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	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 7 of 7 residents (R28, R124, R128, R197, R233, R244, R257) when meals were served on hard plastic trays in the dining room. Further, the facility failed to ensure resident's right to privacy and dignity for 1 of 1 residents (R2) when staff failed to knock and wait for permission before entering the resident's room. Findings include: R28's quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated R28 had intact cognition, and an admission date of 10/24/25. R124's quarterly MDS, dated [DATE], indicated R124 had severely impaired cognition, no hallucinations or delusions, and an admission date of 11/21/18. R128's annual MDS, dated [DATE], indicated R128 had short-term and long-term memory issues, severely impaired daily decision making, and an admission date of 11/13/20. R197's quarterly MDS, dated [DATE], indicated R128 had intact cognition, and an admission date of 11/25/25. R233's quarterly MDS, dated [DATE], indicated R233 had moderately impaired cognition and an admission date of 10/18/24. R244's quarterly MDS, dated [DATE], indicated R244 had short term and long-term memory issues, severely impaired daily decision making, and an admission date of 4/5/19. R257's annual MDS, dated [DATE], indicated R257 had moderately impaired cognition, no hallucinations or delusions, and an admission date of 8/26/22. During an observation of lunch service on 6/23/26 at 12:59 p.m., five residents (R124, R128, R233, R244, R257) were observed eating in the small dining room on the 2W unit, with two staff observed assisting residents at the tables. Positioned on the table in front of each resident was a meal on a hard plastic serving tray. Each hard plastic tray had a food plate, silverware, and beverage containers on it. The warming lids from the plates were tipped upside down on the table in front of the residents. During an observation of lunch service on 6/24/26 at 11:46 a.m., the lunch meal service was observed on the 2nd floor west main dining room. The dining room had a steam serving table with food items. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff placed the food items, beverages, and silverware onto a hard plastic serving tray. The meals were then delivered to each resident at their table. However, the hard plastic servicing trays were then left on the table with plated food, beverages and silverware on top of them. Staff did not ask or offer to remove the items from the serving trays and place them onto the table. R28 and R197 were observed eating from the hard plastic meal tray. R197 stated he did not like the hard plastic serving trays and would not eat from one at home. During an observation on 6/25/26 at 8:03 a.m., breakfast meal service was observed on 2nd floor west main dining room. The residents ate in the dining room and their breakfast meal was served on the hard plastic serving tray. The serving trays remained under each resident's dishes during the meal service. The staff that served the meals in the dining room did not ask residents if they wanted the serving tray removed while the residents ate. During an interview on 6/25/26 at 7:49 a.m., nursing assistant (NA)-A stated the nursing assistants helped serve residents in the dining room. NA-A stated the process was to bring the residents the serving tray of food, set the tray in front of the resident, and take the covers off the plates and beverages. NA-A stated staff had not been directed to take the food items off the hard plastic tray. NA-A stated there was no reason why the food was left on the hard plastic tray when served to residents. During an interview on 6/25/26 at 8:59 a.m., registered nurse unit manager (RN)-D stated nursing staff brought the trays to the residents in the dining room during mealtimes. RN-D acknowledged the meals were served to residents in the dining room on the hard plastic tray. RN-D stated he was not sure why the food was left on the hard plastic trays. During an interview on 6/25/26 at 10:37 a.m., director of nursing (DON) stated meals should have been served without the hard plastic trays. DON stated the food should have been taken off the trays when served to residents to create a more homelike environment. R2's quarterly MDS, dated [DATE], indicated R2 was cognitively intact. During an observation and interview on 06/22/2026 at 11:27 a.m., staff entered R2's room without ensuring privacy was maintained. An unidentified nursing assistant (NA) knocked once on R2's door, and entered the room without waiting for a response, to inform R2 it was time for lunch. R2 stated staff just walk right in, expressed fear of changing clothes due to lack of privacy, and reported he did not feel he had adequate privacy in his room. During an interview on 06/24/2026 at 10:33 a.m., NA-E stated that before staff entered a resident's room, staff were expected to knock and wait for a response. During an interview on 06/25/2026 at approximately 9:11 a.m., the nurse manager/ licensed practical nurse (LPN)-C, stated staff were expected to knock and wait for a response prior to entering the room to ensure resident privacy and dignity. During an interview on 06/25/2026 at 11:20 a.m., director of nursing (DON) stated staff were required to knock and wait for a response before entering resident rooms. DON stated this was the facility's expectation to maintain resident privacy. The facility's Dining Environment policy, dated 10/25, indicated the facility would create an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate dining environment. The facility's Resident Rights policy, dated 11/2025, indicated federal and state law guarantee residents' basic rights, including the right to privacy.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide written information on the duration of the bed-hold and reserve bed payment at the time of transfer for 4 of 4 residents (R21, R147, R203, R260) reviewed for hospitalizations.Findings include: R21's annual Minimum Data Set (MDS), dated [DATE], identified R21 with intact cognition, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's Clinical Assessment screen identified transferred to the hospital on 6/8/26. R21's electronic medical record (EMR) lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/22/26 at 11:46 a.m., R21 stated he had never been offered or signed a bed hold form when he transferred to the hospital, and stated, No one from here reached out to me. R147's quarterly Minimum Data Set (MDS), dated [DATE], identified R147 had intact cognition and diagnoses included chronic respiratory failure, quadriplegia, and R147 required suctioning and tracheostomy care. R147's EMR identified R147 was transferred to the hospital on 3/15/26, and 4/3/26. However, review of R147's EMR lacked evidence the facility provided R147 and/or R147's resident representative with written information regarding the facility's bed hold policy at the time of the hospital transfers. During an interview on 6/25/26 at 7:50 a.m., the social services designee (SSD) stated social services completed bed holds when available, and nursing staff completed the process if social services were unavailable. The SSD stated when a bed hold was not obtained by nursing staff at the time of transfer, social services followed up with the resident's representative. The SSD stated the director of nursing (DON) confirmed completion of bed holds. During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated staff determined if the resident was their own responsible party or if the resident's representative needed to be contacted regarding the bed hold. RN-A stated completion of the bed hold process was documented in the resident's progress notes. During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) stated when a resident was transferred to the hospital, nursing staff notified the resident's representative, discussed the bed hold, and documented the information in the progress notes. The RNCM stated social services were updated and a bed hold form was sent with the resident. The RNCM confirmed R147's EMR lacked evidence bed hold information was provided to R147 and/or R147's resident representative for the hospital transfers on 3/15/26 and 4/3/26. During an interview on 6/25/26 at 1:35 p.m., director of nursing (DON) stated for emergency transfers, social services followed up with the resident and/or resident representative regarding whether they wanted a bed hold and documented the information in the progress notes. The DON stated the process was important to determine if the resident or resident representative wanted to hold the resident's (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed, identify the length of time the bed would be held, and ensured clear communication. R203's quarterly MDS, dated [DATE], identified R203 with moderate cognitive impairment, and diagnoses included hypertension, peripheral vascular disease, kidney disease, receiving hemodialysis, left below the knee amputation, and diabetes. R203's EMR identified transfers to the hospital on 4/27/26, 5/8/26, and 6/3/26. However, R203's EMR lacked evidence bed holds were offered, signed, and followed up on. During an interview on 6/23/26 at 5:21 p.m., RN-K stated nurses were expected to print out a face sheet, orders, and medication list to send with resident to hospital. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-K stated a signed bed hold form was to accompany the resident to the hospital, and a progress note written after the resident transferred to identify status of the bed hold, such as who was notified. During an interview on 6/23/26 at 5:21 p.m., RN-L stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders to transfer were obtained. In addition, the nurse was expected to start a Transfer Form in the EMR. RN-L stated the bed hold form was a separate piece of paper that needs to be signed [by the resident] and followed up if they cannot at the time. RN-L stated expectation of a progress note following the transfer to indicate whether bed hold was signed or offered, and to be followed up by social services if it is not signed. During an interview on 6/24/26 at 11:10 a.m., RN-M stated expectation of nursing staff to print out a face sheet, orders, and medication list to accompany resident to hospital once orders are obtained, and the nurse was expected to start a Transfer Form in the EMR. RN-M stated the bed hold form was expected to be offered to and signed by the resident or guardian and accompany the resident to the hospital. RN-M stated expectation of the nurse to document in a progress note whether the bed hold was offered or signed, and if it was not then social services were to follow up. RN-M acknowledged the process was not followed for R21 and R203. During an interview on 6/24/26 at 11:44 a.m., SS-D reviewed EMR for R21 and R203 and stated he was unable to locate any signed bed hold forms. SS-D stated, The process should be to have the patient or guardian sign the bed hold and [facility] scan it in the EMR. We should be following up if it was done or not in a progress note. SS-D stated the facility failed to document if a written notice was offered and provided to R21 and R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. During an interview on 6/25/26 at 8:41 a.m., R203 stated he had never been offered or signed a bed hold form when he was hospitalized . During an interview on 6/25/26 at 10:51 a.m., DON stated expectation of a signed bed hold to accompany resident at time of transfer. It should be scanned in the EMR but [process] is not reliable. DON verified the facility failed to document if a written notice was offered and provided to R21 or R203, or their guardians on transfer, including notifying the Office of the State Long Term Care Ombudsman. R260's admission MDS, dated [DATE], identified R260 was cognitively intact, was able to express needs and wishes, and was able to understand others, and diagnoses included surgical amputation, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	peripheral vascular disease (a disease with narrowing of the blood vessels which impacts blood circulation throughout the body), and malnutrition. R260's care plan, initiated 3/4/26, identified R260 was at risk for falls and was dependent on staff for cares. R260's progress note, dated 3/25/26 at 5:23 a.m., identified R260 was found on the floor at 5:00 a.m., and denied striking head. At that time, the provider and family were advised. The documentation indicated the provider would follow up with patient to assess. R260's progress note, dated 3/25/26 at 5:14 p.m., identified R260 was noted to have swelling to the left side of face and was confused, and waw not able to recognize family member/power of attorney (POA). Notification was sent to the provider triage nurse and resident was transferred to the hospital for evaluation. The progress note indicated the bed hold was signed by the POA. However, R260's EMR lacked evidence of the signed bed hold from 3/25/26. During interview on 6/25/26 at 11:52 a.m., registered nurse/unit manager (RN/UM)-A stated upon transfer to the hospital, a bed hold wase obtained from the responsible party. This is completed either in person, or via the telephone for verbal consent. Once signed, RN/UM-A stated the document was placed in the medical record. During interview on 6/25/2026, at 2:30 p.m., DON provided a handwritten note which identified 3/25/26 at 5:43 p.m. Bed hold per POA of resident. DON acknowledged this documentation lacked indication as to information provided to the POA, including potential fees and right to appeal. The facility's Bed Hold policy, revised 04/2025, indicated community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed-hold policy, and a copy of the resident's bed-hold or release record will be filed in the resident's medical record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and document review, the facility failed to ensure controlled substance reconciliation was completed in accordance with established policies and procedures to reduce the risk of diversion and/or theft on 2 of 8 medication carts reviewed. This had the potential to affect 8 residents identified to have controlled substances in the reviewed carts.Findings include: During an observation and interview on 6/23/26 at 1:54 p.m., the 2W far south medication cart was reviewed with registered nurse (RN)-A. The mobile cart was locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-A explained that the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a Narcotic Shift to Shift Signature form. RN-A provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. RN-A confirmed the form had approximately half of the spaces filled and stated all the signature spots should have been completed. RN-A stated she did not know why spaces were blank. The facility's 2 [NAME] FS (far south) Narcotic Shift to Shift Signature Sheet, for June 2026, indicated there were 132 possible signature spaces, with 106 documented signatures for 6/1/26 through 6/26/26. During an observation and interview on 6/23/26 at 2:03 p.m., with RN-B and RN-C, the 2W near south mobile medication cart was observed locked with a physical key, along with a separately attached metal narcotic box, which was also locked. The narcotic box was opened and contained numerous controlled substances. RN-C explained the narcotics and controlled substances were counted at each shift exchange, and these reconciliations were recorded on a form to indicate the count had occurred. RN-C provided the flow sheets used to track the documented count(s). However, approximately half of the signature spaces were blank. The facility's 2 [NAME] NS (near south) Narcotic Shift to Shift Signature Sheet, June 2026, indicated there were 132 possible signature spaces for 6/1/26 to 6/22/26. However, there were 41 signatures total on the sheet for 6/1/26 through 6/22/26. During an interview on 6/23/26 at 2:09 p.m., the nurse manager/ licensed practical nurse (LPN)-A stated staff were expected to sign the controlled medication reconciliation form to indicate that controlled medication reconciliation had occurred. LPN-A confirmed approximately half the signatures were missing on the 2W NS form. LPN-A stated that based on documentation, he was unable to confirm that medication reconciliation had occurred. During an interview on 6/24/26 at 10:17 a.m., the director of nursing (DON) stated nursing staff were expected to complete controlled medication reconciliation at each shift change, and the reconciliation should have been documented on the narcotic shift change forms. The facility's Controlled Substances policy, dated 10/2026, indicated the controlled substance records would be reconciled by a physical count of the remaining controlled substance supply at the change of each shift by the oncoming and outgoing licensed nurse/designee.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, and interview, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 5 of 5 residents (R3, R28, R156, R197, R294) reviewed who expressed concerns for food temperatures and palatability. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/16/26, identified R3 had intact cognition with an admission date of 11/13/24. During an interview on 6/24/26 at 10:23 a.m., R3 stated she ate in the main dining room on 2W, and she had brought up the concern of cold food to staff previously. R28's quarterly MDS assessment, dated 5/31/26, identified R28 had intact cognition with an admission date of 10/24/25. During an interview on 6/24/26 at 10:23 a.m., R28 stated the food was always cold. It didn't make a difference if you ate in your room or in the dining room. R28 stated he ate in both places and had brought up the concern of cold food to staff previously. R156's quarterly MDS assessment, dated 5/25/26, identified R156 had intact cognition with an admission date of 2/18/26. During an interview on 6/24/26 at 10:23 a.m., R156 stated the food was served cold when it should be hot most of the time. R156 stated he ate in the dining room most of the time and had brought up the concern of cold food to staff previously. R197's quarterly MDS assessment, dated 6/4/26, identified R128 had intact cognition with an admission date of 11/25/25. During an interview on 6/24/26 at 10:23 a.m., R197 stated the French fries were always cold. R197 stated he ate in the main dining room on 2W most of the time and had brought up the concern of cold food to staff previously. R294's quarterly MDS assessment, dated 4/1/26, identified R294 had intact cognition with an admission date of 1/17/26. During an interview on 6/22/26 at 1:02 p.m., R294 stated the food was served cold when it should have been hot. Furthermore, R294 stated the flavor wasn't always great. During an observation and interview on 6/24/26 at 12:56 p.m., dining staff, including the dietary manager (DM), were observed serving food from the 3 west dining room. After all resident meals were plated, DM temped the food that remained in the food warmer. The following temperatures were obtained: turkey 164 degrees Fahrenheit (F), green beans 173.8 F and sweet potato 149.5 F. After the temperatures were obtained, the food remained on the warming table. The DM then followed the meal cart into the memory care unit, waited until the last tray was ready to be served, and obtained the following food temperatures from the last tray: turkey 103.5 F, green beans 96.5 F, and sweet potato 102.4 F. DM stated all the food should have been above 140 degrees at the time it was served, (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regardless of if it was in the dining room or served in the resident room. DM stated food temperatures that were below 140 degrees were in the danger zone and increased the potential for food-born illnesses.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain consent for use of psychotropic medications for 1 of 5 residents (R9) reviewed for unnecessary medicationsFindings include: R9's admission Minimum Data Set (MDS), dated [DATE], indicated R9 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included edema, dementia, hypertension, insomnia and encephalopathy (broad term for any disease, damage, or malfunction that affects the brain). R9's Order Summary Report, printed 6/25/26, indicated R9 had an order dated 4/13/26 for trazodone 25 milligrams (mg) by mouth at bedtime for insomnia. However, review of R9's medical record lacked evidence consent for trazadone was obtained prior to use. During an interview on 6/25/26 at 10:56 a.m., registered nurse (RN)-I stated nurses were expected to complete a form for consent when a psychotropic medication was ordered. RN-I stated a nurse could initially get verbal consent but then needed to have the form signed the next time the person that gave consent was in the facility. During an interview on 6/25/26 at 11:21 a.m., RN-H stated the expectation was for consent for a medication that required it was obtained when a resident admitted on the medication or a new medication was added. RN-H confirmed R9's medical record lacked evidence or consent for trazodone. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated the consent for psychotropic medications was expected to be obtained when a new psychotropic medication was ordered or when a resident was admitted with a psychotropic medication. The facility's Physician Medication Orders policy did not address obtaining consent for psychotropic medication use.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to assess resident for safety and the ability to self-administer medications for 1 of 1 resident (R21) reviewed for self-administration of medications (SAM). Findings include: R21's annual Minimum Data Set (MDS), dated [DATE], identified R21 was cognitively intact, and diagnoses included diabetes, heart disease, and kidney disease. R21's physician progress note, dated [DATE], identified R21 medication order for nystatin ointment 100000 unit/gram to groin and intergluteal cleft (the deep vertical groove between the buttocks) topically two times a day for fungal rash/dry skin, and with every brief change. R21's electronic medical record (EMR) identified physician orders for nystatin ointment was discontinued on [DATE]. During an observation and interview on [DATE] at 3:37 p.m., R21 had a nearly empty tube of prescription nystatin ointment, with label attached listing R21's name, and instructions for use as indicated on the [DATE] medication order, and the label indicated dates of [DATE], to [DATE]. R21 stated nystatin remained on his rolling bedside table or top of nightstand since January of 2026. R21 stated he applied the ointment when he felt he needed it. R21 stated staff were aware he had it in his room. R21 stated facility staff had never talked to him about an assessment to determine safety and competence to keep the prescription ointment in his room. During an observation on [DATE] at 1:11 p.m., R21's rolling bedside table had a nearly empty tube of the prescription Nystatin ointment. During an interview on [DATE] at 11:21 a.m., registered nurse (RN)-M stated nurses were to document an assessment in the resident EMR if a resident wished to keep prescription and over the counter (OTC) medications at bedside. When a resident was assessed as safe to self-administer their medications, a provider order for self-administration was obtained and the care plan was updated. RN-M stated complete and accurate medication orders were important due to potential risk of contraindications. During an interview on [DATE] at 11:28 a.m., RN-L stated nursing staff were expected to document an assessment in the resident EMR if a resident wished to keep prescription and/or over-the-counter medications at bedside. RN-L stated residents should not have prescription or OTC medications in their rooms unless an assessment was completed and documented in the EMR. RN-L stated, we don't want [residents] medicating themselves and potentially harm[ing] them. During observation and interview on [DATE] at 1:12 p.m., RN-D confirmed the prescription nystatin ointment was in R21's room and verified it was prescribed to R21. RN-D stated the nystatin ointment should not be here because we need to know all meds. RN-D verified a self-administration of medications assessment had not been completed for R21. RN-D stated the discontinued nystatin order meant the nystatin should have been removed from R21's room when it was discontinued.During an interview on [DATE] at 10:56 a.m., director of nursing (DON) stated nurses were expected to document a self-administration assessment for all prescribed and OTC medications left in a resident room. DON stated when a resident was assessed to be safe to self-administer a medication, a provider order for SAM was obtained by staff and documented in the EMR, and the care plan was updated. DON verified R21 was never assessed for safe self-administration of medication, and the order and care plan were never updated. The facility's Self-Administration of Drugs policy, dated 11/2016, indicated residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so and clinically appropriate. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. The nursing staff will rotate bedside stock and will remove expired, discontinued, or recalled medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring a call light was accessible for 2 of 2 residents (R221, R283) reviewed for call lights.Findings include: R221's admission Minimum Data Set (MDS), dated [DATE], identified R221 was cognitively intact, and diagnoses included diagnoses of neurogenic bladder, diabetes, and schizophrenia. Additionally, R221 had impairment on one side of upper and lower extremities, required a walker and wheelchair for mobility, and required substantial assistance for dressing and hygiene. During an observation and interview on 6/25/26 at 8:37 a.m., R221 was seated in a wheelchair in her room, facing her bed with the bedside table between her and her bed. R221's call light was wrapped around the upper bedrail of the bed and out of reach. R221 was unable to access her call light, and stated, it is too far away. R221 attempted to move her wheelchair around the bed stand but was unable to move. Licensed practical nurse (LPN)-B and nursing assistant (NA)-D entered R221's room and verified the call light was not within R221's reach. LPN-B stated the call light should be in reach. NA-D stated the call light should be [in reach]. R283's admission MDS, dated [DATE], identified R283 with impaired cognition, required assistance with hygiene, and diagnoses of cardiomyopathy, heart disease, kidney disease, diabetes, and depression. During an observation and interview on 6/22/26 at 11:02 a.m., R283 was observed in bed as he watched television (TV). However, R283's call light was wrapped around the wall call light unit and was out of R283's sight and reach. R283 stated if he needed assistance, he would call out and it takes all day to get attention. During an interview on 6/22/26 at 11:06 a.m., nursing assistant (NA)-B verified R283's call light was wrapped around the wall unit and was out of R283's sight and reach. NA-B stated the call light should have been within R283's reach so R283 could call for help if needs it. During an observation and interview on 6/23/26 at 5:08 p.m., R283 watched TV from his bed. R283's call light was wrapped around the wall and was out of R283's sight and reach. R283 stated, I don't use it because I can't reach it. During an interview on 6/24/26 at 10:39 a.m., NA-C stated staff were expected to ensure call lights were within reach of every resident when in their rooms. NA-C stated residents could not request help unless the call light was within reach, and it was important for resident safety. During an interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-L stated expectation of call lights to always be in reach of every resident when in their rooms. During an interview on 6/24/26 at 11:19 a.m., RN-M stated call lights should be ideally within reach. RN-M stated call lights wrapped around the wall unit, and not in reach was not acceptable. RN-M stated the call lights were a lifeline for residents to use if they needed assistance. During an interview on 6/25/26 at 10:59 a.m., DON stated expectation of call lights to be in reach of every resident to have for help if needed. The facility's Answering the Call Light policy, effective 10/2025, indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure ongoing assessment and evaluation of physical restraints were completed to determine continued need, risks, benefits, and least restrictive interventions for a wheelchair lap tray and set belt for 1 of 1 resident (R147) reviewed for physical restraints. Findings include:R147's quarterly Minimum Data Set (MDS), dated [DATE], identified R147 had intact cognition and required assistance with activities of daily living (ADLs). R147's diagnoses included quadriplegia (paralysis affecting all four extremities), muscle weakness, lack of coordination (difficulty controlling body movements), and abnormalities of gait and mobility (difficulty with movement and positioning). The MDS further identified R147 did not use restraints.During an observation on 6/22/26 at 5:16 p.m., R147 was seated in his wheelchair with a seat belt secured and a lap tray attached to the wheelchair.During an observation on 6/25/26 at 11:05 a.m., R147 propelled throughout the main area in his power wheelchair. R147's wheelchair seat belt was buckled and a lap tray was positioned across the wheelchair.R147's care plan, dated 5/11/26, identified R147 had a seat belt on his wheelchair and R147 was able to lock and release the seat belt independently. The care plan interventions identified R147 was educated on risks versus benefits, and signed consent to use of the seat belt. R147's care plan further indicated R147 understood the seat belt could be removed at any time, the seat belt would be used when R147 was in the wheelchair as desired, and the seat belt did not impede R147's mobility or ability to reposition in the chair.R147's Physical Restraint Quarterly Assessment history, identified the most recent assessment was completed on 2/17/26. R147's electronic medical record (EMR) lacked evidence additional quarterly restraint assessments were completed after 2/17/26, The assessments were used to evaluate continued use of the lap tray and seat belt, verify R147 continued ability to independently remove the devices, determine if the devices continued to meet R147's assessed needs, or identify if less restrictive interventions or restraint elimination were appropriate.During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated R147 used a seat belt and lap tray on his wheelchair. RN-A stated the nurse manager was responsible for reassessing the continued need for the devices and R147's ability to use them.During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) reviewed R147's medical record and confirmed the last Physical Restraint Quarterly Assessment was completed on 2/17/26. The RNCM stated restraint assessments should have been completed quarterly, and confirmed an assessment should have been completed after 2/17/26. The RNCM stated the assessment had not been completed because it had not triggered in the EMR system. The RNCM stated reassessments were important to ensure continued appropriate use, and to verify the resident's needs remained current.During an interview on 6/25/26 at 1:35 p.m., the director of nursing (DON) stated physical restraint assessments were expected to be completed quarterly. The DON stated when residents were transferred to the hospital, assessments were discontinued in the electronic system and could fall off if they were not reviewed upon return to the facility. The DON confirmed R147 should have had another assessment completed after 2/17/26. The DON stated assessments were important to ensure residents remained able to remove the device independently and, if unable to remove the device, alternative interventions would need to be identified to maintain safety and update the care plan.The facility's Use of Physical Restraints policy, dated 6/2025, identified physical restraints were defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual could not remove easily and restricted freedom of movement or normal access to the body. The policy identified the definition of a restraint was based on the functional status of the resident and not the device. The policy further identified restrained individuals would be reviewed regularly, at least quarterly, to determine whether they were candidates for restraint reduction, less restrictive methods of restraint, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or restraint elimination. The policy identified care plans for residents with restraints would include interventions addressing the resident's needs and measures to reduce or eliminate restraint use.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and document review, the facility failed to ensure psychotropic medications were used in accordance with professional standards by failing to ensure PRN (as needed) psychotropic medication orders were limited to 14 days or contained documented clinical rationale and/or practitioner evaluation to support continued use beyond 14 days. The facility also failed to ensure monitoring was implemented to identify potential adverse effects related to antipsychotic medication use, including orthostatic blood pressure monitoring, for 1 of 5 resident (R152) reviewed for unnecessary medications.Findings include:R152's Medicare 5-day Minimum Data Set (MDS) assessment, dated 5/28/26, identified R152 had intact cognition, and diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), and tracheostomy status. The MDS further identified R152 received antipsychotic and antianxiety medications.R152's physician orders, dated 6/22/26, included lorazepam (an antianxiety medication) 0.5 milligrams (mg) by mouth every six hours as needed (PRN) for anxiety, with a maximum of three doses per day. The order had a start date of 6/9/26, and an end date of 7/9/26, which allowed the PRN psychotropic medication to remain active for 30 days. However, R152's medical record lacked documented clinical rationale from the practitioner to support the continued use of the PRN psychotropic medication beyond 14 days.R152's physician orders, dated 6/22/26, included quetiapine (an antipsychotic medication) 37.5 mg by mouth twice daily PRN for generalized anxiety. The order had a start date of 6/16/26, and an end date of 7/16/26, which allowed the PRN antipsychotic medication to remain active for 30 days. However, R152's medical record lacked documentation the practitioner evaluated R152 and determined the continued use of the PRN antipsychotic medication beyond 14 days was appropriate.R152's physician orders, dated 6/22/26, treatment administration records (TARs), and clinical documentation revealed R152 received an antipsychotic medication. However, orthostatic blood pressure monitoring was not ordered or completed to monitor for potential adverse effects associated with antipsychotic medication use.During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) confirmed PRN psychotropic medications should have been limited to 14 days. The RNCM stated if continued use was needed beyond 14 days, the provider should have been contacted for a new order. The RNCM confirmed R152's lorazepam order had an end date of 7/9/26, and the quetiapine order had an end date of 7/16/26. The RNCM stated the quetiapine order indicated the medication was to continue for seven days, but the stop date indicated in the electronic medical record (EMR) did not match the provider's order. The RNCM stated the previous provider order indicated to continue PRN quetiapine for seven additional days and lorazepam three times daily for two weeks. RNCM stated the extended stop dates were likely a transcription error. The RNCM further stated orthostatic blood pressure monitoring should have been implemented due to antipsychotic (quetiapine) use because of potential adverse effects that could lead to safety concerns. The RNCM confirmed R152 did not have orthostatic blood pressure monitoring in place.During an interview on 6/25/26 at 1:40 p.m., the director of nursing (DON) stated antipsychotic medications and PRN psychotropic medications required 14-day stop dates. The DON stated when a resident routinely required PRN psychotropic medication, the facility reviewed the continued need with the provider to determine if changes were needed, and to prevent unnecessary medication use. The DON further stated residents with ordered antipsychotic medications needed to have orthostatic blood pressures completed because the medication could affect blood pressure, resulting in safety concerns and an increased risk for falls.The facility's Psychotropic Medication Use policy, dated 9/15/24, indicated psychotropic medications were to be used safely and appropriately while minimizing risks and adverse effects in accordance with current practice guidelines and regulatory requirements. The policy indicated PRN psychotropic medication orders should be limited to no more than 14 days. The policy further indicated if the physician/prescriber determined a PRN psychotropic medication, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	excluding antipsychotics, should continue beyond 14 days, the rationale and duration of use should be documented in the resident's medical record. The policy indicated PRN antipsychotic medication orders were limited to 14 days and could not be renewed unless the physician/prescriber evaluated the resident for the appropriateness of continued medication use. The policy further indicated all medications used to treat behaviors should be monitored for efficacy, risks, benefits, and harm or adverse consequences.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 3 of 3 residents (R12, R15, R123) reviewed for MDS accuracy.Findings include: R12's readmission Minimum Data Set (MDS) assessment, dated 3/20/26 indicated R12 had not had any falls in the month prior to admission/re-admission, and indicated R12 had not had any fractures related to a fall in the 6 months prior to admission/re-admission. R12's quarterly MDS assessment, dated 6/22/26, indicated R12 had no falls in the previous 90 days. R12's care plan indicated R12 was at risk for falls related to cognition, unsteady gait and weakness. The care plan further indicated a fall with fractured hip on 3/9/26. During an interview on 6/25/26 at 11:17 a.m., licensed practical nurse manager (LPN)-A stated R12's readmission MDS assessment dated [DATE], and quarterly MDS assessments were inaccurate due to R12's fall with hip fracture on 3/9/26. During an interview on 6/25/26 at 1:52 p.m., Director of Nursing (DON) confirmed R12 had a fall with fracture on 3/9/26, the MDS assessments dated 3/20/26 and 6/22/26 were inaccurately coded. DON stated it was important for the MDS assessments to be accurate so residents received the care they needed and to prevent potential negative outcomes to residents. R15's significant change MDS, dated [DATE], indicated R15 took an anticoagulant and not an antiplatelet. R15's Medication Administration Record (MAR), dated 4/1/26 to 4/30/26, indicated R15 had not received an anticoagulant during the look back period (LBP), but had received 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 8:44 a.m., MDS coordinator (MDSC)-A, a registered nurse (RN), reviewed R15's medical record and stated R15 had taken an antiplatelet medication, aspirin, and had not received an anticoagulant medication during the LBP. R123's annual MDS, dated [DATE], indicated R123 was taking an anticoagulant and not an antiplatelet. R123's May 2026 MAR, dated 5/1/26 to 5/31/26, indicated R123 had not received an anticoagulant during the look back period (LBP) but did receive 81 milligrams (mg) of aspirin (an antiplatelet medication) daily during the LBP. During an interview on 6/25/26 at 7:57 a.m., RN-G reviewed R123's medical record and stated R123 had not been taking an anticoagulant but did take aspirin. During an interview on 6/25/26 at 8:27 a.m., RN-D, a nurse manager, reviewed R123's medical record. RN-D verified R123 had not taken an anticoagulant since 2021 when it was discontinued. RN-D stated R123 was and had been taking aspirin and verified aspirin was not an anticoagulant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/26 at 8:51 a.m., MDSC-A, reviewed R123's medical record and stated R123 had taken an antiplatelet medication (aspirin), and not an anticoagulant medication during the LBP. MDSC-A verified the MDS was coded incorrectly. During an interview on 6/25/26 at 10:35 a.m., DON stated it was important the MDS was accurate as it affected reimbursement and MDS assessment information directed the care plan and interventions. The facility's MDS Assessment Coordinator policy, dated 3/2027, indicated that each individual who completed a portion of the MDS must certify the accuracy of the assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., shaving) was provided to 1 of 1 residents (R12) reviewed for Activities of Daily Living (ADLs) who were dependent on staff for their care.Findings include:R12's admission Minimum Data Set (MDS) assessment, dated 3/6/26, indicated R12 was cognitively intact, required partial to moderate assistance with personal hygiene, and had not refused or rejected cares.R12's care plan, reviewed 6/24/26, indicated R12 required the assistance of one staff for personal hygiene.During an observation and interview on 6/22/26 at 2:04 p.m., R12 had scruffy facial hair, approximately 3/4 of an inch long, covering his face and neck. R12 stated he preferred to be clean shaven. An electric razor was plugged into the wall on the floor next to R12's bed.During an observation on 6/23/26 at 10:27 a.m., R12 continued to have scruffy facial hair covering his face and neck.During an observation on 6/23/26 at 3:15 p.m., R12 had scruffy facial and neck hair present, and the electric shaver was noted on floor.During an observation and interview on 6/24/26 at 10:19 a.m., R12 continued to have scruffy facial and neck hair. R12 asked for assistance and stated he did not ?like this scruff on my face'. The electric razors were still plugged into wall and lying on the floor.During an interview on 6/24/26 at 10:46 a.m., nursing assistant (NA-D) stated she was familiar with R12's care and identified personal hygiene as shaving, assisting with denture care, cleaning face and hair brushing. NA-D stated facility staff assisted R12 with personal hygiene and specifically assisted with shaving on his bath days. NA-D stated she was unaware of R12 refusing cares.During an interview on 6/25/26 at 11:09 a.m., licensed practical nurse manager (LPN-A) stated the NA staff was responsible for the completion of personal hygiene for residents, and that a resident who was listed as requiring substantial maximal assistance, the NA staff completed the task (shaving) for the R12. LPN-A stated personal hygiene/grooming would normally be completed on bath day, however, if the resident did not receive a full bath, personal hygiene, like shaving, would be completed.During an interview on 6/25/26 at 1:52 p.m., director of nursing (DON) stated personal hygiene/cares included hair care, oral care, nail care and shaving. DON stated floor staff were responsible for completing these tasks on bath days for residents. DON stated residents' personal preferences should be honored and if a resident desired to be clean-shaven, staff were expected to make every effort to do so. DON stated she expected resident preferences to be met whenever possible. DON stated it was important to provide personal care in a manner of resident preference because residents have the right to feel good about the way they look.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R6) reviewed for falls. Additionally, the facility failed to comprehensively assess to prevent potential injury for 1 of 1 residents (R44) reviewed for smoking. Findings include: R6's annual Minimum Data Set (MDS), dated [DATE], indicated R6 was cognitively intact, had not rejected cares, was independent with activities of daily living (ADLs), and diagnoses included arthritis and depression. R6's progress note, dated 5/14/26 at 5:13 a.m., indicated that R6 slid from bed and was found on the floor with no injuries observed. R6's fall risk management, dated 5/14/26, indicated R6 had fallen out of bed and was found on her bedside floor by staff. The report indicated R6 stated she was rolling in her bed when she had fallen. The report indicated R6 thought the bed was too small, causing her to fall off her bed, and R6 was given a new and bigger bed to reduce the risk of falling. R6's care plan, dated 5/18/26, indicated R6 was at risk for falls related to gait and balance problems and had fallen on 7/8/25, 1/25/26, 2/10/26, and 5/14/26. The care plan indicated that related to a fall on 5/14/26, R6 was given a bigger bed. R6's progress note, dated 6/22/26 at 5:22 a.m., indicated R6 was found lying on the floor beside her bed, and R6 had stated she was lying on her side in bed and attempted to roll toward the side of the bed and rolled out of bed. The progress note indicated that R6 did not have any injuries at the time of the assessment. During multiple observations on 6/23/26, other beds on the unit were observed and compared to R6's bed. R6's bed appeared to be the standard bed size. During an interview on 6/22/26 at 1:38 p.m., R6 stated she had fallen out of bed a couple of times when trying to reposition herself in bed, and felt her bed was too small. R6 stated she thought she was going to get a bigger bed but never did. During an observation and interview on 6/23/26 at 12:53 p.m., registered nurse (RN)-B stated R6 had a history of falls and R6 was supposed to have given a bigger bed. RN-B stated it appeared R6 had not received a larger bed because the one R6 had was a normal-sized bed. During an interview on 6/23/26 at 1:02 p.m., licensed practical nurse (LPN)-A, the nurse manager for the unit, stated as the fall intervention for R6's fall on 5/14/26, LPN-A ordered a larger bed and thought R6 had received it. LPN-A stated it appeared R6 had not received a larger bed and LPN-A needed to talk to the director of maintenance (DM) to determine what happened. During an interview on 6/23/26 at 1:07 p.m., the DM stated R6's bed was the standard-sized bed, and R6 had not been provided with a larger one. (continued on next page)

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North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 6/24/26 at 1:37 p.m., the DM stated there had been a miscommunication between maintenance and nursing. The DM stated nursing had indicated that a larger mattress was needed, but R6 already had the largest mattress size for her bed frame. The DM stated the ticket had then been closed out and a larger bed was not ordered. R44's admission Minimum Data Set (MDS), dated [DATE], indicated resident was cognitively intact and received supervision to moderate assistance with all activities of daily living (ADLs). R44's Face Sheet, printed 6/25/26, indicated R44 diagnoses included malignant neoplasm of unspecified kidney, dependence on renal dialysis, anxiety, and traumatic subdural hemorrhage without loss of consciousness. During an observation and interview on 6/22/26 at 3:07 p.m., R44 was in his room with his significant other, and two packs of cigarettes were observed on a corner table. R44 stated he smoked several times each day. No burn holes in R44's clothing were observed. During an observation on 6/24/26, at 11:46 a.m., R44 self-propelled in his wheelchair from his room to the designated outside smoking area, at the rear of the facility. R44 independently lit his cigarette, held it safely, extinguished his cigarette safely, and placed the cigarette butt in the smoking pole (a tall container where residents placed their cigarette butts). During an observation on 6/24/2026 at 12:04 p.m., R44 was seated in his room as he ate his noon meal. Two packs of cigarettes were on the corner table beside R44. During an observation on 6/24/26, at 3:58 p.m., R44 again wheeled himself in his wheelchair from his room to the designated outside smoking area. R44 managed the entire smoking process correctly and safely. R44's Smoking Evaluation, dated 5/14/26, indicated R44 did not wish to smoke during his stay, and R44 did not utilize oxygen. The remainder of the assessment was blank. R44's Smoking Evaluation, dated 5/24/26, indicated R44 did not wish to smoke during his stay, and the remainder of the assessment was blank. R44's Comprehensive Care Plan lacked information related to smoking. During an interview on 6/25/26 at 7:30 a.m., registered nurse (RN)-E stated R44 smoked independently at least four times a day. RN-E stated when R44 first admitted , he was not smoking and went outside to get some fresh air. When staff noted R44 was smoking, staff approached R44 and he told staff, I don't have that much more time to live, so I'm going to smoke. During an interview on 6/25/26 at 8:19 a.m., clinical manager (RN)-F stated he was not the clinical manager for R44's wing when R44 was admitted . and was not aware R44 lacked a comprehensive assessment of his smoking abilities. RN-F stated the facility's expectation was that any resident who smoked, whether known at the time of admission or observed afterwards, was assessed by the facility staff for resident safety. During an interview on 6/25/26 at 8:30 a.m., the director of nursing (DON) stated nursing staff were expected to assess and keep eyes on residents who wished to smoke to determine the resident's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ability to smoke safely. If a resident was assessed as safe to smoke independently, they would not need supervision, unless there was a change in their status and needed to be reassessed. The facility's Managing Falls and Fall Risk policy, dated 6/2026, indicated that facility staff would attempt to identify appropriate interventions to reduce the risk of falls. The policy indicated that if a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. The facility's Accident Prevention - Smoking Policy, revised 10/2022, indicated the facility shall establish and maintain safe resident smoking practices. Residents whom wish to smoke will be evaluated for safe smoking per community protocol. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues, per community protocol.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure appropriate provider orders were obtained to maintain an indwelling urinary catheter for 1 of 1 residents (R246) reviewed for catheter care.Findings include: R246's admission Minimum Data Set (MDS), dated [DATE] indicated R246 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included diabetes, atrial fibrillation, hypertension, dementia, and myelodysplastic syndrome (type of cancer in which the bone marrow does not make enough healthy blood cells). R246's Order Summary identified an order dated 6/4/26, for an indwelling (foley) caterer for comfort. However, the order failed to indicate the catheter size and balloon size needed for catheter replacement. R246's treatment administration record (TAR), dated 6/1/26 to 6/30/26 indicated an order for an indwelling (foley) catheter for comfort. However, the orders failed to include catheter size and balloon size needed for catheter replacement. R246's care plan, initiated 6/22/26, indicated R246 had an indwelling foley catheter. However, the care plan lacked the size of catheter and balloon size needed for catheter replacement. During interview on 0/25/26 at 10:56 a.m., registered nurse (RN)-I stated all orders for catheters were expected to include the size of the catheter and amount of normal saline needed to inflate the balloon. RN-I verified R246's orders did not indicate the catheter size and balloon size. During interview on 6/25/26 at 11:21 a.m., RN-H stated all catheter orders should have contained the diagnosis, catheter size and how much to fill the balloon. RN-H verified R246's orders lacked specifics regarding the size of the catheter and balloon size. During interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated indwelling urinary catheter orders were expected to include the diagnosis, size of the catheter and how much normal saline was to be used to fill the balloon. DON stated R246's orders looked as though no one had updated the order with the required information. DON stated it was important the correct catheter size and balloon volume were used to decrease discomfort. A facility policy was requested for catheter orders, but was not received.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and document review, the facility failed to ensure timely and effective interventions were implemented for significant, unplanned weight loss and failed to ensure consistency between physician orders and care plan directives related to weight monitoring for 1 of 1 residents (R256) reviewed for weight loss. Findings include:R256's annual Minimum Data Set (MDS) assessment, dated 5/25/26, indicated R256 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), including feeding, and had a diagnosis of weight loss. R256 received a mechanically altered diet and was not on a prescribed weight-loss regimen.R256's physician order, dated 5/1/23, indicated an order for monthly weights. Additional orders included a house supplement shake 4 oz twice daily, initiated 1/9/24, for nutritional supplementation and ProStat Advanced Wound Care Liquid daily, initiated, 6/27/25 for wound healing.R256's weight records indicated R256 weighed 153.2 pounds (lbs) on 4/3/26 and 127 lbs on 6/3/26. These weights indicated a weight loss of 26.2 lbs (17.1%) over 2 months.R256's care plan, revised 3/1/23, identified R256 was at risk for altered nutritional/hydration status related to dysphagia, with altered textures, aphasia, hemiplegia, impaired mobility, and cardiac disease. Interventions included feeding assistance and weekly weights. However, R256's care plan directed weekly weights while R256's physician orders directed monthly weights.R256's nutrition progress note, dated 5/22/26, indicated R256's current weight was 127 lbs and identified a recent weight change within the last 30 days. The note indicated no notable change in oral intake over the 30-day lookback period and recommended continuation of the current plan of care. Despite ongoing weight loss trends, no new interventions or escalation of nutritional interventions were implemented at that time.During an interview on 6/24/26 at approximately 2:00 p.m., the registered dietitian (RD) stated residents were generally weighed monthly, but high-risk residents with weight loss were weighed weekly. The RD acknowledged the R256's weight loss trend and stated current interventions were not effective. The RD stated R256 could have received up to three nutritional shakes per day, and weekly weight monitoring should have been initiated to better evaluate trends.During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse (LPN)-Unit Manager stated weights were typically obtained monthly per physician order. The LPN stated when discrepancies occurred between care plans and orders, staff followed physician orders, and care plans were expected to be updated accordingly. The LPN further stated the R256's weight loss had not been escalated as a concern requiring intervention change.During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON) stated the resident was monitored as a high-risk resident with weight loss. DON acknowledged R256 continued ongoing nutritional decline and needed for further evaluation of interventions.The facility's Weight Assessment and Intervention policy, dated 10/2025, indicated significant unplanned weight loss was greater than 7.5% weight loss in 3 months and care planning should include individualized identification of the cause of the weight loss, goals and benchmarks and interventions should consider resident choices, preferences, and abilities.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure respiratory care and services were provided according to professional standards of practice and physician orders when the facility failed to ensure tracheostomy orders, included the specific type and size of tracheostomy tube, for 2 of 2 residents (R147 and R152) reviewed for tracheostomy care. In addition, the facility failed to obtain physician orders for oxygen therapy, including prescribed flow rate and administration parameters, for 1 of 3 residents (R152) reviewed for oxygen therapy, and the facility failed to ensure oxygen was administered according to physician orders for 1 of 3 residents (R14) reviewed for oxygen therapy.Findings included:R14R14's quarterly Minimum Data Set (MDS), dated [DATE], identified R14 had intact cognition and required staff assistance with activities of daily living (ADLs). R14's diagnoses included respiratory failure, tracheostomy status (a surgically created opening in the neck to assist with breathing), and acute respiratory failure with hypoxia (low oxygen levels).R14's care plan, dated 5/6/26, identified R14 had a tracheostomy related to impaired breathing mechanics and used a Volera/Metaneb device for secretion management. The care plan directed staff to provide humidified oxygen as prescribed with a goal oxygen saturation greater than or equal to 92%, monitor respiratory status, suction as necessary, and maintain emergency tracheostomy equipment at bedside.R14's physician orders, dated 6/22/26, included an order, initiated 2/24/26, for oxygen at 5 liters per minute (LPM) per tracheostomy collar continuously for hypoxia.During observations on 6/22/26 through 6/25/26, R14's oxygen was set as follows, instead of 5 LPN as per physician orders: On 6/22/26 at 2:04 p.m., R14's oxygen was set at 3 LPM. Additionally, the oxygen tubing contained condensation and was not labeled or dated to identify when it was last changed.On 6/22/26 at 2:04 p.m., R14's oxygen was set at 3 LPM.On 6/23/26 at 1:16 p.m., R14's oxygen was set at 3 LPM.On 6/24/26 at 8:20 a.m., R14's oxygen was set at 3 LPM.On 6/25/26 at 10:53 a.m., R14's oxygen remained set at 3 LPM.R147R147's quarterly MDS, dated [DATE], identified R147 had intact cognition and required staff assistance with ADLs. R147's diagnoses included chronic respiratory failure, respiratory failure, and tracheostomy status. The MDS identified R147 required suctioning and tracheostomy care.R147's care plan, dated 5/11/26, identified R147 had altered respiratory status and difficulty breathing related to tracheostomy status. The care plan directed staff to maintain a clear airway, suction as ordered or required, monitor for signs and symptoms of respiratory distress, and provide oxygen as ordered and needed.Review of R147's physician orders, dated 6/22/26, identified an order initiated 6/12/26, Name of Trach _____ Size of Trach _____ every shift for Tracheostomy care. However, the type or size of tracheostomy tube used by R147 was not identified.R152R152's Medicare 5-day MDS, dated [DATE], identified R152 had intact cognition and required staff assistance with ADLs. R152's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), respiratory failure, and tracheostomy status. The MDS identified R152 received oxygen therapy and required suctioning and tracheostomy care.R152's care plan, dated 5/25/26, identified R152 had a tracheostomy related to impaired breathing mechanics and had a history of adjusting oxygen flow settings despite redirection. The care plan directed staff to check the oxygen flow rate when entering the resident's room, administer humidified oxygen as prescribed, monitor respiratory status, suction as necessary, and maintain emergency tracheostomy equipment at bedside.R152's physician orders, dated 6/22/26, identified an order initiated 6/12/26, Name of Trach _____ Size of Trach _____ every shift for Tracheostomy care, However, the type or size of tracheostomy tube used by R152 was not identified. Additionally, R152's electronic medical record (EMR) had not included a current physician order for oxygen therapy, prescribed liter flow, delivery method, frequency, or parameters. During observations from 6/22/26 through 6/25/26, R152 received oxygen without a physician order:On 6/22/26 at 3:14 p.m., oxygen was set at 5 LPM.On 6/23/26 at 1:19 p.m., oxygen was set at 4.5 LPM.On 6/24/26 at 8:27 a.m., (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen was set at 4 LPM.On 6/25/26 at 7:39 a.m., oxygen was set at 6 LPM.During an interview on 6/25/26 at 10:53 a.m., registered nurse (RN)-A stated staff checked physician orders to verify oxygen liter flow and tracheostomy information. RN-A reviewed R14's orders and confirmed R14's oxygen was set at 3 LPM instead of the ordered 5 LPM. RN-A reviewed R152's record and confirmed there was no oxygen order and no order identified the specific type and size of tracheostomy tube.During an interview on 6/25/26 at 11:07 a.m., the registered nurse case manager (RNCM) confirmed R152 did not have an oxygen order or an order identifying the tracheostomy type and size. The RNCM stated oxygen orders should have identified the prescribed liter flow, and tracheostomy orders should have included the type and size. RNCM stated the information was important in vsdr T253'd tracheostomy required replacement during an emergency.During an interview on 6/25/26 at 1:35 p.m., the Director of Nursing (DON) stated she expected the tracheostomy type and size to be included in physician orders. The DON stated she expected oxygen orders to include oxygen use, liter flow, tubing changes, and oxygen saturation monitoring. The DON stated complete respiratory orders were important so staff knew how to appropriately care for residents.The facility's Oxygen Administration policy, dated 3/2026, directed staff to verify there was a physician order for oxygen administration and review the physician orders and care plan before providing oxygen. The policy directed staff to ensure the proper oxygen flow rate was administered and documentation included oxygen flow rate, route, frequency, duration of treatment, and resident response.The facility's Tracheostomy Care policy, dated 3/2026, directed staff to check physician orders prior to providing tracheostomy care. The policy directed staff to ensure emergency tracheostomy equipment was available at bedside and identified a replacement tracheostomy tube must be available at the bedside at all times.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure non-pharmacological pain interventions were offered, implemented, and documented when administering as-needed pain medication for 1 of 1 resident (R142) reviewed for pain management.Findings include: R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain. R142's Pain Assessment Instrument (PAINAD), dated 6/14/26, documented R142 had no pain. R142's pain assessment, dated 6/16/26, indicated R142 was cognitively intact and had experienced frequent pain during the previous five days. R142's physician orders, dated 6/12/26, included the following as needed (PRN) medications for pain: hydromorphone 8 milligrams (mg) every 2 hours PRN for pain, ibuprofen 600mg every 8 hours PRN for pain, methocarbamol [PHONE NUMBER]mg every 6 hours PRN for muscle spasms, and baclofen 2.5mg two times daily PRN for muscle pain. R142's June 2026 Medication Administration Record (MAR), revealed R142 received PRN hydromorphone up to four times daily 6/12/26 through 6/24/26. Additionally, R142 received PRN ibuprofen one time, and methocarbamol 1000mg one time, between 6/12/26 and 6/24/26. R142's EMR revealed the facility failed to provide and document non-pharmacological pain interventions before or after administration of as-needed pain medication. R142's hospice care plan, initiated 6/15/26, addressed the resident's terminal prognosis related to metastatic prostate cancer. However, individualized, non-pharmacological pain interventions were not identified. During an observation on 6/24/26 at 8:10 a.m., R142's call light was activated. Nurse Manager/Licensed Practical Nurse (LPN)-C responded to the call light. During the encounter, R142 requested pain medication. However, LPN-C did not offer or implement non-pharmacological pain intervention while R142's request was addressed. During an observation on 6/24/26 at 8:15 a.m., LPN-D administered scheduled pain medication, and subsequently administered PRN hydromorphone after R142 requested additional pain medication. However, LPN-D failed to offer or implement any non-pharmacological pain interventions before the PRN narcotic was administered. During an observation and interview on 6/24/26 at 8:32 a.m., nursing assistant (NA)-F assisted R142 with morning cares. NA-F stated R142 frequently experienced significant pain. R142 stated, I don't think just pills will get this pain away. R142 further stated massage had helped in the past but had not been offered since R142 admitted to the facility. During an interview on 6/24/26 at 10:47 a.m., R142 stated his pain remained poorly controlled despite the receipt of pain medication. R142 stated ongoing pain was discussed with the hospice nurse, but no changes had been made. During an observation and interview on 6/24/26 at 1:42 p.m., R142 was in bed and appeared lethargic. R142 stated he felt out of it and did not feel well. During an interview on 6/24/26 at 1:28 p.m., registered nurse (RN)-O stated non-pharmacological interventions were documented under behavior management, and staff were expected to document interventions attempted and their effectiveness in a progress note. During an interview on 6/25/26 at 9:11 a.m., LPN-C stated staff were expected to implement non-pharmacological pain interventions, document interventions attempted in progress notes, and document whether those interventions were effective. LPN-C stated staff were expected to communicate with the provider or hospice when scheduled pain medications had not adequately controlled a resident's pain. During an interview on 6/24/26 at 2:53 p.m., the hospice RN case manager stated facility staff had not communicated concerns that R142 continued to experience uncontrolled pain. During an interview on 6/25/26 at 11:20 a.m., the director of nursing (DON), stated the R142's care plan should have identified individualized non-pharmacological pain interventions were to be attempted. The DON stated nursing staff were expected to document in a nurse's note or progress note the non-pharmacological interventions offered and whether the interventions were effective in managing the resident's pain. The facility's Pain Assessment and Management policy, dated 5/2026, directed staff to monitor the frequency of as-needed (PRN) pain medication use and to (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the practitioner when PRN pain medications were being administered around the clock so routine scheduled pain medication could be considered. The policy further indicated pharmacological interventions alone do not typically address the cause of pain and may result in adverse effects. The policy indicated non-pharmacological interventions may be appropriate, either independently or in conjunction with pain medications, as part of pain management.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview and document review, the facility failed to ensure licensed nursing staff demonstrated competency by administering the incorrect dose of a controlled medication and inaccurately documenting controlled substance administration for 1 of 3 residents (R142) reviewed for medication administration. Findings include:R142's diagnoses list, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain.R142's physician orders, dated 6/12/26, included an order for Methadone HCl 10 milligram (mg) tablets - 50 milligrams (mg) every morning, 20 mg daily (midday), and 40 mg at bedtime for pain. During observation on 6/24/26 at 8:15 a.m., Licensed Practical Nurse (LPN)-D entered R142's room to administer scheduled medications. During the medication pass, R142 requested as-needed pain medication and LPN-D why there were only two pain pills in his medication cup as he should have five pills. LPN-D told R142 that the medication cup contained his morning dose.Review of R142's methadone medication card revealed all three varying doses of methadone were packaged in the same medication card, with each bubble containing either two, four or five 10mg-tablets. LPN-D stated she removed methadone tablets from the medication card in the order they were packaged, rather than verifying the prescribed dose before administration. LPN-D acknowledged she had administered 20 mg (two 10mg-tablets) instead of the ordered 50 milligrams (five 10mg-tablets) for the scheduled 6/24/26 morning dose. Following R142's medication administration on 6/24/26 at 8:15 a.m., LPN-D documented the controlled substance incorrectly in the narcotic accountability record when she recorded an incorrect remaining tablet count. After LPN-D acknowledged she had administered Methadone 20mg instead of 50mg as ordered for R142's morning medication administration, LPN-D corrected the documentation after the error was acknowledged During observation and interview on 6/24/26 at approximately 8:45 a.m., LPN-D returned to R142's room with three additional methadone 10mg-tablets, stated hospice had been contacted, and hospice instructed LPN-D to administer the remaining tablets to complete the prescribed morning dose.During an interview on 6/25/26 at 9:11 a.m., Nurse Manager LPN-C stated licensed nurses were expected to follow the five rights of medication administration, verify medication directions prior to administration, review medication parameters, and maintain accurate narcotic accountability records by documenting the correct quantities administered and remaining. LPN-C stated the nurse should have recognized that multiple methadone doses were packaged within the same medication card. During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), stated licensed nurses were expected to follow the five rights of medication administration by ensuring the right resident, right medication, right dose, right route, and right time before medications were administered. The DON stated nurses were expected to accurately document controlled substance administration and follow up with nurse management if concerns with medication packaging were noted.The facility's Medication Administration policy, dated 10/2025, directed staff to administer medications safely, timely, and as prescribed. The policy required licensed staff to administer medications in accordance with physician orders, verify the right resident, right medication, right dose, right time, and right route before administration by checking the medication label three times, and accurately document medication administration following administration. The policy further directed staff to contact the resident's physician if a prescribed dosage was believed to be inappropriate or excessive and indicated newly authorized staff were not permitted to administer medications until they had been oriented to the facility's medication administration system.

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	245183	A. Building B. Wing	06/25/2026

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North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure recommendations from the consulting pharmacist were acted upon timely to reduce the risk of adverse effects for 1 of 5 residents (R9) reviewed for unnecessary medication use.Findings include: R9's admission Minimum Data Set (MDS), dated [DATE], indicated R9 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included edema, dementia, hypertension, insomnia and encephalopathy (broad term for any disease, damage, or malfunction that affects the brain). R9's Pharmacy Consultation Report, dated 5/19/26, indicated the facility needed to obtain a psychotropic consent for a new order of trazadone (a psychotropic medication) for insomnia. Additionally, the report indicated the facility needed to monitor R9's sleep while R9 received trazadone. However, R9's medical record lacked evidence that the facility obtained psychotropic consent for R9's trazodone. Additionally, R9's medical record lacked evidence sleep monitoring was completed as recommended. During an interview on 6/25/26 at 11:21 a.m., registered nurse (RN)-H stated nurses obtained consent for a psychotropic medication when a resident was admitted to the facility, or when a new psychotropic medication was ordered. RN-H stated she processed the pharmacy recommendations for the nursing department. RN-H verified R9's medical record lacked evidence of psychotropic consent for trazodone. Additionally, RN-H acknowledged sleep monitoring had not been initiated for R9. RN-H stated the sleep monitoring was important to monitor if R9 was sleeping too much or not sleeping enough. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated the nurse managers were responsible for completing nursing department pharmacy recommendations. DON stated the nurse managers were expected to complete nursing pharmacy recommendations within a week. A policy for follow up and review of consulting pharmacist recommendations was requested, however, not received.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure adequate monitoring was completed for 1 of 5 residents (R255) reviewed for unnecessary medications.Findings include: R255's admission Minimum Data Set (MDS), dated [DATE], indicated R255 had severe cognitive impairment, required substantial assistance with activities of daily living (ADLs), and diagnoses included hypertension, chronic kidney disease, dementia, diabetes, and anxiety. R255's order summary report, printed 6/25/26, included an order dated 5/12/26 for metoprolol succinate extended release 50 milligrams (mg) by mouth one time daily, hold for systolic blood pressure (SBP) less than 100 or heart rate (HR) less than 60. R255's medication administration records (MAR) for May 2026 and June 2026, indicated R255's blood pressure was monitored. However, R255's MARs failed to indicate R255's heart rate was monitored and recorded as per provider order. During an interview on 6/25/26 at 10:56 a.m., registered nurse (RN)-I stated staff were expected to check a resident's blood pressure and/or heart rate if the orders had parameters to hold a medication. RN-I verified R255's orders indicated metoprolol was to be held if the SBP was less than 100 or HR less than 60. RN-I stated R255's MAR indicated staff needed to obtain R255's blood pressure prior to the administration of R255's metoprolol. RN-I acknowledged R255's MAR failed to prompt staff to obtain R255's heart rate prior. During an interview on 6/25/26 at 11:05 a.m., RN-J stated when a medication required a heart rate and blood pressure to be taken, the order should have triggered staff to check and record the reading. RN-J stated R255's order did not indicate the HR was to be recorded. During an interview on 6/25/26 at 11:46 a.m., director of nursing (DON) stated when an order was entered into the system supplementary documentation was expected to be added to the order to require both the heart rate and blood pressure to be recorded. DON reviewed R255's orders, stated the supplementary pulse (heart rate) was not selected to require the HR to be recorded, so the metoprolol could have been administered if R255's HR was less than 60. The facility's Physician Medication Orders policy, reviewed 10/2025, did not address medication parameters.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on observation, interview, and document review, the facility failed to coordinate blood draws as ordered by the provider for 1 of 2 residents (R25) reviewed for dialysis.Findings include:R25's admission Minimum Data Set (MDS) assessment, completed on 5/12/26, indicated R25 was cognitively intact, was able to communicate wishes to others, understood others, and diagnoses included renal insufficiency with dependence on dialysis and anemia.R25's progress note on 6/8/26, at 1:56 p.m., indicated a call was received from the lab to alert facility R25 had a critical lab value of hemoglobin (hgb-the oxygen carrying cells in the blood) was low at 6.9 (normal hemoglobin level is 12 - 16). The note indicated that the provider was updated. The progress notes lacked indication of subsequent blood draws following the last blood draw on 6/15/26.During interview on 6/22/26 at 1:19 p.m., R25 stated he felt good and denied any symptoms of nausea or vomiting, although stated he was tired after dialysis. R25 stated he had his Hgb checked while at dialysis and his most recent lab value was at 8.2. R25 was unable to recall when that was completed. R25 stated the lab tech did come to draw blood on Monday, 6/22/26, however, R25 stated he had requested lab draws be done on his dialysis days as they were already accessing his site for dialysis. However, R25's narrative notes lacked any indication that the lab work had been attempted and declined by resident. Additionally, the documentation lacked indication that there had been follow up with dialysis facility to request labs while at dialysis, or subsequent follow up with the provider to inform them this had not been completed.R25's June 2026 Medication Administration Record (MAR)/Treatment Administration Record (TAR), identified the nurse on Sunday evening, 6/21/26, prepared a lab slip for weekly CBC (complete blood count-a test which reviews hemoglobin, white count and other measurements to assess status) to be drawn Monday, 6/22/26. However, R25's records, lacked evidence labs had been drawn. During observation and interview on 6/24/26 at 10:05 a.m., health unit coordinator (HUC)-B reviewed the lab book to see if blood had been drawn on 6/22/26 as ordered. HUC-B identified the lab draw had not been documented as having been done, nor was there documentation it had been declined, or of any subsequent follow up with the provider. HUC-B stated documentation was completed by the nurses. HUC-B stated a CBC had been drawn on 6/15/26 as ordered, however, there had been no subsequent follow up. HUC-B stated she was unaware if labs were able to be drawn during routine dialysis run.During interview on 6/24/26 at 1:57 p.m., the dialysis registered nurse (DRN)-A stated it was possible to draw lab work while at the dialysis facility, however, the request needed to be completed by nursing or lab, to allow coordination. DRN-A verified via email on 6/24/26 at 5:51 p.m., R25's hgb was last drawn at the dialysis facility on 6/18/26 and was at 8.2. During interview on 6/25/26 at 8:01 a.m., registered nurse/unit manager (RN/UM)-A stated R25 was admitted to the unit with orders for routine blood work. RN/UM-A stated she was unsure why the labs were not drawn on 6/22/26, and identified the documentation lacked rationale for missed draw or request for change in blood draw process at dialysis.During interview on 6/25/26 at 2:26 p.m., the director of nursing (DON) stated it was her expectation that if labs were not drawn as ordered, the nursing staff would investigate as to why it had not been completed as ordered and follow up with provider. DON stated refusal of lab draws, and subsequent follow up were to be documented to reflect this in the medical record. DON stated if it were the request to have labs done during the dialysis session, this was to be coordinated with the dialysis facility.The facility's Lab and Diagnostic Test Results-Clinical Guidelines policy, last reviewed 6/25, identified labs were ordered by the physician, and staff were to process test requisitions and arrange for tests per community and contracted lab protocol. The policy defined that a nurse was to review all results and alert the provider accordingly.The facility's Guidelines for Charting and Documentation policy, last reviewed 6/25, identified the purpose of charting was to document a complete account of the resident's care, treatment, and response to the care. The policy outlined refusal of treatments were to be documented and the information recorded was to include the date and time the treatment, the treatment refused, (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's response and reason for refusal, the date/time the provider was notified, and the provider response.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure oral health needs were met for 1 of 1 residents (R2) reviewed for denture fit and function resulting in the resident not consistently receiving or using dentures despite documented issues with improper fit and the resident's expressed desire to use them. Additionally, the facility failed to ensure routine dental service recommendations were followed to promote oral hygiene and reduce the risk of complications for 1 of 1 residents (R21) reviewed for dental services.Findings include:R2's quarterly Minimum Data Set (MDS) assessment, dated 4/6/26 indicated R2 was cognitively intact and required partial to moderate assistance with most activities of daily living (ADLs). R2's dental note, dated 10/1/24, documented R2's dentures did not fit properly and required adjustment, with the provider noting additional adjustments may be needed as the resident continued to adapt to new dentures. R2's MDS oral/dental assessment, dated 12/22/25, indicated the R2's dentures did not fit correctly and recommended evaluation for adjustment. R2's care plan, dated 2/22/23 and revised 8/8/25, identified oral/dental health problems and directed staff to provide mouth care as part of ADL assistance. However, the care plan lacked any specific interventions that addressed denture use, management, or follow-up. R2's electronic medical record (EMR) lacked documentation of dental follow-up or evaluation regarding dentures after December 2025. During an observation and interview on 6/22/26 at approximately 11:19 a.m., R2 was observed without dentures in place, and stated the dentures frequently fell out of his mouth and did not fit right. R2 stated staff stopped attempting to assist with denture use so he no longer consistently wore them. R2 stated he wanted to continue using dentures as he was also experiencing gum tenderness. During an interview on 6/24/26 at 10:33 a.m., Nursing Assistant (NA)-E stated R2 needed assistance of one staff for ADLs. NA-E confirmed staff provided oral care, but did not assist with placement or use of dentures, and did not think R2 wore dentures. During an interview on 6/24/26 at 10:53 a.m., the Health Unit Coordinator (HUC) stated the facility utilized both onsite and outside dental providers. HUC stated scheduling was variable and sometimes providers arrived without prior notice. The HUC was not aware of when R2 last received dental services or follow-up regarding dentures. During an interview on 6/24/26 at 1:28 p.m., the Registered Nurse (RN)-O, confirmed R2's treatment record did not indicate R2 currently used dentures, and RN-O was unaware of any denture use. During an interview on 6/25/26 at 9:11 a.m., the Licensed Practical Nurse/Unit Manager (LPN) stated R2 had dentures and LPN was unaware of concerns regarding improper fit. LPN acknowledged no dental follow-up had been completed after R2's 12/2025 dental assessment. R21's annual Minimum Data Set (MDS), dated [DATE], identified R21 with intact cognition, no behaviors or limitations in upper and lower extremities, required set up for oral hygiene, and diagnoses included diabetes, heart disease, kidney disease, and partial amputation of left foot. R21's electronic medical record (EMR), including R21's care plan, physician orders and progress notes, failed to identify the provision of denture adhesive. During observation and interview with R21 on 6/22/26 at 11:55 a.m., R21 stated he had both upper and lower dentures and, they don't fit like they should, and they [facility] were supposed to get back to me about six weeks ago to put something on the bottom dentures but that has not happened and the bottom ones fit so bad that I worry I will lose them. No denture adhesive was in R21's room or bathroom.During interview with nursing assistant (NA)-D on 6/23/26 at 3:01 p.m., NA-D stated expectation of nursing assistants to review the resident's EMR prior to providing cares. I look in computer for what residents need. NA-D stated denture adhesive was expected to be included if needed by the resident.During interview with R21 on 6/23/26 at 3:37 p.m., R21 stated facility failed to offer or provide denture adhesive to ensure his dentures stayed in his mouth. I have asked several times and it has not been offered.R21's Dental Health Screening assessment, dated 5/8/25, identified please provide denture adhesive for this resident.R21's Dental Health Screening assessment, dated 3/16/26, identified He is concerned that his dentures are loose. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He has asked for adhesive but has not received anything from the home.During interview with registered nurse (RN)-D on 6/24/26 at 1:19 p.m., RN-D verified R21 had upper and lower dentures. RN-D verified denture adhesive was not in R21's room, and his care plan did not indicate denture adhesive was needed. RN-D stated it should be in there so we can make sure he gets what he needs.During interview on 6/25/26 at 11:02 a.m., the Director of Nursing (DON) acknowledged the facility did not have a reliable process to ensure residents were consistently offered dental services as required, and stated there was a lack of an effective system to ensure dental recommendations were followed, documented, and incorporated into the care plan. DON stated the systemic breakdown resulted in failure to ensure ongoing assessment and management of R2's oral health needs. Regarding R21, DON stated, We are supposed to follow recommendations and document that in a progress note and update the care plan and kardex if changes or updates are needed. We do not have a good process now to ensure dental visits are offered as we should because people can miss out on basic routine dental care.The facility's Dentures, Cleaning and Storing policy, dated 10/2025, indicted damaged, broken, ill-fitting, or lost dentures should be documented in the EMR (electronic medical record) and reported to the licensed nurse or social services, as required by facility policy. The facility's Medication Orders and Treatment, Dental Services policy, effective 10/2025, indicated medication orders and treatment will be administered by nursing service personnel as soon as the order has been received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to implement infection prevention and control practices by ensuring staff performed hand hygiene and changed gloves between contaminated and clean resident care tasks during incontinent care for 1 of 1 residents (R142) reviewed for incontinence care.Findings include:R142's admission Minimum Data Set (MDS) assessment was in progress following admission to the facility on 6/12/26.R142's diagnoses, dated 6/12/26, included malignant neoplasm of the prostate with secondary malignant neoplasms of the bone, lung, and lymph nodes, and neoplasm-related pain.R142's pain assessment, dated 6/16/26, indicated R142 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had experienced frequent pain during the previous five days.R142's care plan, dated 6/12/26, indicated the resident had a self-care deficit related to a diagnosis of cancer and required moderate assistance with most activities of daily living (ADLs). During observation on 6/24/26 at 8:32 a.m., Nursing Assistant (NA)-F provided incontinence care for R142. NA-F removed R142's soiled brief and cleansed the resident's perineal area using disposable wipes while wearing gloves. Without removing the contaminated gloves, NA-F applied a clean brief. While still wearing the contaminated gloves, NA-F repositioned R142, removed the soiled linens, placed clean sheets and pillowcases on the bed, and handled other clean linen and environmental surfaces. NA-F wore the same contaminated gloves throughout the care provided.During an interview on 6/25/26 at 8:44 a.m., the Infection Preventionist (IP) stated staff were expected to change gloves after completing a dirty task, such as providing perineal care or changing a soiled brief, before moving to a clean task, such as dressing a resident or handling clean linens. The IP further stated staff were expected to perform hand hygiene after removing contaminated gloves and before donning a new pair of gloves. The IP explained these practices were necessary to prevent contamination of clean surfaces, equipment, and resident care items.During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON), confirmed staff were expected to change gloves and perform hand hygiene between dirty and clean care tasks as described by the IP.The facility's Handwashing/Hand Hygiene policy, dated 10/2025, identified hand hygiene as the primary means of preventing the spread of infection and directed staff to perform hand hygiene before and after bathroom care and resident personal hygiene.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to ensure the staff posting was updated each shift as required, resulting in outdated staffing information being consistently posted over multiple days. This had the ability to affect all 241 residents residing in the care facility. Findings include:From 6/22/26 through 6/25/26, the facility's nurse staffing post was observed to be outdated on multiple occasions. On 6/22/26 at 10:02 a.m., the posted nurse staffing information was dated Friday, 6/19/26. On 6/24/26 at 7:53 a.m., the posted nurse staffing information was dated 6/23/26. On 6/25/26 at 7:50 a.m., the posted nurse staffing information was dated 6/24/26. The posted nurse staffing information had not been updated daily or per shift as required.During an interview on 6/25/26 at 7:46 a.m., front desk staff (O)-1 stated staffing updates were typically maintained by the staffing office.During an interview on 6/25/26 at 7:50am, the staffing coordinator (SC) stated the scheduling staff were responsible for updating the posting on weekdays, and on weekends the house manager was expected to ensure the posting was updated.During an interview on 6/25/26 at 11:20 a.m., the Director of Nursing (DON) stated the expectation was that staff postings were updated each shift to reflect current staffing levels, and on weekends the house supervisor was responsible for ensuring the posted nursing staff information remained accurate and timely.The facility's Posting Direct Care Daily Staffing Numbers policy, dated 10/2025, indicated at the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear andreadable format.