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	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337 Based on interview, observation and document review, the facility failed to review a progress note from a physician's appointment for 1 of 4 residents (R1). The progress note identified suicidal ideation and physical abuse allegations, putting R1 at risk for harm from self or others. Findings include: R1's face sheet dated 6/7/24, indicated R1 had diagnoses of adult failure to thrive, cirrhosis of liver, neoplasm of breast, depression, unspecified symptoms and signs involving cognitive function, cognitive communication deficit and dementia. R1's 5-day Minimum Data Set (MDS) assessment dated [DATE] identified R1 was significantly cognitively impaired and required assist of 1 to 2 staff for activities of daily living. R1's patient health questionnaire (PHQ-9) dated 6/3/24 indicated R1 had little interest or pleasure in doing things, was feeling down, depressed, or hopeless, was feeling tired and had thoughts that she would be better off dead or hurting herself in some way over the past two weeks. R1's care plan dated 6/7/24 indicated R1 expressed suicidal ideation without a plan. Interventions dated 6/3/24 indicated administer medications as ordered, educate family members regarding expectation of treatment, concerns with side effects and to monitor mood to determine if the problem seems to be related to external causes. R1's Endocrinology Clinic note dated 6/5/24 was uploaded to the facility's electronic health record system (EHR) on 6/6/24. The note indicated an assessment of suicidal ideation and R1 was provided an urgent mental health evaluation. R1 indicated in the note that staff at the facility hit her and won't let her go the bathroom. R1 stated she will kill herself if the clinic staff send her back to the facility. R1 was crying during parts of the appointment. On 6/7/24 at 10:03 a.m., R1 was observed in her room at the facility. She did not open her eyes and was unable to answer any questions. At 10:16 a.m., paramedics arrived and transported her to the hospital. (continued on next page)

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.

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

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	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/24 at 10:12 a.m., registered nurse (RN)-A was interviewed and stated R1 started to decline the night of 6/6/24, was not eating and was sleepy. The nurse practitioner assessed R1 that morning and gave orders to send her to the hospital. R1 did not make any comments about abuse or suicidal ideation to RN-A. On 6/7/24 at 12:08 p.m., the licensed social worker (LSW)-A was interviewed and stated she completed R1's patient health questionnaire on 6/3/24. R1 told LSW-A she would feel better if she was not at the facility and that she did not have a plan to commit suicide. LSW-A updated her care plan on 6/3/24. LSW-A was not aware of the endocrinology clinic note. On 6/7/24 at 2:20 p.m., the administrator and director of nursing were interviewed. Neither staff were aware of the endocrinology clinic note. They stated nurses would be responsible for reviewing clinic notes. On 6/7/24 at 2:42 p.m., RN-B, for R1's unit was interviewed and stated she was not aware of the endocrinology clinic note. She stated the health unit coordinators are responsible for scanning paperwork into the EHR. If a resident comes back from an appointment with a clinic note, the floor nurse would be responsible for reading it and entering new orders. On 6/7/24 at 3:00 p.m., the health information manager (HIM) was interviewed. The HIM indicated he uploaded the endocrinology clinic note but did not read it. The clinical team should read it which includes the nurses, nurse manager and physicians. The HIM indicated R1 did not come back from the appointment with a hard copy of the clinic note and R1's physician requested a copy. The HIM downloaded the note from the clinic's EHR and uploaded to the facility's EHR on 6/6/24. On 6/7/24 at 3:17 p.m. RN-C was interviewed. RN-C was assigned to R1 when R1 returned from the endocrinology appointment. RN-C stated R1 did not have a hard copy of the clinic note and she did not receive a call from the clinic. R1 did not make any comments about abuse or suicidal ideation to RN-C. RN-C stated the health unit coordinators would upload any papers and notify the nurse managers of anything urgent. RN-C said she was not notified of anything urgent by her coworkers. The facility policy, Suicide Threats, last reviewed 9/2023 indicated staff should report any threats of suicide immediately to the nurse manager. A staff should stay with the resident until the nurse manager evaluates the patient. The attending physician should be notified and if the physician chooses for the resident to remain at the facility the care plan should be updated accordingly.