Electronically delivered

July 14, 2021

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

RE: CCN: 245183
Cycle Start Date: June 25, 2021

Dear Administrator:

On June 25, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 29, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 29, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 29, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 29, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, North Ridge Health And Rehab will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 29, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. 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), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro A District Office
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: jamie.perell@state.mn.us
Office: (651) 245-8094

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 - Health Regulation Division 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE 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 December 25, 2021 if your facility does not

achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 06/25/2021

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

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F 000	INITIAL COMMENTS On 6/23/21, through 6/25/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5183338C (MN74027), with a deficiency cited at F684. The following complaint was found to be UNSUBSTANTIATED, however, related deficiencies were cited: H5183340C (MN74045), with a deficiency cited at F684. The following complaints were found to be UNSUBSTANTIATED: H5183337C (MN60323) H5183339C (MN57785) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		7/21/21

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

Electronically Signed | 07/15/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct through skin assessments to identify and initiate treatment for a worsening skin condition for 1 of 3 residents (R1) reviewed for skin conditions. This resulted in actual harm for R1 when he developed a wound infection to an open wound on his right underarm which required antibiotic treatment and daily wound dressings. In addition, the facility failed to conduct neurological assessments after a fall with a head injury for 1 of 3 residents (R5) reviewed for falls. Findings include: SKIN CONDITION R1's Face Sheet printed 6/25/21, indicated R1's diagnosis included chronic respiratory failure, acute myocardial infarction (heart attack), morbid obesity, and recent cardiac arrest. R1's admission Minimum Data Set (MDS) dated 6/11/21, indicated R1 was cognitively intact. R1 required limited assistance with dressing, bathing, and personal hygiene. No skin issues were noted on R1's MDS.	F 684	R1 has discharged from the facility. R5□s neuro evaluation has been completed. All current residents have received a thorough skin assessment, if skin alterations noted, appropriate treatment initiated in accordance with the MD orders and protocol. Current residents who fall with noted head injury are receiving a neurological assessment. Neuro check protocol has been reviewed and updated. In conjunction with the facility Medical Director, the following protocol was initiated for neuro checks: Complete neurological assessment post fall with head injury, daily X 3 days. If a fall is unwitnessed, the resident will be assessed for evidence of a head injury such as statement, “I hit my head”, or physical signs such as abrasion, swelling, ecchymosis. If evidence of head injury, neurological assessments will be initiated. An assessment was created for Point Click Care and the assessment reflects the updated protocol.	

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F 684	Continued From page 2 R1's hospital wound initial assessment note dated 5/17/21, indicated R1 had a wound to his right upper medial arm which was caused by extravasation (leakage of fluid) of unknown intravenous (IV) fluids. The wound measured 12 centimeters (cm.) by 13 cm. 40 percent of the wound contained an open blister with red/purple tissue beneath it. The remainder of the wound was a deep purple color in the center which gradually faded to red on the outer wound. The outer portion of the wound was ecchymotic (bruise), flat, and warm. There was serosanguinous (pink colored) drainage an no odor. R1's hospital wound assessment note dated 6/2/21, indicated R1 had wound to his right upper medial arm. The wound base had dark non-viable tissue which appeared to be partial thickness. The outer wound had resolving erythema. Bloody serious drainage was noted. The assessment note lacked wound measurements. Mepilex dressings were being applied to the wound. R1's admission skin assessment dated 6/4/21, indicated R1 had a "scar" to his right inner forearm. R1's care plan dated 6/7/21, did not identify R1 had any wounds. R1's Skin and Wound Evaluation forms dated 6/11/21, and 6/18/21, indicated R1's skin was "intact." A progress note dated 6/19/21, at 8:17 p.m. indicated R1 had a 2.5 cm. by 2.5 cm. wound under his right arm. Black tissue was noted in the middle of the wound. Redness was noted to	F 684	Nursing staff have been re-educated regarding thorough skin assessments, identifying, monitoring, and initiating appropriate treatment. Nursing staff have been educated regarding new neurological assessment protocol post fall with head injury. The DON or designee will audit 5 skin assessments for 3 weeks, then 3 skin assessments for 2 weeks, then one skin assessment weekly for 2 weeks. The DON or designee will audit 5 falls for 3 weeks and 3 falls for 2 weeks and then one fall for 2 weeks to ensure neurological assessments are completed as appropriate.	

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"encircle" the wound. The wound was noted to have "yellowish drainage", no odor, and warm to touch. The area was cleaned, and a foam dressing was applied. The progress notes further indicated R1 verbalized the wound was from, "the site the IV was." A nurse practitioner was notified and an order for Keflex (antibiotic) 500 milligrams (mg) was obtained.

A nurse practioner progress note dated 6/19/21, at 10:20 a.m. indicated R1 had an open area under his right arm which was warm to touch and the tissue surrounding the wound was reddened. The wound measured 3 cm. by 2.5 cm. The center of the wound was dark and necrotic (dead tissue). R1 had a small to moderate amount of pus draining from the wound. The nurse practitioner progress notes further indicated the wound had "worsened." R1 was ordered an antibiotic which included Keflex 500 mg 3 times daily for 7 days. Further, the wound was to be cleaned and covered with gauze. The dressing was to be changed daily and as needed.

R1's skin and wound evaluation dated 6/21/21, indicated R1 had a wound to his right upper arm which was present upon admission. The skin and wound evaluation indicated the wound was present 6/4/21, and measured 3.5 cm by 3.0 cm. The wound depth was 0.8 cm. The wound contained 40 percent slough (dead tissue separating from living tissue) and 60 percent eschar (a dry dark scab or falling away of dead skin). The wound was noted to have redness and inflammation. A moderate amount of serosanguineous drainage was noted. "Moderate" odor was also noted. Tissue which surrounded the wound was noted to be reddened. Further, it was noted the wound was caused by

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extravasation of IV fluids and R1 had "no wound care orders on admission." Education was provided to the nurse who documented "scar" upon R1's admission.

A facility complaint/grievance report dated 6/21/21, indicated family member (FM)-A had a concern regarding a wound on R1's right upper arm. An investigation revealed R1 had extravasation on 6/2/21, and there were not treatment orders upon R1 being admitted to the facility. The report further indicated extravasation had a natural progression which would progress to an ulceration in one to three weeks. The facility obtained treatment orders on 6/19/21, when the area of "decompensation was noted."

A wound audit report dated 6/24/21, indicated R1 had a right upper medial arm extravasation from an IV. R1 had dark non-viable tissue which was lifting from the wound. The wound audit report further indicated skin alterations, such as R1's, often progressed to a dry/black eschar in one to two weeks. The wound then sloughs and reveals an ulcer. R1 had "no wound care orders on admission" and R1's wife noticed the wound when visiting."

During an interview on 6/23/21, at 12:00 p.m. R1 stated he developed a right upper arm wound when hospitalized, however, it had improved. R1 stated four to five days after admission to the facility he smelled an odor coming from his right arm, however, was unable to visualize the area. R1 stated he was showered at the facility on 6/11/21, and 6/18/21, and was able to wash himself. R1 stated he required a nursing assistant to rinse the soap off of him. R1 stated no one completed a full skin assessment during the

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showers and he felt "rushed" by staff. R1 stated no one paid attention to the wound on his right upper arm until his wife told staff on 6/19/21. R1 stated on 6/19/21, licensed practical nurse (LPN)-A cleaned the wound and called the doctor. R1 stated LPN-A was concerned when she looked at the wound and verbalized R1 could not wait to see the doctor.

During an interview on 6/23/21, at 12:30 p.m. LPN-A stated residents were to receive a head-to-toe skin assessment on their scheduled bath day. LPN-A explained a head-to toe skin assessment involved looking at all skin surfaces which included skin folds. LPN-A stated on 6/19/21, R1's wife was cutting his toenails and smelled an odor. LPN-A stated R1's wife checked the wound on R1's right arm and informed her of the skin concern. LPN-A stated the wound was 2.5 cm. by 2.5 cm., and it was draining a yellow substance and smelled. LPN-A stated she asked registered nurse (RN)-F (who completed R1's skin assessments on 6/11/21, and 6/18/21) about R1's wound. LPN-A stated RN-F verbalized he was unaware R1 had a wound.

During an interview on 6/23/21, at 2:27 p.m. RN-F stated he received documentation from R1's hospital stay and checked R1's admission orders. RN-F described a thorough skin assessment as checking every inch of the body. RN-F stated he conducted skin assessments for R1 on 6/11/21, and 6/18/21 as it was "missed by the unit staff." RN-F stated he was unable to remember if he looked under R1's arms during the skin assessments and he was, "surprised" when he learned of R1's wound. RN-F then stated he was not "triggered" to look under R1's arms and R1 denied pain or concern. RN-F stated on 6/19/21,

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F 684	Continued From page 6 R1's wife requested to speak with a nurse. RN-F stated he asked LPN-A to speak with R1's wife as his shift had ended. RN-F stated he had not seen a wound like R1's in 15 years and he changed R1's right upper wound dressing on 6/20/21. R1 stated the wound had a moderate amount of dark red secretions and was unable to assess the wound depth related to a large area of dead tissue which covered the wound. During an interview on 6/25/21, at 9:55 a.m. RN-H stated she conducted R1's admission skin assessment on 6/4/21. RN-H stated she found a bruise on R1's right upper and the area looked like a scar. RN-H stated R1 told her the wound originated when hospital staff performed cardiopulmonary resuscitation (CPR). RN-H stated she touched R1's wound and asked R1 if he felt pain. RN-H stated R1 responded he usually did not look at the wound, but it was there. RN-H stated R1 denied pain. During an interview on 6/25/21, at 12:28 p.m. RN-G stated staff were expected to complete a comprehensive head-to-toe assessment and focus on areas which may lead to skin breakdown. RN-G further explained staff were expected to focus their comprehensive skin assessment on a resident's groin, coccyx, heels, and shoulder blades. RN-G stated RN-H failed to correctly identify R1's wound. RN-G stated she provided education to RN-H using online resources and pictures due to the wound misidentification. RN-G stated she was, "100 percent confident" R1's wound developed from a clear skin assessment on 6/18/21, to an open area on 6/19/21, which measured 2.5 cm. x 2.5 cm. and drained a yellow substance.	F 684		

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F 684	Continued From page 7 During an interview on 6/25/21, at 1:32 p.m. nurse practitioner (NP)-B stated R1's would had been unlikely to develop in one day from a negative skin assessment on 6/18/21. NP-B stated a wound was caused by medication leaking into R1's tissue and broke down blood vessels and blood supply which caused some sort of nerve injury. NP-A stated the nerve injury impacted R1's ability to feel pain. During an interview on 6/25/21, at 3:13 p.m., the director of nursing (DON) started RN-H had documented a scar located on R1's lower right arm. The DON stated her expectation was for nursing to document what they had saw and contact a nurse manager with any questions or concerns. The DON described R1's wound as "red surrounding tissue" and an open ulceration with an irregular boarder. The DON stated there was an area of slough and non-viable tissue. The DON stated R1's wound was caused when IV medication leaked into the surrounding skin tissue. The DON stated R1 wound would worsen over time before appearing on the surface. The DON was unable to verify if R1's wound had gotten worse. Although R1 was discharged from the hospital with a partial thickness wound to his right upper medial arm the facility failed to identify, monitor, and implement interventions to prevent a wound infection. The facility was unaware of the wound until prompted by R1's representative 15 days later. R1's wound was subsequently found to be infected and required antibiotic treatment. The facility policy Admission Assessment and Follow Up: Role of Nurse - Guidelines effective 5/21, directed "Contact the Attending Physician to	F 684		

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	245183	A. BUILDING _____ B. WING _____	C 06/25/2021

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F 684	Continued From page 8	F 684		

communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings."
NEUROLOGICAL ASSESSMENT

R5's Face Sheet dated 6/25/21, indicated R5's diagnosis included cognitive communication deficit, difficulty walking, weakness, and unsteadiness on feet.

R5's annual Minimum Data Set (MDS) dated 6/7/21, indicated R5 was cognitively intact. R5 required extensive assistance with bed mobility and transfers. R5 utilized a wheelchair for locomotion.

R5's falls Care Area Assessment (CAA) dated 6/10/21, indicated R5 was assisted with activities of daily living (ADL) including bed mobility and transfers. R5 had two falls during review period with an abrasion and bruising.

R5's physician orders dated 6/24/21, included an order for enteric coated aspirin 81 milligrams. Staff was to administer 2 tablets daily for thrombosis (blood clot) prevention for 42 days following an orthopedic procedure.

R5's care plan dated 6/28/19, indicated R5 was at risk for falls due to deconditioning, gait/balance problems, and psychoactive drug use. The care plan directed staff to follow facility fall protocol.

R5's fall incident report dated 5/30/21, at 8:28 p.m. indicated R5 was found on the floor lying on his back. R5 was had an abrasion to the right side of his forehead. R5's initial neurological exam was negative.

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A progress note dated 5/30/21, at 11:29 p.m. indicated R5 was found on the floor lying on his back. R5 was transferred back to bed using a Hoyer lift. R5 was noted to have an abrasion to his right forehead. The progress notes further indicated staff would continue to monitor and the next shift was notified.

When interviewed on 6/15/21, at 12:10 p.m. registered nurse (RN)-A stated post-fall assessment included ongoing monitoring of vital signs, range of motion, and neurological assessments if a resident were to hit their head. RN-A stated neurological assessments should be conducted every two hours for the first eight hours. RN-A stated she needed to double-check further assessment timelines on the computer and progress notes were used to document neurological assessments. RN-A verified R5 had a fall on 5/30/21, and suffered a head abrasion. RN-A stated it was determined emergent care was not needed and R5's family and the nurse practitioner were updated. RN-A stated she cleaned R5's head and completed an initial neurological assessment for R5. RN-A stated it was almost the end of her shift, so she "probably" did not document the assessment findings. RN-A stated she communicated information related to R5's fall during report to night shift and requested "normal vitals" to be completed. RN-A stated she did not specifically ask for neurological assessments to be completed. RN-A confirmed she was not familiar with the facility neurological assessment protocol, however, she checked on R5 for the remainder of her shift. RN-A stated she did not document the checks.

When interviewed on 6/25/21, at 2:10 p.m. RN-B

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F 684	Continued From page 10	F 684		

stated she received report for R5 on 6/1/21, however, it was not communicated neurological assessments needed to be completed. RN-B stated if a resident had a fall with a head injury, a head-to-toe assessment which included vital signs, range of motion, and neurological assessments needed to be completed. RN-B stated neurological assessments were to be conducted post-fall for 24 to 72 hours and were done every two, four, and six hours progressively. RN-B stated the need for ongoing assessment needed to be communicated during shift report.

When interviewed on 6/25/21, at 2:17 p.m. RN-D stated staff were expected to complete post-fall neurological examinations if a resident hit their head. RN-D stated were to complete neurological assessments for 72 hours and document the findings in a resident's progress notes. RN-D reviewed R5's progress notes and verified she did not see neurological assessments documented.

When interviewed on 6/25/21, at 2:23 p.m. RN-C stated she was unaware of the facility policy regarding neurological assessments. RN-C stated neurological assessments were typically completed for 72 hours after a fall with a head injury. RN-C stated nurses were expected to complete neurological assessments.

When interviewed on 6/25/21, at 3:40 p.m. the director of nursing (DON) stated staff received falls training during orientation via an online education platform. The DON was unsure how often the training was provided. The DON stated the facility did not have a house protocol for neurological assessments.

When interviewed on 6/28/21, at 4:21 p.m. the

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F 684	Continued From page 11 medical director stated the facility would rely on a resident's initial assessment if there were no significant risk factors for a intracranial bleed. The medical director stated he would defer doing frequent neuro checks and would rather have the nurse most familiar with a resident to conduct reassessments at regular intervals; depend upon availability. The medical director stated the intervals could be anywhere from two to 24 hours as it was of greater clinical value than a subjective assessment competed by a staff-member who was unfamiliar with a resident. Facility policy titled Falls and Fall Risk, Managing F 689 dated 5/21, lacked indication of conducting neurological assessments after a fall with potential head injury.	F 684		

Electronically delivered
July 14, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: QO5J11

Dear Administrator:

The above facility was surveyed on June 23, 2021 through June 25, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro A District Office
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: jamie.perell@state.mn.us
Office: (651) 245-8094

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,

Kamala Fiske-Downing

Kamala Fiske-Downing

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/23/21, through 6/25/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5183338C (MN74027), with a deficiency cited at 0830. The following complaint was found to be UNSUBSTANTIATED, however, related deficiencies were cited: H5183340C (MN74045), with a deficiency cited at 0830. The following complaints were found to be UNSUBSTANTIATED: H5183337C (MN60323) H5183339C (MN57785) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		7/21/21

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2 830	Continued From page 3 by: Based on interview and document review, the facility failed to conduct through skin assessments to identify and initiate treatment for a worsening skin condition for 1 of 3 residents (R1) reviewed for skin conditions. This resulted in actual harm for R1 when he developed a wound infection to an open wound to his right underarm which required antibiotic treatment and daily wound dressings. In addition, the facility failed to conduct neurological assessments after a fall with a head injury for 1 of 3 residents (R5) reviewed for falls. Findings include: SKIN CONDITION R1's Face Sheet printed 6/25/21, indicated R1's diagnosis included chronic respiratory failure, acute myocardial infarction (heart attack), morbid obesity, and recent cardiac arrest. R1's admission Minimum Data Set (MDS) dated 6/11/21, indicated R1 was cognitively intact. R1 required limited assistance with dressing, bathing, and personal hygiene. No skin issues were noted on R1's MDS. R1's hospital wound initial assessment note dated 5/17/21, indicated R1 had a wound to his right upper medial arm which was caused by extravasation (leakage of fluid) of unknown intravenous (IV) fluids. The wound measured 12 centimeters (cm.) by 13 cm. 40 percent of the wound contained an open blister with red/purple tissue beneath it. The remainder of the wound was a deep purple color in the center which gradually faded to red on the outer wound. The outer portion of the wound was ecchymotic	2 830	Corrected	

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2 830	Continued From page 4 (bruise), flat, and warm. There was serosanguinous (pink colored) drainage an no odor. R1's hospital wound assessment note dated 6/2/21, indicated R1 had wound to his right upper medial arm. The wound base had dark non-viable tissue which appeared to be partial thickness. The outer wound had resolving erythema. Bloody serious drainage was noted. The assessment note lacked wound measurements. Mepilex dressings were being applied to the wound. R1's admission skin assessment dated 6/4/21, indicated R1 had a "scar" to his right inner forearm. R1's care plan dated 6/7/21, did not identify R1 had any wounds. R1's Skin and Wound Evaluation forms dated 6/11/21, and 6/18/21, indicated R1's skin was "intact." A progress note dated 6/19/21, at 8:17 p.m. indicated R1 had a 2.5 cm. by 2.5 cm. wound under his right arm. Black tissue was noted in the middle of the wound. Redness was noted to "encircle" the wound. The wound was noted to have "yellowish drainage", no odor, and warm to touch. The area was cleaned, and a foam dressing was applied. The progress notes further indicated R1 verbalized the wound was from, "the site the IV was." A nurse practitioner was notified and an order for Keflex (antibiotic) 500 milligrams (mg) was obtained. A nurse practioner progress note dated 6/19/21, at 10:20 a.m. indicated R1 had an open area under his right arm which was warm to touch and	2 830		

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2 830	Continued From page 5 the tissue surrounding the wound was reddened. The wound measured 3 cm. by 2.5 cm. The center of the wound was dark and necrotic (dead tissue). R1 had a small to moderate amount of pus draining from the wound. The nurse practitioner progress notes further indicated the wound had "worsened." R1 was ordered an antibiotic which included Keflex 500 mg 3 times daily for 7 days. Further, the wound was to be cleaned and covered with gauze. The dressing was to be changed daily and as needed. R1's skin and wound evaluation dated 6/21/21, indicated R1 had a wound to his right upper arm which was present upon admission. The skin and wound evaluation indicated the wound was present 6/4/21, and measured 3.5 cm by 3.0 cm. The wound depth was 0.8 cm. The wound contained 40 percent slough (dead tissue separating from living tissue) and 60 percent eschar (a dry dark scab or falling away of dead skin). The wound was noted to have redness and inflammation. A moderate amount of serosanguineous drainage was noted. "Moderate" odor was also noted. Tissue which surrounded the wound was noted to be reddened. Further, it was noted the wound was caused by extravasation of IV fluids and R1 had "no wound care orders on admission." Education was provided to the nurse who documented "scar" upon R1's admission. A facility complaint/grievance report dated 6/21/21, indicated family member (FM)-A had a concern regarding a wound on R1's right upper arm. An investigation revealed R1 had extravasation on 6/2/21, and there were not treatment orders upon R1 being admitted to the facility. The report further indicated extravasation had a natural progression which would progress	2 830		

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2 830	Continued From page 6 to an ulceration in one to three weeks. The facility obtained treatment orders on 6/19/21, when the area of "decompensation was noted." A wound audit report dated 6/24/21, indicated R1 had a right upper medial arm extravasation from an IV. R1 had dark non-viable tissue which was lifting from the wound. The wound audit report further indicated skin alterations, such as R1's, often progressed to a dry/black eschar in one to two weeks. The wound then sloughs and reveals an ulcer. R1 had "no wound care orders on admission" and R1's wife noticed the wound when visiting." During an interview on 6/23/21, at 12:00 p.m. R1 stated he developed a right upper arm wound when hospitalized, however, it had improved. R1 stated four to five days after admission to the facility he smelled an odor coming from his right arm, however, was unable to visualize the area. R1 stated he was showered at the facility on 6/11/21, and 6/18/21, and was able to wash himself. R1 stated he required a nursing assistant to rinse the soap off of him. R1 stated no one completed a full skin assessment during the showers and he felt "rushed" by staff. R1 stated no one paid attention to the wound on his right upper arm until his wife told staff on 6/19/21. R1 stated on 6/19/21, licensed practical nurse (LPN)-A cleaned the wound and called the doctor. R1 stated LPN-A was concerned when she looked at the wound and verbalized R1 could not wait to see the doctor. During an interview on 6/23/21, at 12:30 p.m. LPN-A stated residents were to receive a head-to-toe skin assessment on their scheduled bath day. LPN-A explained a head-to toe skin assessment involved looking at all skin surfaces	2 830		

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

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2 830	Continued From page 7 which included skin folds. LPN-A stated on 6/19/21, R1's wife was cutting his toenails and smelled an odor. LPN-A stated R1's wife checked the wound on R1's right arm and informed her of the skin concern. LPN-A stated the wound was 2.5 cm. by 2.5 cm., and it was draining a yellow substance and smelled. LPN-A stated she asked registered nurse (RN)-F (who completed R1's skin assessments on 6/11/21, and 6/18/21) about R1's wound. LPN-A stated RN-F verbalized he was unaware R1 had a wound. During an interview on 6/23/21, at 2:27 p.m. RN-F stated he received documentation from R1's hospital stay and checked R1's admission orders. RN-F described a thorough skin assessment as checking every inch of the body. RN-F stated he conducted skin assessments for R1 on 6/11/21, and 6/18/21 as it was "missed by the unit staff." RN-F stated he was unable to remember if he looked under R1's arms during the skin assessments and he was, "surprised" when he learned of R1's wound. RN-F then stated he was not "triggered" to look under R1's arms and R1 denied pain or concern. RN-F stated on 6/19/21, R1's wife requested to speak with a nurse. RN-F stated he asked LPN-A to speak with R1's wife as his shift had ended. RN-F stated he had not seen a wound like R1's in 15 years and he changed R1's right upper wound dressing on 6/20/21. R1 stated the wound had a moderate amount of dark red secretions and was unable to assess the wound depth related to a large area of dead tissue which covered the wound. During an interview on 6/25/21, at 9:55 a.m. RN-H stated she conducted R1's admission skin assessment on 6/4/21. RN-H stated she found a bruise on R1's right upper and the area looked like a scar. RN-H stated R1 told her the wound	2 830		

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2 830	Continued From page 8	2 830		

originated when hospital staff performed cardiopulmonary resuscitation (CPR). RN-H stated she touched R1's wound and asked R1 if he felt pain. RN-H stated R1 responded he usually did not look at the wound, but it was there. RN-H stated R1 denied pain.

During an interview on 6/25/21, at 12:28 p.m. RN-G stated staff were expected to complete a comprehensive head-to-toe assessment and focus on areas which may lead to skin breakdown. RN-G further explained staff were expected to focus their comprehensive skin assessment on a resident's groin, coccyx, heels, and shoulder blades. RN-G stated RN-H failed to correctly identify R1's wound. RN-G stated she provided education to RN-H using online resources and pictures due to the wound misidentification. RN-G stated she was, "100 percent confident" R1's wound developed from a clear skin assessment on 6/18/21, to an open area on 6/19/21, which measured 2.5 cm. x 2.5 cm. and drained a yellow substance.

During an interview on 6/25/21, at 1:32 p.m. nurse practitioner (NP)-B stated R1's would had been unlikely to develop in one day from a negative skin assessment on 6/18/21. NP-B stated a wound was caused by medication leaking into R1's tissue and broke down blood vessels and blood supply which caused some sort of nerve injury. NP-A stated the nerve injury impacted R1's ability to feel pain.

During an interview on 6/25/21, at 3:13 p.m., the director of nursing (DON) started RN-H had documented a scar located on R1's lower right arm. The DON stated her expectation was for nursing to document what they had saw and contact a nurse manager with any questions or

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2 830	Continued From page 9	2 830		

concerns. The DON described R1's wound as "red surrounding tissue" and an open ulceration with an irregular boarder. The DON stated there was an area of slough and non-viable tissue. The DON stated R1's wound was caused when IV medication leaked into the surrounding skin tissue. The DON stated R1 wound would worsen over time before appearing on the surface. The DON was unable to verify if R1's wound had gotten worse.

Although R1 was discharged from the hospital with a partial thickness wound to his right upper medial arm the facility failed to identify, monitor, and implement interventions to prevent a wound infection. The facility was unaware of the wound until prompted by R1's representative 15 days later. R1's wound was subsequently found to be infected and required antibiotic treatment.

The facility policy Admission Assessment and Follow Up: Role of Nurse - Guidelines effective 5/21, directed "Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings."

NEUROLOGICAL ASSESSMENT

R5's Face Sheet dated 6/25/21, indicated R5's diagnosis included cognitive communication deficit, difficulty walking, weakness, and unsteadiness on feet.

R5's annual Minimum Data Set (MDS) dated 6/7/21, indicated R5 was cognitively intact. R5 required extensive assistance with bed mobility and transfers. R5 utilized a wheelchair for locomotion.

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2 830	Continued From page 10 R5's falls Care Area Assessment (CAA) dated 6/10/21, indicated R5 was assisted with activities of daily living (ADL) including bed mobility and transfers. R5 had two falls during review period with an abrasion and bruising. R5's physician orders dated 6/24/21, included an order for enteric coated aspirin 81 milligrams. Staff was to administer 2 tablets daily for thrombosis (blood clot) prevention for 42 days following an orthopedic procedure. R5's care plan dated 6/28/19, indicated R5 was at risk for falls due to deconditioning, gait/balance problems, and psychoactive drug use. The care plan directed staff to follow facility fall protocol. R5's fall incident report dated 5/30/21, at 8:28 p.m. indicated R5 was found on the floor lying on his back. R5 was had an abrasion to the right side of his forehead. R5's initial neurological exam was negative. A progress note dated 5/30/21, at 11:29 p.m. indicated R5 was found on the floor lying on his back. R5 was transferred back to bed using a Hoyer lift. R5 was noted to have an abrasion to his right forehead. The progress notes further indicated staff would continue to monitor and the next shift was notified. When interviewed on 6/15/21, at 12:10 p.m. registered nurse (RN)-A stated post-fall assessment included ongoing monitoring of vital signs, range of motion, and neurological assessments if a resident were to hit their head. RN-A stated neurological assessments should be conducted every two hours for the first eight hours. RN-A stated she needed to double-check	2 830		

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further assessment timelines on the computer and progress notes were used to document neurological assessments. RN-A verified R5 had a fall on 5/30/21, and suffered a head abrasion. RN-A stated it was determined emergent care was not needed and R5's family and the nurse practitioner were updated. RN-A stated she cleaned R5's head and completed an initial neurological assessment for R5. RN-A stated it was almost the end of her shift, so she "probably" did not document the assessment findings. RN-A stated she communicated information related to R5's fall during report to night shift and requested "normal vitals" to be completed. RN-A stated she did not specifically ask for neurological assessments to be completed. RN-A confirmed she was not familiar with the facility neurological assessment protocol, however, she checked on R5 for the remainder of her shift. RN-A stated she did not document the checks.

When interviewed on 6/25/21, at 2:10 p.m. RN-B stated she received report for R5 on 6/1/21, however, it was not communicated neurological assessments needed to be completed. RN-B stated if a resident had a fall with a head injury, a head-to-toe assessment which included vital signs, range of motion, and neurological assessments needed to be completed. RN-B stated neurological assessments were to be conducted post-fall for 24 to 72 hours and were done every two, four, and six hours progressively. RN-B stated the need for ongoing assessment needed to be communicated during shift report.

When interviewed on 6/25/21, at 2:17 p.m. RN-D stated staff were expected to complete post-fall neurological examinations if a resident hit their head. RN-D stated were to complete neurological assessments for 72 hours and document the

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2 830	Continued From page 12 findings in a resident's progress notes. RN-D reviewed R5's progress notes and verified she did not see neurological assessments documented. When interviewed on 6/25/21, at 2:23 p.m. RN-C stated she was unaware of the facility policy regarding neurological assessments. RN-C stated neurological assessments were typically completed for 72 hours after a fall with a head injury. RN-C stated nurses were expected to complete neurological assessments. When interviewed on 6/25/21, at 3:40 p.m. the director of nursing (DON) stated staff received falls training during orientation via an online education platform. The DON was unsure how often the training was provided. The DON stated the facility did not have a house protocol for neurological assessments. When interviewed on 6/28/21, at 4:21 p.m. the medical director stated the facility would rely on a resident's initial assessment if there were no significant risk factors for a intracranial bleed. The medical director stated he would defer doing frequent neuro checks and would rather have the nurse most familiar with a resident to conduct reassessments at regular intervals; depend upon availability. The medical director stated the intervals could be anywhere from two to 24 hours as it was of greater clinical value than a subjective assessment competed by a staff-member who was unfamiliar with a resident. Facility policy titled Falls and Fall Risk, Managing F 689 dated 5/21, lacked indication of conducting neurological assessments after a fall with potential head injury. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 13 The Director of Nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure skin conditions are properly identified and monitored for all residents. Further, the could develop policies and procedures regarding neurological assessments. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		