

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2024
NAME OF PROVIDER OR SUPPLIER North Ridge Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</p> <p>Based on observation, interview and document review, the facility failed to provide timely notification of critical lab results to the physician for 1 of 3 residents (R3) reviewed for change in condition.</p> <p>Findings include:</p> <p>R3's quarterly Minimum Data Set (MDS) dated [DATE] indicated R3 was cognitively intact, with diagnoses of chronic kidney disease and benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). R3 required an indwelling urinary catheter (tube inserted into the bladder to drain urine), and used anticoagulants (medications used to prevent blood clots from forming).</p> <p>R3's care plan dated 7/8/24 indicated R3 had an indwelling urinary catheter, and staff should monitor for blood-tinged urine.</p> <p>R3's Physician's Orders dated 10/28/24 directed to observe for symptoms of bleeding such as red or dark brown urine, and document unusual findings in the progress notes.</p> <p>R3's laboratory (lab) results dated 10/18/24, indicated R3 had a positive culture for escheria coli (E.coli - a type of bacteria that can cause diarrhea, vomiting, and kidney failure) and pseudomonas aeruginosa (pseudomonas - an infection that can affect skin, blood, lungs, urinary tract, and digestive tract that can cause cloudy or bloody urine).</p> <p>R3's progress notes lacked indication the physician was informed of R3's lab results.</p> <p>On 11/4/24 at 12:02 p.m., R3 stated he knew his urine had blood in it, and knew the facility was working with a provider to adjust his medications because his urine had blood in it.</p> <p>On 11/4/24 at 2:14 p.m., family member (FM)-A stated R3's urine was a dark maroon color, had not been that color previously, but he did have some blood in his urine previously.</p> <p>(continued on next page)</p>

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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/4/24 at 1:11 p.m., during observation, registered nurse (RN)-A stated R3 had slightly red urine that morning on 11/4/24, but acknowledged his urine was dark red during the observation. She stated R3's urine was better than it had been on 10/31/24, when there were blood clots in the urine. The blood in the urine was concerning as it could indicate internal bleeding. He had not documented these findings, nor notified R3's physician of the change in the urine, because R3's urine was intermittently bloody. He would notify the provider before the end of his shift and document his findings in a progress note.</p> <p>On 11/4/24 at 2:42 p.m., during a subsequent interview, RN-A stated he was not aware R3 had E.coli or pseudomonas in his urine. R3 was already on contact precautions because he had an indwelling catheter. When nurses received lab results which indicated an abnormal value, nurses should notify the physician.</p> <p>On 11/5/24 at 9:53 a.m., physician's assistant (PA)-A stated the providers were not notified of R3's lab results on 10/18/24 which indicated R3 had E.coli and pseudomonas, but had she known, she would have prescribed an antibiotic to treat both infections. R3 had a history of intermittent hematuria (blood in urine) which was normal for a resident who had an indwelling urinary catheter, who was also using anticoagulants.</p> <p>On 11/5/24 at 11:45 a.m., the health unit coordinator (HUC)-A stated when a lab result was ordered, staff would fax the results of the lab result to the ordering provider. The facility would stamp the lab results document with the word FAXED, and initial and date the document to identify it was faxed to the provider. After it was faxed, the results were uploaded into the provider's medical record portal. R3's lab results were stamped with the word FAXED, but were not initialed or dated, indicating the document was not faxed to the provider.</p> <p>On 11/5/24 at 12:27 p.m., the director of nursing (DON) stated if a resident's laboratory values fell outside of normal values, the provider would be promptly notified. She was unaware the provider was not notified of R3's abnormal laboratory value on 10/18/24, until 11/4/24. Additionally, she expected the nurse managers would follow up on abnormal test results to ensure providers were aware, and implement subsequent new orders.</p> <p>The facility policy Change in Resident's Condition dated 10/24, directed the facility staff shall promptly notify the resident, his or her attending physician, and resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).</p> <p>The facility policy Test Results dated 10/24, directed results of laboratory tests shall be reported to the resident's attending physician, physician assistant, nurse practitioner, or clinical nurse specialist, and test results which fall outside clinical reference ranges (as identified on the test result) will be promptly reported to the physician or their extender or per physician orders.</p>		