply a e physician could be treatment for the other a.m. LPN-E stated she R81 to have been turned ording to the care plan. She not able to complete ely manner, they were				
	· · · · · · · · · · · · · · · · · · ·					
	During review of the N	Nursing Daily Pressure				

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00238 B. WING 11/08/20 ⁴		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	OF PROVIDER OR SUPPLIER	
NORTH RIDGE HEALTH AND REHAB 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	TH RIDGE HEALTH AND F	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTION TAGES TO SHOULD BE CORRECTION	EFIX (EACH DEFICI	
ind interest in the state of th	Injury Documenta 11/1/18, and 10/3 four dates the coor an open area. On indicated there was buttock. The documentation of the wound bed to tissue/character are edges and surrou. On 11/7/18, at 10: wound documentated for the passing had been doing the stated they were stated th	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00238		B. WING		C 11/08/2018		
	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA IE AVENUE NO E, MN 55428		1.002010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 900	(DON) stated she had than two months and working on various castated wound assessic clinical coordinators whaving the whole interest the DON further state risk for pressure ulcerepositioned at least edirected by the care pure the facility's Skin Interest to prevent pressure injuries unless to prevent pressure injuries unlessed to prevent new ulcers from the services consistent with prevent new ulcers from the prevent new ulcers from the prevent new ulcers from the prevent and long term in required total physical t	m. the director of nursing dispense at the facility for less was in the process of are concerns. The DON ments were something the were working on as well as rdisciplinary team round. The edit residents who were at the swere supposed to be every two hours or as colan. The edit residents who were at the swere supposed to be every two hours or as colan. The edit residents who were at the swere supposed to be every two hours or as colan. The edit residents who were at the swere supposed to be every two hours or as colan. The edit receive care, assional standards of practice every supposed in the edit of the edi	2 900			
ı	R31's care plan dated	I 11/2/18, identified a risk				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:	
					С
		00238	B. WING		11/08/2018
		00200			11/00/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
5430 BOONE AVENUE NORTH					
NORTH R	IDGE HEALTH AND REH	AB NEW HOF	E, MN 55428		
	0.111114171477		1	DD0///DEDIG D/ AM OF GODDEGTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	` ,
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
0.000	0 " 15	4	0.000		
2 900	Continued From page	9 47	2 900		
	for skin breakdown di	ue to bladder and bowel			
		e loss and decreased			
	_	n directed staff to offer			
	repositioning every tw	o hours and as needed.			
		continuously observed			
		l:34 a.m. (5 hours and 9			
	minutes). At 7:50 a.m	. nursing assistant (NA)-F			
	approached R31, tilte	d the wheelchair back and			
	left R31 in the televisi	on lounge. At 8:41 a.m. the			
	registered dietician (F	RD) wheeled R31 to the			
	- '	1 ate and was assisted			
		ning room for an activity			
	_	ntil 11:20 a.m. when the			
		At 11:20 a.m., NA-F stated			
		unit at 7:50 a.m. he had			
		evision lounge and had			
		pack and at the same time			
		legs. When asked if that			
		orm of repositioning, NA-F			
		cated it helped a resident			
		-F stated he did not know			
	when R31 had been r	epositioned last as the			
	night shift had gotten	him up. At 11:40 a.m.,			
	NA-F and NA-I were	observed to use a			
	mechanical lift to get	R31 onto the bed. R31's			
	brief was observed to	be wet from urine.			
	On 11/7/18, at 2:02 p.	.m. registered nurse (RN)-I			
		to have tissue relief of at			
	least two minutes for				
		neant a resident had to be			
		urface. RN-I verified R31			
		hour repositioning schedule			
	_				
	and starr were suppos	sed to follow the care plan.			
	On 11/7/18, at 2:26 p.				
	residents who were a	t risk for pressure ulcers			

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			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
00238		B. WING		C 11/08/2018	
					11/00/2010
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA ONE AVENUE NO		
NORTH R	IDGE HEALTH AND REH	AB	ONE AVENUE NO PE, MN 55428	אנח	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 900	Continued From page	e 48	2 900		
	were supposed to be two hours or as direct asked what she cons	repositioned at least every ted by the care plan. When idered to be appropriate N stated a resident needed			
	The director of nursin all residents at risk fo they are receiving the treatment/services to from developing and pressure ulcers. The designee, could cond delivery of care; to enservices are implement pressure ulcer development.	prevent pressure ulcers to promote healing of director of nursing or uct random audits of the sure appropriate care and nted; to reduce the risk for			
2 910	(14) days. MN Rule 4658.0525 S Incontinence	Subp. 5 A.B Rehab -	2 910		12/18/18
	have a continuous promanagement to reduce unnecessary use of a comprehensive reside home must ensure the A. a resident who without an indwelling unless the resident's that catheterization we B. a resident who receives appropriate	o enters a nursing home catheter is not catheterized clinical condition indicates			

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO E, MN 55428	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
2 910	Continued From page much normal bladder		2 910			
	by: Based on observatior review the facility faile for 2 of 7 residents (R			Corrected.		
	admitted on 8/3/18, w weakness, essential I diabetes, morbid obe fibrillation, and major of Minimum Date Set					
	indicated R224 had "e bowel incontinence", included assisting her hours and as needed and management of p. Review of the Nursing movement evaluation "based upon the 3 da continent, with the an based upon the voiding the source of the second provides and the second provi	g 3 day voiding/ bowel dated 9/4/18, indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAN OF CONNECTION		A. BUILDING: _		COMPLETED	
00238		B. WING		C 11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	DRESS, CITY, STA	TE. ZIP CODE	11/00/2010
		5430 BOO	NE AVENUE N		
NORTH R	IDGE HEALTH AND REH	AB	E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 910	Continued From page	e 50	2 910		
	Bladder Incontinence indicated R224 had unot of recent onset.	Evaluation dated 10/8/18, rinary frequency that was			
	indicated she was column with a small pad but a removed in the facility	1/05/18, at 1:30 p.m., R224 Intinent of bladder at home Ifter her catheter was If the staff told her to "go in cated she had never been			
	offered the commode	or assistance into the tell the staff after she went			
	On 11/7/18, at 10:00 a.m., registered nurse (RN)-B indicated she would talk to R224 to see who had told her to "go in her diaper" and stated when a urinary catheter was discontinued, a three day assessment was completed and retraining should have been attempted, and verified R224 lacked retraining after the urinary catheter was removed.				
	hemiplegia, obtained dated 8/8/18. In addit had severely impaired and long term memor dependent on two sta The MDS further iden	uded aphasia, dementia and from the quarterly MDS ion the MDS indicated R31 d cognition, had both short by problems and was totally lift for toileting and transfers. Intified R31 was always and bowel and was not on			
	hemiplegia, dementia The care plan directe down via a mechanic	d 11/2/18, identified er and bowel related to and decreased mobility. d staff to assist R31 to lay al lift to check and change pon rising, after meals,			

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Minnesot	<u>a Department of Healtl</u>	<u>n</u>			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		00000	B. WING		
		00238	B: Will (11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		5430 BO	ONE AVENUE NO	ORTH	
NORTH R	IDGE HEALTH AND REH	AB NEW HO	PE, MN 55428		
	OLIMANA DV OT		<u> </u>	PROMINERIO DI ANI OF CORRECTIO	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	` '
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
2 910	Continued From page	2 51	2 910		
2 310	Continued From page	501	2 3 10		
	before bed and as ne	eded.			
	On 11/7/18, R31 was	continuously observed			
	from 6:25 a.m. unit 1	1:34 a.m. (5 hours and 9			
	minutes). At 7:50 a.m	n. nursing assistant (NA)-F			
	approached R31 from	n the back, tilted the			
	wheelchair back and	left R31 in the television			
	lounge. At 8:41 a.m. t	the registered dietician (RD)			
	_	heelchair to the dining room			
		in the dining room until			
		f wheeled him to the main			
		tivity. R31 remained in the			
	activity until 11:20 a.r				
	-	a.m. NA-F stated when he			
		50 a.m., he had noticed			
		lounge and had tilted the			
	wheelchair back and	•			
		s. NA-F confirmed he had			
	_	nged R31 after breakfast.			
		rought R31 into the room,			
	and with assistance fi	•			
		R31 onto the bed. R31's			
	brief was saturated w	in urine.			
	DOALS disams sees in al.	und and all a managements a suitable of a su			
	_	uded dementia with Lewy			
	· ·	lisease, muscle weakness			
		lysfunction of bladder,			
	I	arterly MDS dated 8/30/18.			
		ndicated R31 had severely			
	impaired cognition an	· · · · · · · · · · · · · · · · · · ·			
		ff with toileting, bed mobility			
	and transfers. The MI	DS further indicated R31 did			
	not refuse cares and	was frequently incontinent			
	of bladder and bowel				
	R81's care plan dated	d 9/12/18, identified R81			
		adder and bowel related to			

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00238	B. WING		C 11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	11/00/2010
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO E, MN 55428	DRTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 910	immobility, obesity, codementia. The care pon rising, after meals, needed. On 11/7/18, R81 was from 6:25 a.m. to 9:54 minutes). During the R81's room until at 9: approached licensed indicated R81 had no changed since 6:25 a.m. to 9:54 a.m. nursing a did not know the last checked and changed that morning. At 9:52 R81 and cued her the change and reposition At 9:54 a.m. which was of continuous observaturned R81 to the left was saturated with ur wet. At 10:05 a.m. LPN-E expected the NA's to R81 according to the not able to get it comp supposed to let her kill.	continuously observed 4 a.m. (3 hours and 15 observation no staff went to 40 a.m. when surveyor practical nurse (LPN)-E and t been checked and .m. assistant (NA)-F stated he time R81 had been d as he had come in late a.m. NA-F approached ey were going to check, h her and R81 stated "yes." as 3 hours and 29 minutes ation NA-F and NA-M side. R81's incontinent pad ine and her skin was visibly stated she would have turn, reposition and toilet care plan and if they were oleted timely they were	2 910	DEFICIENCY)	
	actual working sched	.m. RN-I reviewed the ule and verified R81 was am from the beginning of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	STREET A 5430 BO	DDRESS, CITY, STA ONE AVENUE N PE, MN 55428		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
2 910	the shift. RN-I stated was confused if he w On 11/7/18, at 2:02 p stated residents were directed by the care p On 11/7/18, at 2:26 p (DON) stated all residence and change provided cares as directed and change provided cares as directed and change provided cares as directed and bladder assessm procedures, educate ensure compliance. The ensure staff are educated plan.	there was no reason NA-F as assigned to assist R81. .m. registered nurse (RN)-I e supposed to be toileted as olan. .m. the director of nursing dent's who required to be d were supposed to be ected by the care plan. OD OF CORRECTION: g could review/revise bowel	2 910		
21015	in the operation of the times.	ary conditi	21015		12/18/18
	by: Based on observation review the facility faile	n, interview and document ed ensure food stored in perly dated and labeled in 4		Corrected.	

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21015 Continued From page 54 of 6 refrigerators and failed to ensure 5 of 6 refrigerators, 1 of 1 freezer, 1 of 2 microwaves, 2 of 2 stainless steel storage cabinets, and 1 of 2 cereal carts were clean. Findings include: On 11/04/18, at 11:48 a.m. the initial tour of the kitchen and kitchenette was conducted with the executive chef (EC). The walk in freezer did not have a thermometer on the inside. The EC got one right away and placed it in the freezer. On the floor of the walk in freezer were pieces of paper debris. In the walk in cooler there was an open bag of hard boiled eggs that was not marked with the date open. There was also a meat sandwich wrapped in plastic wrap that was not marked with the date prepared. The floor of the walk in cooler had debris and smears of dark gray substance on the floor. The EC was asked how often the floors were swept and mopped.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NORTH RIDGE HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES. (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21015 Continued From page 54 of 6 refrigerators and failed to ensure 5 of 6 refrigerators, 1 of 1 freezer, 1 of 2 microwaves, 2 of 2 stainless steel storage cabinets, and 1 of 2 cereal carts were clean. Findings include: On 11/04/18, at 11:48 a.m. the initial tour of the kitchen and kitchenette was conducted with the executive chef (EC). The walk in freezer did not have a thermometer on the inside. The EC got one right away and placed it in the freezer. On the floor of the walk in freezer were pieces of paper debris. In the walk in cooler there was an open bag of hard boiled eggs that was not marked with the date open. There was also a meat sandwich wrapped in plastic wrap that was not marked with the date prepared. The floor of the walk in cooler had debris and smears of dark gray substance on the floor. The EC was asked how often the floors were swept and mopped.			00238	B. WING			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21015 Continued From page 54 of 6 refrigerators and failed to ensure 5 of 6 refrigerators, 1 of 1 freezer, 1 of 2 microwaves, 2 of 2 stainless steel storage cabinets, and 1 of 2 cereal carts were clean. Findings include: On 11/04/18, at 11:48 a.m. the initial tour of the kitchen and kitchenette was conducted with the executive chef (EC). The walk in freezer did not have a thermometer on the inside. The EC got one right away and placed it in the freezer. On the floor of the walk in freezer were pieces of paper debris. In the walk in cooler there was an open bag of hard boiled eggs that was not marked with the date open. There was also a meat sandwich wrapped in plastic wrap that was not marked with the date prepared. The floor of the walk in cooler had debris and smears of dark gray substance on the floor. The EC was asked how often the floors were swept and mopped.	NORTH RIDGE HEALTH AND REHAB 5430 BOO			IE AVENUE NO			
of 6 refrigerators and failed to ensure 5 of 6 refrigerators, 1 of 1 freezer, 1 of 2 microwaves, 2 of 2 stainless steel storage cabinets, and 1 of 2 cereal carts were clean. Findings include: On 11/04/18, at 11:48 a.m. the initial tour of the kitchen and kitchenette was conducted with the executive chef (EC). The walk in freezer did not have a thermometer on the inside. The EC got one right away and placed it in the freezer. On the floor of the walk in freezer were pieces of paper debris. In the walk in cooler there was an open bag of hard boiled eggs that was not marked with the date open. There was also a meat sandwich wrapped in plastic wrap that was not marked with the date prepared. The floor of the walk in cooler had debris and smears of dark gray substance on the floor. The EC was asked how often the floors were swept and mopped.	PREFIX	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE	
The EC was unsure, but another kitchen staff member stated the staff tried to sweep and mop it twice a week. At 11:59 a.m. a second walk in freezer was inspected and the floor of that freezer was dirty. In the kitchen there were two metal storage cabinets for kitchen equipment, bowls, and utensils. Both cabinets had debris on the all the shelves and smears of grease or a white substance on the outside of the doors. Immediately following the main kitchen the 2 west kitchenette was inspected with the EC. A stack of pre-sliced cheese was loosely wrapped in plastic wrap. The plastic wrap was not sealed	21015	of 6 refrigerators and refrigerators, 1 of 1 fro of 2 stainless steel stocereal carts were clear carts were carts wer	failed to ensure 5 of 6 eezer, 1 of 2 microwaves, 2 orage cabinets, and 1 of 2 an. B a.m. the initial tour of the te was conducted with the The walk in freezer did not on the inside. The EC got acced it in the freezer. On oracle freezer were pieces of ralk in cooler there was an eed eggs that was not open. There was also a oracle din plastic wrap that was late prepared. The floor of oracle debris and smears of dark ee floor. The EC was asked overe swept and mopped. Out another kitchen staff aff tried to sweep and mop and walk in freezer was or of that freezer was or of the doors.	21015	DET OFFICE OF THE PROPERTY OF		

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STATEMEN	T OF DEFICIENCIES DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	11/00/2010	
		5430 BOO	NE AVENUE NO			
NORTH R	IDGE HEALTH AND REH	AB NEW HOP	E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
	placed in the refrigera Nutritional Supplement The label indicated the kept for 3 days after to on the container indice from the freezer and properties. The bottom of the refrigered juice spill. A carted dispensers was cover around the dispenser second shelf there was At 12:36 p.m. the kitch inspected. There was	chenette on 3 west was an open bag of Sysco				
	interior bottom of the spills. At 12:45 p.m. the Bri was inspected. A cart thick supplement drin The microwave had a turn table and food sp. At 4:54 p.m. with cook itchenette refrigerate third shelf in the back not dated. C-A put the The inside of the refrijuice spills. C-A state responsible for cleanion on 11/06/18, at 10:08 kitchen and kitchenet dietary director (DD), freezer there were five	k (C)-A the Bridgeway back or was inspected. On the was a dish of fruit that was e dish in the dirty dish rack. gerator was also dirty with d housekeeping was				

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Minnesot	<u>a Department of Health</u>	1			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
			D 14/11/0		С
		00238	B. WING	<u>-</u>	11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		5430 BOO	NE AVENUE N	ORTH	
NORTH R	DGE HEALTH AND REH	AB NEW HOP	E, MN 55428		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
1/40			170	DEFICIENCY)	
21015	Continued From page	÷ 56	21015		
		range brown substance			
	· · · · · · · · · · · · · · · · · · ·	c. The DD stated the food			
		off the plastic and the floor			
		lking coolers should be			
	•	nily. The floor of the walk-in			
		nd had paper scraps on it. ts were still smears on the			
		on the shelves. The DD			
	stated all food going i				
		d appropriately and marked			
		expiration date. The DD			
	•	esponsible for making sure			
		and dated appropriately.			
		e inspected immediately			
	after the kitchen. The				
	refrigerator still had ju	ice spills on the inside			
	bottom and the cart w	rith the dry cereal			
	dispensers was still c	overed with cereal crumbs,			
	dust and debris. The	3 west kitchenette			
	-	irty with juice spills on the			
		ors on Bridgeway Front and			
	Back still contained ju	iice spills.			
	On 11/7/18, at 2:23 p	.m. the DD stated the			
		onsible for the cleaning of			
	the refrigerators. She	<u> </u>			
		ess, but the staff had not			
	been following it. The	DD stated the kitchen staff			
	were responsible for t	he cleaning of the kitchen			
	•	s. The DD also stated the			
		ponsible for making sure all			
	open food got marked				
	opened or used by da	ite.			
	A malian fam al a a ::	of the a medicine metallic const			
		of the refrigerators was			
	requested, but not red	ceived.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED	
		00229	B. WING		4.	C
		00238	B. Will (1	1/08/2018
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
NORTH R	IDGE HEALTH AND REH	AB	OONE AVENUE NOR OPE, MN 55428	TH		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
21015	Continued From page	e 57	21015			
	The administrator with services or designee (as necessary the poli regarding kitchen sandietary or designee (sall appropriate staff or procedures. The directions of the services of the servi	sitation. The director of s) could provide training for in these policies and ctor of dietary or designee ssure staff are cleaning the CORRECTION:				
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 3 Tuberculosis	21426			12/18/18
	maintain a comprehe infection control progressive tuberculosis it issued by the United Control and Preventic Tuberculosis Eliminat Morbidity and Mortalit This program must in infection control plan unpaid employees, coresidents, and volunted Health shall provide to regarding implemental	ram according to the most infection control guidelines. States Centers for Disease on (CDC), Division of iton, as published in CDC's by Weekly Report (MMWR). It clude a tuberculosis that covers all paid and intractors, students, eers. The Department of echnical assistance ation of the guidelines.				

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wiinnesoi	a Department of Healtr	1	1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					l c	
		00238	B. WING		1	3/2018
			1		1 11100	5/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
NORTH R	IDGE HEALTH AND REH	5430 BOO	NE AVENUE N	ORTH		
NOINT IN	DOL HEALIN AND KEN	NEW HOP	E, MN 55428			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIAIE	DATE
				,		
21426	Continued From page	e 58	21426			
	This MN Requiremen	t is not met as evidenced				
	by:	t le net met de evidenced				
	•	nd document review, the		Corrected.		
		a program in place to read		0 5 11 5 5 15 15 15 15 15 15 15 15 15 15		
	•	ts in a consistent manner to				
		ntoux's were read in the				
		er receiving their Mantoux's				
		. The lack of a consistent				
	•	esident's Mantoux's affected				
	5 of 5 residents (R213					
	R147) whose Mantou					
		esidents (R147) reviewed				
	did not have a two ste	, ,				
	Findings include:					
	Five random residents	s were reviewed for				
		ng. Five of five residents did				
		steps one and two were				
		ive a two step Mantoux				
		eived step on one day and				
	then the Mantoux was	s read the following day not				
	leaving enough time f	or a correct reading of the				
	Mantoux.					
	R213 was admitted to	the facility on 8/25/17.				
	R213 was screened f	or signs and symptoms of				
		18. R213 had the first step				
		no time documented when				
	_	n 9/12/18, there was no				
		read. Results of the step 1				
		ve and 0.0 indentation. The				
		was done on 9/24/18 at				
	4:00 p.m. and read or	n 9/26/18, there was no				
	documented time who	en read. The results of the				

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second step Mantoux were negative and 0.0

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Minnesot	a Department of Health	<u>1</u>	1			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (DI CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETEU
			5 14": 15		1	С
		00238	B. WING		11/	/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
NODTUD	IDOE HEALTH AND DEH	5430 BC	ONE AVENUE NO	RTH		
NORTHR	IDGE HEALTH AND REH	NEW HO	OPE, MN 55428			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG			140	DEFICIENCY)		
21426	Continued From page	<u> 50</u>	21426			
21420		. 55	21420			
	induration.					
	D005	. H f: :h 44/07/47				
		o the facility on 11/27/17. or signs and symptoms of				
		/17. R225 had the first				
		2/17, at 2:00 p.m. and				
		re was no documentation				
		f the step 1 Mantoux were				
	_	ntation. The second step				
		n 12/26/17, at 12:00 p.m.				
		, there was no documented				
		results of the second step				
	Mantoux were negative	ve and 0.0 induration.				
	R178 was admitted to	o the facility on 1/5/18.				
		or signs and symptoms of				
		18. R178 had the first step				
		at 7:30 p.m. and read on				
		documentation when read.				
	•	Mantoux were negative and				
		second step Mantoux was				
	done on 3/9/18, at 9:1					
	*	documented time when				
	were negative and 0.0	ne second step Mantoux				
	were negative and o.	o madration.				
	R241 was admitted to	o the facility on 9/24/18.				
		or signs and symptoms of				
	tuberculosis on 9/24/	18. R241 had the first step				
		at 3:00 p.m. and read on				
	· ·	documentation when read.				
	I	Mantoux were negative and				
		second step Mantoux was				
	done on 10/9/18, at 6	:45 p.m. and read on o documented time when				
	· ·	ne second step Mantoux				
	were negative and 0.0					
	,		1			1

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00238	B. WING		C 11/08	8/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
NODTU D	DOE HEALTH AND DEH	5430 BOO	NE AVENUE NO	ORTH		
NORTHR	IDGE HEALTH AND REH	NEW HOP	E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	Continued From page	e 60	21426			
	R147 was admitted to R147 was screened of tuberculosis on 9/16// Mantoux on 9/30/18, given and read on 10/documentation when Mantoux were negative second step Mantoux. Registered nurse (RN 11/8/18, at 11:19 a.m. findings. In addition, Fhad a designated staff Mantoux's but there weread resident Mantoux was read our reading of Mantoux at two step Mantoux cor survey, RN-H was the officer for one month Control Officer was not the facilities Tubercu Administration and Inskin Tests policy was qualified nurse or hear interpret the TST forty	of the facility on 9/16/18. of r signs and symptoms of 18. R147 had the first step no time documented when /2/18, there was no read. Results of the step 1 we and 0.0 induration. The was not done. 1)-H was interviewed on, and confirmed the above RN-H stated that the facility ff member to read employee was no one designated to x's. RN-H agreed that R214 atside of the time frame for and R147 did not have the mpleted. At the time of a interim Infection Control since the previous Infection to longer at the facility. Ilosis Screening - terpretation of Tuberculin revised on 12/09. A althcare practitioner will y-eight (48) to seventy-two histration. All test results				
	The Director of nursin review and revise polistaff and monitor to as (TST) are read, result given and read, and a	OD OF CORRECTION: ng and/or designee could icies and procedures, train ssure Tuberculin Skin Tests as documented with time assure that residents are osis (TB) using a symptom				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	5430 BO	DONE AVENUE NOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21426	State regulations.	a single step IGRA	21426		
21435	home must provide an recreation program. based on each individual strengths, and needs meet the physical, mewell-being of each rescomprehensive reside comprehensive planto 4658.0400 and 4658 provided opportunities	requirements. A nursing on organized activity and organized must be designed to cental, and psychological sident, as determined by the cent assessment and of care required in parts of contact of contact organized in parts.	21435		12/18/18
	by: Based on observation review the facility faile	t is not met as evidenced n, interview and document ed to provide activity 1 resident (R82) reviewed		Corrected.	
	R82's Activity Assessi indicated it was very i participate in her favo	mportant to her that she			

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/0	8/2018
NORTH RIDGE HEALTH AND REHAB		5430 BOOM	RESS, CITY, STANE AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21435	assessment identified included: religious se music, books, newspanimals. R82's quarterly minimindicated she was seand required extensive toileting and bed mobes 8/4/18, indicated she activities. The care plane R82 to activities and in ail care, special evetime. The care plan in kind of music. R82's activity participand included the folloom 8/7/18 to 8/31/18, R8 one activities, 2 groupdirected activity. 9/1/18 to 9/30/18, R8 one activities, one groupdirected activity. 9/1/18 to 10/9, R82 attendance. The activity attendance activity processes	I activities of interest that rvices, group activities, apers, group activities and a num data set dated 8/31/18, werely cognitively impaired re assistance for transfers, sility. R82's care plan dated was dependent on staff for an directed staff to escort dentified her preferences as nts, church and toddler adicated R82 enjoyed any activites: 2 participated in 2 one to programs and one self 2 participated in 2 one to pup activity and one television. That no documented activity are was requested through vided after 10/9/18. attendance lacked evidence	21435			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00238	B. WING		11	C / 08/2018	
	ROVIDER OR SUPPLIER	5430 BO	DDRESS, CITY, STAT ONE AVENUE NO PE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21435	reclining chair in the truits station on the reclining chair until 9:: At 11:35 a.m. R82 wain the hallway outside p.m. she was asleep iroom. On 11/6/18, at 7:33 a. a blue reclining chair the unit. R95 appeare leaning on her left sid arm rest of the chair. the way back. R95 sti 9:29 a.m. At 1:09 p.m. R82 again nurses station alone. On 11/7/18, at 6:50 a. R82 to remain seated "I've ben sitting here staff member stated," to fall." On 11/7/18, at 6:24 a. wheel chair in the connurses station. R82 si sitting just like this at suburing interview on 1 registered nurse (RN) participate in activities She stated she usuall R82 used to have a tagent and tagen	m. R95 was asleep in a elevision room outside the unit. R95 remained in the 26 a.m. s asleep in her wheel chair the nurses station. At 1:29 in a wheel chair in her m. R95 was again lying in in the television room on d to be asleep. She was e with her head lying on the The chair was reclined all ill remained in the chair at in was seated outside the in her chair. R82 replied, ever since I got up." The 'I know but I don't want you m. R82 was seated in a mon area outside the supper time."	21435				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		00238	B. WING		1.	C 1/08/2018
	ROVIDER OR SUPPLIER	5430 BC	ADDRESS, CITY, STATE, DONE AVENUE NOR DPE, MN 55428		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21435	R82 liked to comb he and stated the table upon it. During interview on 1 licensed practical nur didn't really do anythicabout activities R82 wonce in a while she withink they don't take hone to one." LPN-B significant box in her roomused to comb her hair On 11/7/18, at 1:55 pito sit and comb her hicomb it all day. RN-Kitable in front of her.	r hair and do her makeup used to have those things 1/6/18, at 2:27 p.m. rse (LPN)-B stated R82 rg. She stated if asked would say no and stated yould go. LPN-B stated, "I her because she would be a tated R82 used to have a m that contained items she	21435			
21610	The activity director of systems of ensuring a residents. The Activity appropriate staff and to ensure ongoing continue PERIOD FOR 0 Twenty-One (21) day	CORRECTION:	21610			12/18/18
21010	and Preparation Area Subpart 1. Storage of must store all drugs in		21010			12/10/10

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		11/0) 8/2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
NORTH R	IDGE HEALTH AND REH	AB .	ONE AVENUE N PE, MN 55428	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21610	by: Based on observation review, the facility fails medications between (F) in 1 of 5 medicatio the facility failed to remedications from medication carts, whise residents residing on (TCU), first floor south second floor north we Findings include: On 11/8/18 at 9:00 a.r. E verified the first sour refrigerator temperature temperature was not 1 range (36 - 46 degree indicated the refrigerational than 36 degrees F. 25 Stored in the refrigerationsulin for R89, and 2 Novolog flex pens for influenza vaccine. RN would be called to adjuited.	t is not met as evidenced i, interview and document ed to store refrigerated 36 - 46 degrees Fahrenheit in refrigerators. Additionally, move expired stock dication storage on 4 of 9 ch had the potential to affect the transitional care unit in, third floor north and st. m., registered nurse (RN)- th west medication are log indicated the kept within the allowable as F). Review of the log stor temperature was less times in the last 26 days. stor were 17 vials Lantus Levemir flex pens and 11 R51, and 11 vials of E indicated maintenance ust the temperatures	21610	Corrected.		
	with licensed practical following medications	on 11/5/18, at 10:32 a.m. I nurse (LPN)-A, the were found to be expired: 10 tablet bottle, one fourth				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
		00238	B. WING		C 11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		5430 BO	ONE AVENUE NO	ORTH	
NORTHR	IDGE HEALTH AND REH	NEW HO	PE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21610	Continued From page	e 66	21610		
		-			
	wing medication cart with registered nurse medications were fou -Vitamin E 400 iu 100 8/18Optic-vits with lutein expired 6/18Fexofenadine hcl tab 1/2 full, expired 10/18 -Magnesium oxide 50 full expired 10/18Aspirin 325 mg, 100 expired 1/18Calcium 600 mg +40 bottle, 3/4 full, expired	36 tabs bottle, 1/2 full 36 tabs bottle, 1/2 full blet 180 mg, 30 tab bottle 3. 30 mg, 100 tablet bottle, 3/4 tablet bottle, 3/4 full, 30 iu vitamin D, 60 tablet d 10/18. verified by RN-D, as being d did not think any			
	medication cart on 11 LPN-B, the following be expired: -Calcium 600 mg, 150 expired 10/18 -Magnesium oxide 50 full expired 6/18 -Zinc sulfate 220 mg, expired 9/18	orage review of 3 north near /8/18 at 8:44 a.m., with medications were found to 0 tablet bottle, full bottle, 00 mg, 100 tablet bottle, 3/4 100 tablet bottle, 1/2 full, 00 softgel bottle, full bottle,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018
	ROVIDER OR SUPPLIER	5430 BO	DDRESS, CITY, STAT ONE AVENUE NO PE, MN 55428	•	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21610	expired 5/18 -Naproxen 220 mg 10 expired 6/18 All medications were stock medications, ar residents were currer medications. During medication sto north medication cart with LPN-C, the follow found to be expired: -Magnesium oxide 50 expired 10/18. All medications were stock medications. Review of facility's dis medication policy dat 12. Expired medicati state or contract phar Review of the facility' policy dated 2007 ind 9. Medications require stored in a refrigerate at the nurses; station Medication must be s and must be labeled SUGGESTED METH The director of nursin develop and implement related to staff keeping	100 softgel bottle 1/4 full, 20 tablet bottle, 1/4 full, verified by LPN-B as being and did not think any antly receiving these prage review of 2 west far on 11/8/18, at 9:14 a.m. wing medications were 20 mg, 100 tablets, 1/2 full, verified by LPN-C as being scarding and destroying ed 2012: ons will be disposed of per macy guidelines. s storage of medication dicated: ring refrigeration must be or located in the drug room or other secured location. stored separately from food	21610		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
			7 BOILBING.		C	
		00238	B. WING		11/08	3/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE NO E, MN 55428	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21610	all nursing staff relate importance of securin quality assessment at could perform random compliance. TIME PERIOD FOR (21) days.	e, could provide training for d to staff about the g the medication carts. The nd assurance committee n audits to ensure	21610			
21695	provide housekeeping necessary to maintair comfortable interior, in ceilings, registers, fixt and furnishings.	ation, & Maintenance sing. A nursing home must g and maintenance services	21695			12/18/18
	by: Based on observation review, the facility fail environment that was in good repair in room and failed to assure we free from debris for the R103) who resided in Findings include:	n, interview and document ed to maintain an clean, free from odors and ns 132, 282, 390, 247, 338 wheel chairs were clean and ree residents (R31,R54,		Corrected.		
	was noted that room	g unit in the room was				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		00238	B. WING		11/08/2018
		00200			11/00/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
NODTH D	IDGE HEALTH AND REH	5430 BOO	NE AVENUE N	ORTH	
NORTH	IDOL HEALIH AND KEH	NEW HOP	E, MN 55428		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
21695	Continued From page	e 69	21695		
	In room 282 a feedin	g pump stand base was			
		wn dried on substance. The			
	_	observed on the carpet. In			
		gouges in the sheet rock			
		n room 390 there were			
	, ,	s stacked in the room. In			
		foul odor detected in the			
		nere were gouges in the			
		, R31, and R54 had soiled			
	wheelchairs.				
	Op 11/9/19 at 0:42 a	m the maintenance			
	On 11/8/18, at 9:42 a				
	, ,	nmental services director			
	(ESD), and communit	-			
		with the surveyor to interview			
		ns noted on 11/7/18. In			
		nance director (MD) stated			
	-	ne rooms were checked for			
		e MD stated the facility had			
		air quality coming out of the			
	_	D stated he would check			
	the room with the me	ter after the tour.			
	In room 202 the ECC) stated the stand and			
		sibility of housekeeping to			
	•	called a housekeeper to			
	_	aning the feeding tube			
		et. In room 247 the MD			
		e checked regularly for			
		eeds. The MD stated no			
		completed for that room.			
		repairs were needed the			
		d out a work order and the			
	maintenance departm	3			
	completed as soon as	s possible. The ESD was			
	shown R103's, R31's	, and R54's wheelchairs			
	and asked if there wa	s a system for cleaning the			
	wheelchairs. The ESI	D stated a system was being			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 11/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
NORTH R	DGE HEALTH AND REH	5430 BOO	NE AVENUE NO	ORTH		
HOKITIK	DOE HEAETH AND REIL	NEW HOP	E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21695	Continued From page	: 70	21695			
	worked on, but she wolean the wheelchairs gouges in the wall. Ag would do an inspection make sure the walls with room 390 there was boxes and bags were ESD stated it was diffused because the resident leave. The ESD state discussion with the so interdisciplinary team cleaning room 390. At 11/8/18, at 11:23 at the staff was expecte request on the compuciening or maintenant.	ould get the housekeeper to a Room 338 also had gain the MD stated he on of all the rooms and were repaired and painted. As still a foul odor and the cluttering the room. The ficult to clean room 390 told the housekeepers to d she had not had a pocial worker or to come up with a plan for the administrator stated d to fill out a maintenance				
	how to complete the reduring orientation.	maintenance requests				
		2014, indicated facility staff completing a work order				
	administrator, mainted environmental service ensure a preventative developed and the sta importance of informing environmental service were needed. The face	e director, or designee could e maintenance schedule was aff were educated on the ng maintenance and/or es of cleaning or repairs that bility could report those assurance performance				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S COMPL	
		00238	B. WING		11/0)8/2018
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
NORTH R	IDGE HEALTH AND REH	AB	OONE AVENUE NOF OPE, MN 55428	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21695	Continued From page	e 71	21695			
	recommendations to compliance.	ensure ongoing				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21800	MN St. Statute144.65 Residents of HC Fac		21800			12/18/18
	and residents shall, a there are legal rights their stay at the facilit of treatment and main	on about rights. Patients at admission, be told that for their protection during by or throughout their course intenance in the community				
	and that these are de accompanying writter applicable rights and					

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relating to vulnerable adults.

this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557,

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					C
		00238	B. WING		11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE N	ORTH	
	I		E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21800	Continued From page	: 72	21800		
	by: Based on observation review, the facility fail residents (R175) reviewas provided privacy facility. In addition, fail	ewed for dignity concerns		Corrected.	
	Findings include:				
	from the quarterly Mir dated 10/5/18. In add R175 required extens for activities of daily li getting dressed and palso indicated R175 h R175's care plan date dependence on staff the related to cognitive definition.	uscle weakness obtained nimum Data Set (MDS) ition, the MDS indicated ive assist of one to two staff ving (ADL's) including personal hygiene. The MDS had not rejected cares.			
	sitting in a wheelchair with her shirt over her were hanging out of the residents, staff and vince observation nursing a across from R175 was cover R175 until surve	m. R175 was observed that the dining room table thead. R175's bare breasts the bra exposed to other sitors. During the ssistant (NA)-G was sitting tching television, but did not eyor questioned her. During were nine residents in the			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					l c	
		00238	B. WING		1	3/2018
NAME OF D	2011252 02 011251 155	070557.40	DDE00 0171/ 074	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NORTH RI	DGE HEALTH AND REH	AB	NE AVENUE N	DRIH		
		NEW HOP	PE, MN 55428			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
		,		DEFICIENCY)		
21800	Continued From page	73	21800			
21000	Continued From page	<i>51</i> 3	21000			
	_	luding two male resident's				
	right across the table	from R175.				
		.m. R175 was observed				
		nair by the nursing station.				
		ed over her head and her				
		posed again. At this time				
		75 from the front then went				
		led her down the hallway ed to the back nursing				
	·	proximately 200 meters. As				
		our other residents were				
	•	and looked at R175. NA-H				
		who put this on this woman.				
		you can get her ready." At				
	-	ached R175 and adjusted				
		d as he wheeled R175 to				
	her room.					
	At 7:09 p.m. when as	ked about the observation				
		noticed R175 was exposed				
	•	wheeled her out of the area				
	to the unit. When ask					
	· ·	stated he was not assigned				
		why he had brought her				
	back to the unit for NA	A-I to put her to bed.				
	On 11/6/19 at 2:00 =	m registered pures (DN) I				
	· ·	.m. registered nurse (RN)-I ct the staff to redirect, divert				
	•	s this was not dignified to				
	leave R175 in that ma	•				
	ieave ix i / O iii tiiat iiia	aiiiGi.				
	On 11/6/18 at 2:40 n	.m. the director of nursing				
	-	idents belong to all staff				
		have covered her and				
	removed her from the					
	dignified of staff to do					
	dignified of staff to do	that."				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00220	B. WING		C
		00238	D. 71110		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
NORTH R	IDGE HEALTH AND REH	AB	NE AVENUE N	ORTH	
	OLIMANA DV. OT		E, MN 55428	DDOWNERIO DI AM OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21800	Continued From page	e 74	21800		
	Dignified dining expe	rience:			
	R95's significant char indicated she was set and required extensive care plan dated 10/1/deficit and indicated shoods independently wher and directed staff. Review of a facility Prindicated R95's intake excellent, however has R95 was unable to contake was now 0-25°. During observation on R95 was seated in the assisting her to eat mand pureed quiche. Ron the table and nurs moving items out of hNA-J assisted R95 to R95 continued to reackept placing the cup of then used a spoon to together on her plate, her juice and NA-J coher reach. NA-J fed Fitogether food. When a second spoonful, RAt 12:48, NA-J moved without offering her and During interview on 1 registered nurse (RN)	nge MDS dated 8/31/18, verely cognitively impaired re assistance to eat. R95's 18, identified a self care she could eat some finger when staff handed them to to feed all other foods. regress Note dated 11/5/18, e had previously been ad been lower recently. As ommunicate, unsure why %. In 11/8/18, at 12:43 p.m. e dining room with staff rashed potatoes and gravy 195 was reaching for things ing assistant (NA)- J was her reach. At 12:45 p.m. drink a small sip of juice. In the cup and NA-J pout of R95's reach. NA-J mix all of R95's reach. NA-J mix all of R95's reach of the mixed NA-J attempted to feed R95 195 turned her head away. In the cup and R95 away from the table nymore food or fluids.			
	mixture on R95's plat "100% not ok to mix f	e. RN-A stated it was ood together." RN-A further			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		00238	B. WING		11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA		
NORTH R	IDGE HEALTH AND REH	AB	IE AVENUE NO E, MN 55428	UKIN	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21800	stated R95 should habefore leaving the tab At 12:53 p.m. NA-J in problem with mixing F stated she mixed up a ate. NA-J stated R95 she wanted all of her asked about the fluids her some juice." SUGGESTED METHOM The administrator, directly designee could develocate by the interdiscipal residents dignity is be could update policies staff on these change ensure resident(s) dig could be completed, a are reviewed by the operformance improve could ensure compliant.	ve been offered more fluids ble. dicated she did not see a R95's food together and all her own food when she was not able to tell her if food mixed together. When s, NA-J responded, "I gave OD OF CORRECTION: ector of nursing (DON), or op and implement a plan of olinary team to ensure sing maintained. The facility and procedures, educate is, and audit periodically tognity are maintained. Audits and results of these audits quality assessment and ment (QAPI) committee	21800		

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