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| 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 01/28/2025 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300</p> <p>Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring call lights were within reach for 3 of 5 (R3, R4, R5) residents reviewed for call light usage.</p> <p>R3's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition with diagnoses that included dementia, muscle weakness and repeated falls.</p> <p>R3's care plan dated 1/20/25 lacked direction regarding call light usage.</p> <p>On 1/27/25 at 1:13 p.m., R3 was observed seated in her wheelchair with the call light cord lying in a coil on the floor behind her wheelchair. R3 stated she pushed her call light button when she needed help. She could not reach her call light and if she tried to pick it up off the floor, she would probably fall out of her wheelchair.</p> <p>On 1/27/25 at 1:20 p.m., registered nurse (RN)-A confirmed R3's call light button was out of her reach. All residents should have their call lights within reach before a staff person leaves the room.</p> <p>On 1/28/25 at 9:59 a.m., nursing assistant (NA)-B stated R3 used her call light when she needed assistance. A staff person should make sure a resident has their call light before they left their room.</p> <p>R4's quarterly MDS dated [DATE] indicated intact cognition with diagnoses that included type 2 diabetes and muscle weakness.</p> <p>R4's care plan dated 1/9/25 directed to be sure the call light is within reach, and encourage to use it for assistance as needed.</p> <p>On 1/27/25 at 1:45 p.m., R4 was observed seated in her wheelchair with no call light. R4 stated she would push her call light if she needed help. She did not know where her call light button was, and guessed it was between the bed and the wall where she could not reach.</p> <p>On 1/27/25 at 1:53 p.m., licensed practical nurse (LPN)-A confirmed R4's call light button was out of reach. It's really stuck as he pulled the cord from between the wall and the bed. All staff should make sure the resident can reach their call light before they left the room.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R5's quarterly MDS dated [DATE] indicated intact cognition with diagnoses that included encephalopathy.</p> <p>R5's care plan dated 1/21/25 instructed to keep call light within reach.</p> <p>On 1/27/25 at 12:42 p.m., R5 was observed lying in bed with his call light cord lying in a coil on the floor near the head of the bed. R5 stated he did not know where his call light was. If he needed help and could not find his button, he said he would yell out the door.</p> <p>On 1/27/25 at 12:50 p.m., NA-A confirmed R5's call light button was out of his reach. It was the staff member's job to be sure a resident's call light was within reach before leaving the room. R5 was able to use his call light, but didn't always remember why he pressed it.</p> <p>On 1/28/25 at 1:51 p.m., the director of nursing (DON) stated a resident's call light should be within reach before a staff person left the resident's room. A resident needed their call light so they could get help when they needed it.</p> <p>The facility policy Answering the Call Light dated 10/24 directed when the resident is in bed or confined to a chair be sure the call light is with easy reach of the resident.</p> | | |