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	03/07/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review, the facility failed to provide timely and quarterly care conferences for 3 of 4 residents (R184, R224, R146) reviewed for care planning. Findings include: R184: R184's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R184 was cognitively intact. Diagnoses included cancer, gastroesophageal reflux disease and post-traumatic stress disorder Review of R184's progress notes indicated a staff member with Anoka County requested a care conference on 11/18/24. Review of R184's care conference forms and progress notes identified care conferences were held on 1/24/25, 5/6/24 and 1/30/24. The care conference forms, and progress notes lacked a documented care conference around 11/24 as requested by Anoka County. During an interview on 3/3/25 at 6:29 p.m., R17 stated there is never an invite sent for care conferences and was not sure when the last care conference occurred. During an interview on 3/5/25 at 10:42 a.m., registered nurse (RN)-R stated care conferences were set up by the social worker about 14-21 days after admission and then quarterly and annually after that, RN-A stated nursing attended the care conferences to discuss the resident's medical care and how the resident wanted their medical care to proceed. During an interview on 3/5/25 at 10:48 a.m. licensed social worker (LSW)-C stated care conferences would be 21 days after admission, quarterly and annually. Social services department was responsible to set up the care conferences each time and to send out the invites. LSW-C stated R184 was always invited to the care conferences but did not sign the forms. LSW-C reviewed the care conference forms in the electronic medical record (EMR), the progress notes in the EMR and the handwritten notes from R184's care conference file and stated nothing was found related to a care conference around 11/24. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 10:27 a.m., the director of nursing stated care conferences should be held after admission, quarterly and annually based on the MDS dates. The Care conference was important because the resident had the ability to let staff know what their expectations were related to care and their stay at the facility. R224: R224's admission record indicated an initial admitted [DATE]. R224's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R224 was cognitively intact. Diagnoses included diabetes mellitus and respiratory failure. Review of R224's care plan undated, lacked information related to discharge planning and discharge goals. Review of R224's care conference forms and progress notes identified care conferences were held on 1/31/25. The documentation lacked any other care conference information prior to 1/31/25. During an interview on 3/5/25 at 10:42 a.m., registered nurse (RN)-R stated care conferences were set up by the social worker about 14-21 days after admission and then quarterly and annually after that, RN-A stated nursing attended the care conferences to discuss the resident's medical care and how the resident wanted their medical care to proceed. During an interview on 3/5/25 at 10:48 a.m. social services designee (SSD)-A stated care conferences would be 21 days after admission, quarterly and annually. Social services department was responsible to set up the care conferences each time and to send out the invites. Items discussed as part of the admission care conference included resident goals and discharge plans. Those conversations were important so the facility could start looking at discharge plans right away. All information obtained during the admission care conference would then be utilized to build the social services part of the comprehensive assessment, which included discharge planing. SSD-A stated she had not worked with R224 until around 12/24. Prior to 12/24, a different social worker worked with R224 and would have been responsible for the admission care conference and first comprehensive care plan. During an interview on 3/6/25 at 11:18 a.m. licensed social worker (LSW)-C stated she had worked with R224 for the first 2 months of stay at the facility but did not do a care conference. LSW-C confirmed the admission care conference should be done within the first 21 days of stay at the facilty. During an interview on 3/7/25 at 10:27 a.m., the director of nursing stated care conferences should be held after admission, quarterly and annually based on the MDS dates. The admission care conference was important because the resident had the ability to let staff know what their expectations were related to care and their stay at the facility. The resident could also vocalize to the staff their discharge goals and plans. Facility policy Resident/Family Participation-Assessment/Care Plans last reviewed 10/24 indicated each resident/family member was encouraged to participate in the development of the resident's comprehensive assessment and person-centered care plan. The resident and/or family members are invited to each care conference. The policy lacked information related to how often the care conferences should occur. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47263 R146: R146's Minimum Data Set (MDS) indicated R 146 was mildly cognitively impaired. R146's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left dominate side, cognitive communication deficit, and diabetes type 2. R146's careplan was last reviewed 12/20/24. R146's most recent care conference was documented on 8/23/24, in the electronic medical record (EMR) Care Plan Conference Summary flow sheet. The social worker and nurse manager were in attendance. R146 had been invited but chose not to attend. A Social Services Quarterly Review was completed on 2/25/25, however there was no documentation to support a care conference had been held in conjunction with completion of the Social Services Quarterly Review. During an interview on 3/3/25 at 6:35 p.m., R146 stated that nobody was really talking to them about their careplan or their plan of care. They stated they were not sure if they had ever been to a care conference meeting or been invited. During an interview on 3/7/25 at 10:19 a.m., registered nurse RN-C stated it was the social worker's (SW) responsibility to schedule and invite the resident, family and staff to the care conference. Care conferences are expected to occur at least quarterly and then as needed. I would expect quarterly. Care conferences are needed because conferences give family and residents an opportunity to hear and give input into care and express needs or concerns. During a follow-up interview on 3/7/25 at 12:30 p.m., R146 confirmed that they had not attended or been invited to a care conference in a long time. Facility policy Resident/Family Participation-Assessment/Care Plans last reviewed 10/24 indicated each resident/family member was encouraged to participate in the development of the resident's comprehensive assessment and person-centered care plan. The resident and/or family members are invited to each care conference. The policy lacked information related to how often the care conferences should occur.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48109 Based on observation and interview the facility failed to ensure the actual working hours for nursing staff was recorded on the daily staffing sheet posted each day. This had the potential to impact any residents, family or staff who may have wanted to view the actual working hours. Findings include: During observations on 3/4, 3/5, and 3/6/25 the facility posted daily staffing reports including the staff positions, number of staff, facility census, and scheduled hours. The posted staffing didn't include the actual working hours of staff scheduled that day. A review of the facility's posted staffing from 2/20/25 to 3/3/25 revealed no actual working hours for nursing staff. During an interview on 3/6/25 at 2:58 p.m., the lead staffing person (LSP) stated she was responsible for posting the daily staffing, but was not aware the actual hours needed to be posted on the staffing sheet. The LSP added that the actual schedule had those hours on it, but this information was not pulled to the daily staffing posting and hadn't been for about a year since they got a new staffing program. During an interview on 3/6/25 at 3:10 p.m., the director of nursing (DON) stated it was important to post the actual hours worked daily to show they had adequate staffing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 22.58 % with 7 errors out of 31 opportunities for error involving 4 of 9 residents (R309, R193, R183, R38) who were observed during the medication passes. Findings include: R309's Admission Record dated [DATE], identified R309 had diagnoses which included rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs) , and protein-calorie malnutrition. R309's Active Orders as of [DATE], identified R309 had an order for calcium carbonate-vitamin D with minerals - give one tablet by mouth two times a day. On [DATE] at 5:10 p.m., licensed practical nurse (LPN)-C brought R309 calcium carbonate 500 plus D, LPN-C verified the expiration date on the bottle was ,d+[DATE], and that the medication was expired. R193's Admission Record dated [DATE], identified R193 had diagnoses which included dementia, dysphagia (difficulty swallowing foods or liquids), Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), and neurocognitive disorder with Lewy bodies (a progressive brain disorder that causes a decline in thinking, reasoning, and independence). R193's Active Orders as of [DATE], identified R193 had an order for potassium chloride oral packet 20 milliequivilent (mEq) give by mouth in the evening. On [DATE] at 5:21 p.m., LPN-F opened the potassium chloride packet 20 mEq which was a powder form. LPN-F poured the powder into a plastic 30 milliliter (ml) cup, then put a couple of teaspoons of pudding on top of the powder and mixed it. LPN-F then went into R193's room and gave her water to drink followed by two teaspoons of pudding/medication followed by a couple of sips of water. On [DATE] at 5:29 p.m., LPN-F verified the directions on the potassium chloride box identified the powder was to be dissolved in four to eight ounces of water or juice. On [DATE] at 6:04 p.m., family member (FM)-F stated some staff would mix the medication in pudding and some would mix it with water or juice. R183's Admission Record dated [DATE], identified R183 had diagnoses which included end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids) and gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R183's Active Orders dated [DATE], identified R183 had dialysis 3 days a week on Tuesday, Thursday and Saturday. Zofran oral tablet 4 milligrams (mg). Instructions were to give 30 minutes prior to dialysis. On [DATE] at 8:51 a.m., registered nurse (RN)-S was notified that R183 was in dialysis and needed medication for nausea, RN-S went to dialysis and checked on R183, she did not want anything for pain just anti-nausea medications. On [DATE] at 8:57 a.m., back on the nursing unit RN-S removed ondansetron 4 mg from the medication cart stating it wasn't due until 10:00 a.m., and brought the medication to R183 in the dialysis unit. On [DATE] at 9:06 a.m., R183 received her ondansetron, which was scheduled for 30 minutes prior to going to dialysis. R38's Admission Record dated [DATE], identified R38 had diagnoses which included hypertension, atherosclerotic heart disease, chronic venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes), chronic kidney disease stage 3 (a moderate level of kidney damage, where the kidneys are not filtering waste effectively), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce bood flow to the limbs), and acquired absence of right leg below the knee. R38's Active Orders dated [DATE], identified R38's medications included the following medications: ezetimibe 10 mg give one tablet by mouth one time a day for cholesterol control gabapentin 300 mg give one capsule by mouth three times a day for neuropathic pain hydrochlorothiazide 25 mg one time a day for edema losartan potassium 25 mg one time a day for hypertension R83's medication orders did not have any parameters listed to hold any medications On [DATE] at 9:41 a.m., LPN-G prepared R38's medications and stated he could not find the gabapentin or the ezetimibe but stated both had been re-ordered. LPN-G did not prepare any hydrochlorothiazide or losartan. At 10:09 a.m., LPN-G went to R38's room and measured her blood pressure ,d+[DATE] and heart rate 74. LPN-G told her that her blood pressure was low and she would not need her blood pressure medications. A review of R38's medication administration record for March revealed the following: ezetimibe on [DATE], and [DATE], were charted as 3 per the key indicated supply re-ordered hydrochlorothiazide on [DATE], was charted as 8 per the key indicated hold losartan on [DATE], was charted as 8 per the key indicated hold (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gabapentin on [DATE], was charted as 3 per the key indicated supply re-ordered A review of R38's March nurses notes did not include any notes regarding medications not given or held. On [DATE] at 9:18 a.m., the director of nursing (DON) stated residents should not go more than a day with medications missing. The DON stated she would expect staff to make a phone call to the pharmacy to check on missing medications. The DON stated medications should be given as ordered. On [DATE] at 10:23 a.m. the consultant pharmacist (CP)- E stated she would expect staff to make sure medications are not expired, to follow the directions on the package for mixing/administration, and if medications were missing to call the pharmacy to see why they had not been delivered. CP-E stated medications could be held but would expect staff to call the provider to notify them about why the medication was held and to write a progress note. Medication Administration dated [DATE], identified staff should Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. In addition, to check the expiration date on on the medication and to follow the manufacturer medication administration guidelines.