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	12/08/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for one of one resident (R2) when R2 had an order for Oxycodone 10 milligrams (mg) with instructions to separate the doses by a minimum of four hours and to separate doses from Suboxone by a minimum of two hours. The facility failed to follow these instructions 12 times between 10/10/25 and 10/27/25. The facility also failed to ensure medications were given within one hour before the scheduled administration time to one hour after the scheduled administration time. Between 10/1/25 and 10/31/25, the facility failed to ensure medications were given within one hour of the scheduled administration time to one hour after the scheduled administration time 360 times. These deficiencies had the potential to impact all resident's in the facility. R2's admission record dated 12/3/25 indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of acute and subacute infective endocarditis. R2's additional diagnoses included pneumonitis due to inhalation of food and vomit, displaced bicondylar fracture of left tibia subsequent encounter for closed fracture with routine healing, cognitive communication deficit, and fibromyalgia. R2 was discharged from the facility on 11/21/25. R2's care plan dated 9/19/25 indicated staff would give medications as ordered by the physician. R2's care plan dated 10/2/25 indicated staff would anticipate R2's need for pain relief and response immediately to any complaints of pain. Another intervention included staff would evaluate the effectiveness of pain interventions and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability, and impact on cognition. R2's physician visit note dated 10/9/25 indicated the physician ordered Oxycodone 5mg two tablets by mouth four times a day as needed. The physician ordered Buprenorphine-naloxone (Suboxone) 2-0.5mg one tablet sublingual (SL) twice a day. The physician instructed staff to separate the Oxycodone and the Suboxone doses by a minimum of two hours. R2's medication administration record (MAR) dated 10/9/25 indicated the physician wrote an order for Buprenorphine-HCL-Naloxone HCL sublingual tablet 2-0.5mg with directions to given one tablet sublingually two times a day for pain and to separate the doses from Oxycodone by a minimum of two hours. This ordered was discontinued on 10/20/25. The MAR indicated the physician wrote an order for Oxycodone 5mg with directions to given one tablet by mouth as needed for pain every four hours as needed and to separate the doses by a minimum of hour hours and to separate the doses from Suboxone by a minimum of two hours. This order was discontinued on 10/10/25. R2's MAR dated 10/10/25 indicated the physician wrote an order for Oxycodone 5mg with the directions to give two tablets by mouth as needed for pain every four hours as needed and to separate the doses by a minimum of four hours and to separate the dose from Suboxone by a minimum of two hours. This order was discontinued on 11/15/25. R2's MAR dated 10/20/25 indicated the physician wrote an order for Buprenorphine HCL-Naloxone HCL 0.5mg sublingual tablet with directions to given one tablet sublingually every eight hours for pain. This order was discontinued on 11/15/25. According to the medication administration audit report for October, the following were medication errors when staff did not give Oxycodone 10mg separate from another Oxycodone 10mg dose by four hours:- 10/10/25- Given at 5:17 a.m. and 8:47 a.m. This was given three hours and thirty minutes apart.- 10/12/25- Given at 8:53 a.m. and 12:33 p.m. This was given three hours and forty minutes apart. According to the medication administration audit report for October, the following were medication errors when staff did not separate the Oxycodone 10mg dose by two hours from the Suboxone 0.5mg:- 10/10/25- Oxycodone was given at 7:44 p.m. and Suboxone was given at 9:00 p.m. These doses were given one hour and 16 minutes apart.- 10/12/25- Oxycodone was given at 7:35 p.m. and Suboxone was given at 8:38 p.m. These doses were given one hour and three minutes apart.- 10/15/25- Suboxone was given at 7:57 a.m. and Oxycodone was given at 8:21 a.m. These doses were given twenty-four minutes apart.- 10/21/25- Oxycodone was given at 7:28 a.m. and Suboxone was given at 8:33 a.m. These doses were given one hour and five minutes apart. - 10/22/25- Suboxone was given at 7:29 a.m. and Oxycodone was given at 7:50 a.m. These doses were given twenty-one minutes apart.- 10/23/25-10/24/25- Oxycodone was given on 10/23/25 at 11:30 p.m. and Suboxone was given on 10/24/25 at 1:11 a.m. These doses were given one hour and forty-one minutes apart. - 10/25/25- Suboxone was given at 8:00 a.m. and Oxycodone was given at 9:05 a.m. These doses were given one hour and five minutes apart.- 10/26/25- Oxycodone was given at 12:14 a.m. and Suboxone was given at 2:13 a.m. These doses were given one hour and fifty-nine minutes apart.- 10/26/25- Oxycodone was given at 7:39 a.m. and Suboxone was given at 9:21 a.m. These doses were given one hour and forty-two

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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** Based on interview and record review, the facility failed to accurately document turning and repositioning for one of one resident (R2) reviewed when R2's care plan stated she would be turned and repositioned every two hours and the staff stated they do not document when a resident is turned and reposition nor could recall turning and repositioning R2.R2's admission record dated 12/3/25 indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of acute and subacute infective endocarditis. R2's additional diagnoses included pneumonitis due to inhalation of food and vomit, displaced bicondylar fracture of left tibia, chronic obstructive pulmonary disease, dysphagia, other lack of coordination, difficulty walking, cognitive communication deficit, peripheral vascular disease, and personal history of other venous thrombosis and embolism. R2 was discharged from the facility on 11/21/25. R2's care plan dated 9/19/25 indicated R2 would be repositioned every two hours to facilitate lung secretion movement and drainage. R2's care plan dated 10/2/25 indicated R2 needed assistance with repositioning at least every two hours, more often as needed, or when R2 requested to be repositioned. During an interview on 12/3/25 at 12:00 p.m., nursing assistant (NA)-A stated she repositioned residents every two hours but does not document when the residents are repositioned. During an interview on 12/3/25 at 1:22 p.m., NA-E stated she repositioned residents every two hours but does not document when the residents are repositioned. During an interview on 12/3/25 at 2:14 p. m., NA-B stated he repositioned residents every two hours but does not document when the residents are repositioned. During an interview on 12/3/25 at 2:20 p.m., NA-C stated he repositioned residents every two hours but does not document when the residents are repositioned. During an email correspondence on 12/8/25 at 12:03 p.m., registered nurse (RN)-K stated the facility staff does not document when residents were rounded on. During an interview on 12/8/25 at 1:23 p.m., RN-K stated the facility does not document when each resident has been turned or repositioned. Policy for activities of daily living (ADL) documentation was requested but none was given.