

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 07/10/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement resident-directed care and treatment consistent with provider orders and professional standards for 1 of 3 residents (R2) reviewed for supplemental oxygen use. Findings include: R2's quarterly minimum data set (MDS) dated [DATE], identified moderately impaired cognition with diagnoses which include acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). R2 utilized oxygen therapy while at the facility. R2's provider order dated 12/18/24, instructed staff to apply continuous oxygen at 2 liters per minute (lpm) by nasal cannula to maintain oxygen saturations above 90% with a frequency check of every shift. Required supplementary documentation included oxygen saturations. R2's care plan dated 7/10/25, instructed staff to administer oxygen according to provider order. Review of R2's vital signs documentation from 5/8/25, through 7/10/25, revealed R2's oxygen saturation had been checked once on 5/8/25, 5/15/25, 5/22/25, 5/29/25, 6/13/25, 6/20/25, 6/27/25 and 7/4/25. The electronic health record (EHR) lacked documentation staff checked R2's Oxygen saturation levels every shift. During an interview on 7/10/2025 at 9:07 a.m., R2 stated he always utilized supplemental oxygen at night however, he did not like to use it during the day. Staff checked his oxygen saturations once and a while, however, not every day. During an interview on 7/10/2025 at 11:04 a.m., licensed practical nurse (LPN)-A stated a resident should have their oxygen saturation levels checked at least once a shift if they had a provider order to maintain oxygen saturations at a certain level. There should have been a task on the treatment administration record (TAR) to check oxygen saturations. LPN-A confirmed there was no task to check oxygen saturations on R2's TAR. LPN-A had not checked R2's oxygen saturation on his shift which had started at 6 a.m. that morning. During an interview on 7/10/2025 at 3:38 p.m., nurse practitioner (NP)-A stated if a resident was on supplemental oxygen, they should be monitored according to the provider orders. If the staff were not following provider orders, whatever was being monitored would not be accurate. Lack of monitoring placed the residents at risk of not receiving the correct amount of supplemental oxygen. During an interview on 7/10/2025 at 4:04 p.m., director of nursing (DON) stated R2 had a provider order to monitor oxygen saturation each shift. DON confirmed R2's electronic health record lacked documentation of oxygen saturation monitoring every shift. Review of the facility policy titled The Oxygen Administration policy dated 10/2024, instructed while the resident was receiving oxygen therapy, assess for signs or symptoms of cyanosis (blue tone to skin and mucous membranes), hypoxia (rapid breathing, rapid pulse, restlessness, confusion), and oxygen toxicity (difficulty breathing or slow, shallow breathing), vital signs, lung sounds, arterial blood gases and oxygen saturation if applicable; and other laboratory results if applicable.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide respiratory care consistent with professional standards and the comprehensive person-centered care plan for 1 of 3 (R3) residents reviewed for supplemental oxygen use. Findings include: R3's quarterly minimum data set (MDS) dated [DATE], indicated intact cognition with diagnoses which included chronic kidney disease and heart failure. R3 did not use oxygen therapy at the facility. R3's provider order list dated 7/10/25, lacked an order for supplemental oxygen use and monitoring. R3's care plan lacked information regarding supplemental oxygen use. Review of R3's vital signs documentation from 5/1/25 through 7/10/25, revealed R3 utilized oxygen via nasal cannula (NC) on six days in July, at least 17 days in June (9 days there was no information documented), and 11 days in May starting on 5/16/25 (3 days there was no information documented). A nursing note dated 6/2/25, indicated R3 utilized 2 liters per minute (L) of supplemental oxygen. A provider visit note written by nurse practitioner (NP)-A dated 5/20/25, indicated acute and chronic respiratory failure with hypoxia: no change was made, on 4L oxygen through NC. The note lacked an order for supplemental oxygen. A provider visit note written by NP-A dated 5/29/25, indicated R3's acute and chronic respiratory failure with hypoxia was stable on 3L oxygen through NC. The note lacked an order for supplemental oxygen. A provider visit note written by NP-A dated 6/26/25, indicated R3's acute and chronic respiratory failure with hypoxia was stable on 3L oxygen through NC. The note lacked an order for supplemental oxygen. A provider visit note dated 7/7/25, indicated R3's acute and chronic respiratory failure with hypoxia was stable on 3L oxygen through NC. The note lacked an order for supplemental oxygen. On 7/10/2025 at 10:24 a.m., R3 was observed laying in bed wearing a nasal cannula. The nasal cannula tubing was connected to an oxygen tank with the liters per minute set at 2L. During an interview on 7/10/2025 at 12:22 p.m., licensed practical nurse (LPN)-B stated R3 was on 2L supplemental oxygen when LPN-B checked R3's vital signs at the beginning of LPN-B's shift. During an interview on 7/10/2025 at 12:42 p.m., registered nurse (RN)-A stated R3 did not have an order for supplemental oxygen prior to 7/10/25. During an interview on 7/10/2025 at 3:38 p.m., NP-A stated a provider order was needed for supplemental oxygen. R3 had utilized supplemental oxygen when NP-A had seen her for provider visits in May 2025, and June 2025. NP-A stated a facility nurse should have contacted the provider if an order for supplemental oxygen was needed. During an interview on 7/10/2025 at 4:04 p.m., director of nursing (DON) confirmed R3 did not have a provider order for supplemental oxygen before 7/10/25. Oxygen was considered a medication, so it required a provider order. Review of facility policy titled The Oxygen Administration policy dated 10/2024, instructed staff to verify there was a physician's order for oxygen administration</p>		