

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER North Ridge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1445 N 7th St Manitowoc, WI 54220	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure the accurate administration of medication for 4 residents (R) (R1, R5, R4, and R3) of 9 sampled residents. In addition, the facility did not ensure narcotic medication was consistently reconciled. These practices had the potential to affect more than 4 of the 57 residents residing in the facility. R1, R5, R4, and R3's medications were not administered in accordance with the ordered administration time and facility policy. Nursing staff did not complete controlled substance counts at shift change. Findings include: The facility's undated Medication Administration policy indicates: .b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. The facility's undated Liberalized Medication Administration policy indicates: Medication Administration Timeframes: .c) Twice daily, Three or More Times Daily: Administer within 30 minutes to 1 hour before or after scheduled time or as directed by provider and/or pharmacist. 1. On 10/7/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), morbid obesity, chronic pulmonary edema, lymphedema, chronic pain, anxiety disorder, and obstructive sleep apnea. R1's Minimum Data Set (MDS) assessment, dated 7/17/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. On 10/7/25, Surveyor reviewed R1's medication orders which included: ~ Furosemide oral tablet 40 milligrams (mg), give 1 tablet by mouth twice daily (BID) for CHF (dated 11/16/24) R1's Medication Administration Record (MAR) indicated furosemide should be administered at 6:00 AM and 11:00 AM. Surveyor reviewed R1's MAR for 9/1/25 to 10/6/25 and noted furosemide was administered at the following times: ~ 9/6/25 - 3:41 PM and 3:43 PM ~ 9/12/25 - 4:24 PM and 4:25 PM ~ 9/25/25 - 9:22 AM and 10:08 [NAME] 10/7/25 at 1:50 PM, Surveyor interviewed R1 who indicated the AM medication pass is from 6:00 AM to 10:00 AM. R1 indicated residents can receive medications 1 to 2 hours after the ordered medication administration time. R1 stated R1 receives medications 2 or more hours after the ordered medication administration time. 2. On 10/7/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease (COPD), anxiety, CHF, thrombocytopenia, rheumatoid arthritis, and dependence upon a ventilator. R5's MDS assessment, dated 8/11/25, had a BIMS score of 12 out of 15 which indicated R5 had moderate cognitive impairment. R5 was responsible for R5's healthcare decisions. On 10/7/25 at 9:30 AM, Registered Nurse (RN)-D administered the following medications to R5. The medications were scheduled to be administered at 6:00 AM: ~ Atorvastatin 40 mg, give 1 tablet daily for hyperlipidemia ~ Buspirone HCL 10 mg, give 1 tablet BID for anxiety ~ Ferrous sulfate 325 mg, give 1 tablet daily ~ Folic acid 5 mg, give 1 tablet daily ~ Gabapentin 300 mg, give 1 tablet 3 times daily (TID) for neuropathy ~ Hydroxyzine HCL 50 mg, give 1 tablet TID ~ Lidocaine 4% apply to back once daily for chronic pain ~ Polyethylene glycol 3350, give 17 grams (gm) daily for constipation ~ Quetiapine fumarate 25 mg, give 1.5 tablet daily for mood ~ Senna-S 8.6-50 mg BID for constipation ~ Spironolactone 25 mg, give 1/2 tablet daily for edema 3. On 10/7/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, COPD, anxiety, hypotension, schizoaffective disorder, depression, and dependence upon a ventilator. R4's MDS assessment, dated 8/14/25, indicated R4 was rarely/never understood. R4 had an activated Power of Attorney for Healthcare (POAHC). On 10/7/25 at 10:03 AM, RN-D administered the following medications to R4. The medication were scheduled to be administered at 6:00 AM: ~ Midodrine 2 mg TID for hypotension ~ Valproic acid 250 mg/5 ml daily ~ Tramadol 100 mg, give 1 tablet TID ~ Benzotropine 2 mg, give 1 tablet BID ~ Eliquis 2.5 mg, give 1 tablet daily ~ Folic acid 800 mg, give 1 tablet daily ~ Methenamine, give 1 gm BID ~ Polyethylene glycol 3350, give 17 gm BID for constipation 4. On 10/7/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including hemiplegia right side, chronic respiratory failure, dysphagia, Parkinson's disease, atrial fibrillation, metabolic encephalopathy, CHF, and dependence upon a ventilator. R3's MDS assessment, dated 6/28/25, indicated R3 was rarely/never understood. R3 had an activated POAHC. On 10/7/25 at 10:22 AM, RN-D administered the following medications to R4. The medications were scheduled to be administered at 6:00 AM: ~ Furosemide 20 mg, give 1 tablet daily for edema ~ Eliquis 5 mg BID for atrial fibrillation ~ Docusate sodium 100 mg daily for constipation ~ Iron liquid-ferrous sulfate 220 mg/5 ml daily ~ Metoprolol tartrate 25 mg, give 1/2 tablet BID On 10/7/25 at 1:35 PM, Surveyor interviewed RN-D</p>		