DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4BQS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00935

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245201**
2.STATE VENDOR OR MEDICAID NO.
(L2) **973842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT FRIDLEY LLC**
(L4) **5700 EAST RIVER ROAD**
(L5) **FRIDLEY, MN** (L6) **55432**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**
6. DATE OF SURVEY **06/28/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Complaint investigation: Project #H5201055

17. SURVEYOR SIGNATURE — Date :
~~Susanne Reuss, Unit Supervisor~~ 07/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
~~Joanne Simon, Enforcement Specialist~~ 07/26/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/07/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245201

July 26, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Dear Ms. Hagenow:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 14, 2018 the above facility is recommended for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

July 26, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: Project Number S5201027 and H5201055

Dear Ms. Hagenow:

On May 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on April 5, 2018 that included an investigation of complaint number H5201055. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 24, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 29, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 5, 2018. (42 CFR 488.417 (b))

Also, you were notified in our letter of May 24, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 5, 2018.

This was based on the deficiencies cited by the Department of Health and Public Safety for a standard survey completed on May 10, 2018. The most serious deficiencies at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 5, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

On June 14, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 5,2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June14, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 14, 2018, as of June 14, 2018.

June 28, 2018, the Minnesota Department of Health completed a PCR by review of your plan of correction and on June 25, 2018, the Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June14, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 14, 2018, as of June 14, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 14, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 24, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 5, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 5, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 5, 2018, is to be rescinded.

In our letter of May 24, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 5, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 14, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4BQS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00935

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(L1) **245201**
2.STATE VENDOR OR MEDICAID NO.
(L2) **973842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT FRIDLEY LLC**
(L4) **5700 EAST RIVER ROAD**
(L5) **FRIDLEY, MN** (L6) **55432**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**
6. DATE OF SURVEY **05/10/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Complaint investigation: Project #H5201055

17. SURVEYOR SIGNATURE — Date:
Magdalene Jares, HFE NE II — 06/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 06/06/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

May 24, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: Project Number S5201027 and H5201055

Dear Ms. Hagenow:

On May 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 5, 2018 that included an investigation of complaint number H5201055. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 10, 2018, the Minnesota Department of Health and on May 9, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The standard survey found that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our survey, completed on April 5, 2018. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective May 29, 2018. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 5, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 5, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Estates At Fridley LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for

its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by October 5, 2018 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/7/18, through 5/10/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		6/14/18

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

Electronically Signed | 06/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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	245201	A. BUILDING _____ B. WING _____	05/10/2018

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E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not provide an essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code and NFPA 110 (2010) Standard for Emergency and Standby Power Systems. This had the potential to affect all 42 residents residing in the facility. Findings include: On a facility tour between the hours of 10:00 a.m. and 2:00 p.m. on May 9, 2018, it was revealed that the facility did not have a remote emergency shutdown switch for the outdoor emergency generator, that was located outside of the containment unit.	E 041	Facility in process of installing remote location of emergency shutdown switch for the generator.	

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E 041	Continued From page 3 During an inspection of the facility on 5/9/18, at 1:00 p.m. the Fire Marshall with the maintenance director (MD) identified the facility did not have a remote emergency shutdown switch for the outdoor emergency generator located outside of the containment unit. On 5/10/18, at 11:27 a.m. administrator verified there was no external shut off switch for the generator. She stated this had been explained to her and the facility team by the Fire Marshall and the facility was now aware and would be installing the button.	E 041		
F 000	INITIAL COMMENTS On 5/7/18 through 5/10/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		6/14/18

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F 582	Continued From page 4 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		

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F 582	Continued From page 5 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to submit 4 of 4 residents (R1, R15, R20, R46) denial letters to the fiscal intermediary for reconsideration of medicare denial for residents who were on Medicare and continued to reside in the facility. In addition the facility billed the residents or their secondary insurance after the residents requested Medicare reconsideration. Findings include: R1's 30-day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 12/29/17, indicated R1 was cognitively intact and was receiving physical and occupational therapy. R1's MDS indicated R1 was on a medicare stay that had started on 12/2/17. On 1/23/18, R1 was given Notice of Medicare Non-Coverage for last date for covered services was 1/25/18, and the notices was signed on 1/23/18, by the R1. R1 remained the facility for two more days and was given the Skilled Nursing	F 582	MDS Coordinator misinterpreted document and was re-educated on the form and acknowledges mistake. MDS Coordinator confirmed that residents did not request demand bills and if they did would have informed the business office manager per regulations. MDS Coordinator is utilizing a new SNFABN form that is clear and concise along with a company specific form for Notice of Exclusions from Medicare Benefits. BOM confirmed that the billing was correct for the identified residents. MDS will put in a nursing note stating that wrong option was checked on the SNFABN from with explanation. 5/18/18 Business Office Meeting was held with Corporate Billing Office, all business office managers were educated on what the demand bills are, the process of what happens when a resident requests a	

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F 582	Continued From page 6 Facility Advance Beneficiary Notice (SNFABN) notice dated 1/23/18, and signed by resident on 1/23/18, which indicated resident had MA however had requested the bill to be submitted to Medicare for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision." On 5/9/18, at 12:53 p.m. Business office manager (BOM) provided R1's billing information that indicated from 1/26/18, through 2/8/18, facility billed Medicaid for R1's stay. BOM verified R1 had Medicare days remaining on 1/25/18. During interview on 5/9/18 at 1:23 p.m. BOM verified facility did not submit a demand bill for reconsideration and continued to bill Medical Assistance for R1's stay. R20's quarterly MDS dated 3/23/18 indicated R20 was cognitively intact and had received physical and occupational therapy during the seven day assessment period. On 2/21/18, R20's power of attorney (POA) was notified by phone of last day of Medicare coverage for R20 was 2/24/18. Note indicated the notices were going to be sent to POA to sign and return which included the SNFABN because R20 was remaining in the facility. The POA returned	F 582	demand bill. Going forward MDS will email a copy of the SNFABN to BOM and Corporate Business Office Consultant verify that the resident and or their responsible party doesn't want to appeal the denial with Kepro. BOM will scan SNFABN into the PCC make payer change and notify the billing office of the payer change. Billing Office will review the SNFABN and update payer change or discharge the resident. An audit each week for 4 weeks will be conducted of SNFABN's to ensure that all information was relayed properly and to the appropriate channels. Residents will continue to be given the correct/appropriate notifications of Medicaid/Medicare Coverage/Liabilities. Administrator or designee will be the responsible party. QAA to provide re-direction or change when necessary & dictate continuation or completion of this monitoring process based on compliance date.	

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F 582	Continued From page 7	F 582		

the Notice of Medicare Non-Coverage for last date for covered services was 2/24/18, and the notice was signed on 3/5/18. The POA also returned the SNFABN which POA signed on 3/5/18 and indicated R20's POA had requested the bill to be submitted to Medicare for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision."

On 5/9/18, at 12:53 p.m. BOM provided R20's billing information that indicated the facility billed Medica for R20's continued stay in the facility from 2/25-2/28/18

During interview on 5/9/18 at 1:23 p.m. BOM verified facility did not submit a demand bill for reconsideration and billed Medica for R20's stay.

R15's 5-day Prospective Payment System (PPS) MDS dated 3/8/18, indicated R15 was cognitively intact and was receiving physical and occupational therapy. R15's MDS indicated R15 was on a Medicare stay that had started on 3/2/18.

R15 Notice of Medicare Non-Coverage for last date for covered services was 3/20/18, and the notice was signed on 3/16/18. by the resident. Then the resident remained at the facility and was given the SNFABN notice date 3/16/18, signed by

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F 582	Continued From page 8	F 582		

resident 3/16/18, which indicated resident had requested the bill to be submitted for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision."

On 5/9/18, at 12:53 p.m. BOM provided R15's billing information that indicated from 3/1 to 3/20/18, the facility billed Medicare. From 3/21-4/19/18 the facility billed Medica.

During interview on 5/9/18 at 1:23 p.m. BOM verified facility did not submit a demand bill for reconsideration and billed Medica for R15's stay.

R46's significant change of condition MDS dated 12/26/17, indicated R46 was cognitively intact and was receiving physical and occupational therapy. R46's MDS indicated R46 was on a Medicare stay that had started on 12/5/17.

R46 was given a Notice of Medicare Non-Coverage with last date of covered services of 12/25/17, and the notices was signed on 12/22/17, by the resident. The resident remained at the facility and was given the SNFABN notice dated 12/22/17, and was signed by resident on 12/22/17, which indicated resident had requested the bill to be submitted for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I

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F 582	Continued From page 9 understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision." During interview on 5/9/18, at 1:50 p.m. BOM verified facility did not submit a demand bill for reconsideration and billed Medical assistance for R46's stay from 12/26/17, until death 2/11/18. The BOM indicated the facility was not aware the residents had requested Medicare to review the decision to discontinue Medicare coverage. Registered nurse (RN)- indicated the residents signed the requests for Medicare reconsideration in error and appeals were not sent. RN- stated was not aware that the residents had requested an appeal. On 5/10/18, at 10:23 a.m. the Adminstrator stated the facility was to follow the regulations regarding the processing of requests for Medicare review and were not to bill the residents or their insurance company until the results of the appeal were known.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		6/14/18

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F 584	Continued From page 10 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow up on a concern of a missing personal item for 1 of 2 residents (R2) reviewed for personal property. In addition,	F 584	R2 reported phone missing to Administrator, administrator did full room search at time of event and did not locate phone but located charger which was	

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F 584	Continued From page 11 failed to ensure 2 of 2 resident's (R246, R244) soiled linen was changed when reviewed for environmental concerns. Findings include: R2's quarterly minimum data set (MDS) dated 1/26/18, indicated R2 was cognitively intact with diagnoses that included depression and anxiety disorder. R2's care plan dated 5/1/18, indicated the facility would provide support with discharge planning and anxiousness of change and help R2 arrange for services and equipment that she would need once she left the facility. The care plan indicated that R2 was to be discharged to an assisted living facility on 5/16/18. On 5/7/18, at 7:19 p.m. when asked if she had any missing items, R2 stated she had reported her phone went missing during the night at least a month ago. R2 stated she reported the missing phone to the administrator and was told they were still looking for it, "it hurts me, I am all alone and don't have my phone." R2 stated the facility had not discussed replacing the phone. During interview on 5/9/18, at 7:45 a.m. licensed social worker (LSW) stated he wasn't here a month ago, but knew the phone was reported, "it would be on a missing items form." During interview on 5/9/18, at 7:59 a.m. LSW provided a missing item sheet reporting the missing phone and stated the phone was not found, that R2 had just told him that she wanted another phone "last Friday" and stated "it's hard to reimburse for something that was free."	F 584	labeled with R2's name. Administrator worked with resident to get replacement phone from the Obama phone. When calling Obama phone line with resident, they informed Administrator and resident that the phone was initially given for the first time in 2017 and then resident misplaced the first phone and received a replacement phone August 2017. Resident and Administrator were informed R2 would not be eligible for a phone until August 2018. Resident and Administrator discussed other options which were: utilizing the resident cordless phone and/or utilizing the phone in the facility's "River Room" which had a door to close that allowed for R2 to have a private space. R2 had no plans of discharge and was satisfied with the solution at that time. R2 was concerned that another resident had taken the cell phone, room search was conducted on that resident and no belongings were found. Report was filed with OHFC on 5/9/18 with a disposition date of 5/11/18. When R2 and LSW called the Obama phone line with the new information of a $25 replacement fee the facility agreed to cover the cost now that resident was discharging to community. LSW and Administrator are working with R2's case worker on getting the phone replaced. Administrator or designee will be responsible party.	

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F 584	Continued From page 12 During interview on 5/9/18, at 1:05 p.m. the administrater stated that they did a full room search with R2, did call and tried to get a replacement, but were told she would have to wait until August of 2018 to get another phone. The administrator further stated she had not thought about replacing it, was not sure they had a policy for replacement and did not believe it was reported to the state agency. During the resident council group interview on 5/9/18, at 10:30 a.m., R2 stated her grievance regarding her missing cell phone had not been resolved. She stated the phone was plugged in and charging during the night and was not there in the morning. She reported it to the staff and they had not resolved the issue. On 5/10/18, at 7:56 a.m. the administrator stated she had visited with R2 regarding the missing phone and that R2 had indicated she thought it was taken by another resident. The administrator stated that yesterday they had reported the missing phone to the state agency, were going to replace the phone for R2 as they were told it was worth $25.00, and acknowledged that R2 had indicated the phone was valuable to her. Review of the Lost, Missing, and Damaged Items form dated 3/9/18, indicated "Obama phone from a few years ago, flat button phone" was missing and that the room was searched on 3/9/18 and not found. The options discussed with R2 were to keep the phone in a locked drawer or with her at all times. The facility Lost, Missing and Damaged Items policy with revision date 5/2017, indicated the	F 584	QAA to provide re-direction or change when necessary & dictate continuation or completion of this monitoring process based on compliance date. Missing and Damaged items will be audited each week for the next 4 weeks for any items of psychosocial value.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13	F 584		

administrator would respond to the owner/resident representative of the missing/damaged item regarding the investigation outcome and the suggested resolution within "5 business days of receiving the reports." The policy further indicated that in the event that the missing item cannot be recovered, a policy report may be filed at the resident or family's request and requests to replace missing items will be evaluated and determined by the Vice President of Operations.

Soiled linen:

R246's diagnoses included morbid obesity, fibromyalgia and asthma obtained from the admission MDS dated 3/22/18. The MDS indicated R246 required extensive assitance with activities of daily living (ADL's) including bed mobility, dressing and personal hygiene. In addition, the MDS indicated R246 had intact cognition.

On 5/8/18, at 9:34 a.m. when asked if she felt the room was clean. R246 stated, "they come to our room and make my roommates bed but have not changed my bed for over a week and there are blood stains on the sheets. R246 showed the surveyor the blood stains on the top and fitted sheets.

On 5/9/18, at 8:11 a.m. during a random room observation the bed was observed not made and the top sheet was observed with multiple dried stains of blood. The door to the room was wide open and the soiled sheets were visible from the hallway.

On 5/9/18, at 1:38 p.m. NA-A verified the linen

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	245201	A. BUILDING _____ B. WING _____	05/10/2018

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F 584	Continued From page 14	F 584		

had stains of blood on the top and fitted sheets. When asked when the bedding was changed NA-A stated it was supposed to be changed on the scheduled bath day which for R246 was Tuesday morning and Sunday evening.

On 5/9/18, at 1:49 p.m. the director of nursing (DON) stated R246's bed linens were supposed to be changed weekly and she was going to provide education to staff.

On 5/9/18, at 2:48 p.m. R246 stated she had noticed her bed had been changed and made. R246 further stated it was great to have a clean bed, despite she had already opened and messed it up.

R244 diagnoses included end stage renal disease, dependence on renal dialysis, anxiety and depression obtained from the admission Minimum Data Set (MDS) dated 4/15/18. In addition the MDS indicated R244 required extensive physical assistance of one staff with all ADL's including bed mobility, toilet use and personal hygiene.

On 5/7/18, at 7:28 p.m. R244 was observed lying in bed and was noted to have a nose bleed. When approached R244 stated "I wish they would stop this bleeding." R244's both hand fingers were observed with dried blood and under R244's head was a long pillow which had multiple dried blood stains. The blood stains were visible when standing outside the door to the room, in the hallway.

On 5/8/18, at 8:42 a.m. R244 was observed lying in bed and the pillow under R244's head was

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F 584	Continued From page 15	F 584		

observed with stains of dried blood.

On 5/8/18, at 1:41 p.m. during a random observation, R244 was lying in bed asleep with the door to room wide open and under R244's head was a long pillow which was observed with multiple dried blood stains.

On 5/9/18, at 7:36 a.m. a long blood stained pillow was observed lying on top of R244's made bed and the pillow was visible when standing in the hallway outside R22's room. At 7:38 a.m. R244 was observed to wheel down the hallway and go into his room. At this time licensed practical nurse (LPN)-A came into R244's room and asked R244 if she could help with transfers but R244 stated "I can do it, Thank you." LPN-A assisted to pull the blanket off the bed. At 7:39 a.m. NA-A came to the room and stated, "That pillow, we don't know what to do to it", when asked about the dried blood on the pillow. LPN-A then asked NA-A to help R244 get into bed and LPN-A left.
-At 7:43 a.m. NA-A explained that R244's family had brought the pillow to the facility and R244 did not care how soiled the pillow looked. When asked how the pillow and soiled linen was to be cleaned, NA-A stated she did not know and she had asked registered nurse (RN)-B what to do and was waiting for an answer. NA-A further stated she would usually put soiled linen/clothing in a plastic bag and was going to do the same for the pillow until she got word what to do.
-At 7:48 a.m. NA-A was observed to come out of R244's room with the soiled pillow in a biohazard red bag and went into the soiled utility room.

On 5/9/18, at 1:49 p.m. the director of nursing stated the staff should have removed the soiled

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F 584	Continued From page 16 pillow from the room and bagged it and should have not left it in the room. The facility Infection Control policy dated 1/1/2000, directed staff to remove soiled linen from the units to keep the areas infection free.	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		6/14/18

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F 625	Continued From page 17 by: Based on interview and document review, the facility failed to ensure 3 of 4 residents (R15, R244, R21) or legal representatives had been informed of bed hold rights at the time of hospitalizations. Findings include: R15's admission Minimum Data Set (MDS) dated 2/20/18, indicated R15 had intact cognition. On 5/8/18, at 9:17 a.m. when asked if she had been to the hospital recently, R15 stated she went to the hospital on 2/26/18, and she was not sure if the facility staff had told her about the bed hold. During review of the medical record, it was revealed R15 had been sent to the hospital on 2/24/18, due to elevated temperature for evaluation. During review of the progress notes it was revealed the hospital staff had called to the facility on 2/25/18, and reported R15 had tested positive for Influenza. The Progress notes lacked documentation indicating a bed hold notice had been provided prior to transfer or had been discussed with R15. On 5/9/18, at 8:56 a.m. the licensed social worker (LSW) stated social services provided the bed hold notices when residents were sent to the hospital. LWS verified the medical record did not have a bed hold notice for R15, however he was going to check with the administrator to verify. -At 9:26 a.m. LSW stated "It appears we did not give it."	F 625	Two of the three residents missing bed holds now updated and signed, the third is due to resident discharging from facility 5/10/18. The IDT team added a Bed Hold review section to the morning stand up and reviews every morning. Education is provided to nurses on bed hold policy and procedure to increase medical record documentation and to ensure bed holds are being administered before/upon transfer is resident capable and/or the resident representative is available.	

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F 625	Continued From page 18	F 625		

R244 diagnoses included end stage renal disease, dependence on renal dialysis, anxiety and depression obtained from the admission record dated 5/10/18. In addition the admission record indicated R244 was his own responsible party.

During review of the medical record it was revealed R244 had been sent to the hospital on 4/2/18, directly from his dialysis appointment due to complains of severe pain "all over" and returned back to the facility on 4/7/18, with admitting hospital in patient diagnosis of hypertension and possible sepsis. During further review, it was revealed R244 had been sent to the hospital from the dialysis center on 4/21/18 and had returned to the facility on 5/3/18. The medical record lacked evidence of the facility providing or attempting to inform R244 of the bed hold during both hospital transfers.

On 5/9/18, at 2:32 p.m. the administrator and LSW acknowledged R244 had been sent to the hospital two times since he had been admitted to the facility. When asked if bed hold notices had been given to R244 or his representative the LSW stated he was going to find the notices and would get back to the surveyor.

On 5/9/18, at 2:32 p.m. the facility administrator stated she would expect bed hold notices to be given to all residents when being transferred to the hospital for evaluation otherwise staff was supposed to call the hospital and fax the bed hold notice for the residents to sign.

On 5/9/18, at 3:00 p.m. LSW stated R244 had not been given the bed hold notices either of the times he had been sent to the hospital.

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F 625	Continued From page 19	F 625		

R21 quarterly MDS dated 3/27/18 indicated resident had intact cognition and the face sheet dated 5/11/18, indicated R21 was her own decision maker.

The progress note dated 3/6/18 indicated R21 was hospitalized for an acute gastrointestinal condition, and returned to the facilty on 3/12/18. The medical record did not contain a bed hold notice, or documentation of communication with the resident or family regarding a bed hold during the time R21 was hospitalized.

On 5/10/18 at 8:00 a.m. the LSW verified there was no bed hold completed at the time of hospitalization and it had been missed.

The facility policy titled "Bed Hold for Therapeutic Leave or Hospitalization" dated 12/2016, directed the staff to give a bed hold notice to the resident or representative, have it signed, and make an entry in the medical reocord of the bed hold.

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	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/09/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 09, 2018. At the time of this survey, The Estates at Fridley was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2018

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.

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Estates at Fridley is a 1-story building with a partial basement and was determined to be of Type II (111) construction. Original year of construction was 1962 with additions being built in 1990 and in 2007 both buildings are of the same type of construction and only 1-story. The facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors and resident sleeping rooms that is monitored for automatic fire department notification.

Since the original building and additions are of conforming construction, the facility will now be surveyed as one building.

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K 000	Continued From page 2 The facility has a capacity of 54 beds and had a census of 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 915 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not provide and essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code, Sections 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 and NFPA 110 (2010) Standard for Emergency and Standby Power Systems, Section 5.6.5.6. This deficient	K 915	Facility in process of installing remote location of emergency shutdown switch for generator.	6/14/18

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K 915	Continued From page 3 practice could effect all 47 residents. Findings include: On a facility tour between the hours of 10:00 AM and 2:00 PM on May 09, 2018, it was revealed that the facility did not have a remote emergency shutdown switch for the outdoor emergency generator, that was located outside of the containment unit. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 915		

Electronically delivered
May 24, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Re: State Nursing Home Licensing Orders - Project Number S5201027 and H5201055

Dear Ms. Hagenow:

The above facility was surveyed on May 7, 2018 through May 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5201055. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	05/10/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 5/7/18 -5/10/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 6 residents (R8) was properly screened for Tuberculosis (TB) per the State Regulation. Findings include:	21426	Corrected.	6/14/18

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21426	Continued From page 3 R8 was admitted to the facility 2/11/18, and the record did not include a screening for a history of TB, previous mantoux, chest x-ray or blood test for exposure to TB. During review of the admission nursing assessment dated 2/11/18, and the physician orders dated 2/11/18, it was revealed both did not include an order to screen for TB. On 5/10/18 at 10:00 a.m. the director of nursing stated there was no TB screening found for R8 from the admission process or the prior placement. She stated the facility should have checked for this on admission and documented in the medical network. SUGGESTED METHOD OF CORRECTION: The Director of nursing and/or designee could review and revise policies and procedures, train staff and monitor to assure Tuberculin Skin Tests (TST) are read, results documented; and assure that employees are screened for tuberculosis (TB) using a symptom screen, and by either a single step IGRA (Interferon Gamma Release Assay blood test) or a two-step TST and documented appropriately per State regulation. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and	21695		6/14/18

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21695	Continued From page 4 comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 resident's (R246, R244) soiled linen was changed when reviewed for environmental concerns. Findings include: R246's diagnoses included morbid obesity, fibromyalgia and asthma obtained from the admission MDS dated 3/22/18. The MDS indicated R246 required extensive assitance with activities of daily living (ADL's) including bed mobility, dressing and personal hygiene. In addition, the MDS indicated R246 had intact cognition. On 5/8/18, at 9:34 a.m. when asked if she felt the room was clean. R246 stated, "they come to our room and make my roommates bed but have not changed my bed for over a week and there are blood stains on the sheets. R246 showed the surveyor the blood stains on the top and fitted sheets. On 5/9/18, at 8:11 a.m. during a random room observation the bed was observed not made and the top sheet was observed with multiple dried stains of blood. The door to the room was wide open and the soiled sheets were visible from the hallway. On 5/9/18, at 1:38 p.m. NA-A verified the linen	21695	Corrected: Remaining of F584: Re-education to nursing staff will be provided and include sanitation specific to what items are allowed in the facility from resident homes and needing to be cleanable surface. Audits will be conducted weekly for 4 weeks of clean beds and linens on shower days and random observations for residents on non-shower days. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring processes based on compliance date.	

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21695	Continued From page 5	21695		

had stains of blood on the top and fitted sheets. When asked when the bedding was changed NA-A stated it was supposed to be changed on the scheduled bath day which for R246 was Tuesday morning and Sunday evening.

On 5/9/18, at 1:49 p.m. the director of nursing (DON) stated R246's bed linens were supposed to be changed weekly and she was going to provide education to staff.

On 5/9/18, at 2:48 p.m. R246 stated she had noticed her bed had been changed and made. R246 further stated it was great to have a clean bed, despite she had already opened and messed it up.

R244 diagnoses included end stage renal disease, dependence on renal dialysis, anxiety and depression obtained from the admission Minimum Data Set (MDS) dated 4/15/18. In addition the MDS indicated R244 required extensive physical assistance of one staff with all ADL's including bed mobility, toilet use and personal hygiene.

On 5/7/18, at 7:28 p.m. R244 was observed lying in bed and was noted to have a nose bleed. When approached R244 stated "I wish they would stop this bleeding." R244's both hand fingers were observed with dried blood and under R244's head was a long pillow which had multiple dried blood stains. The blood stains were visible when standing outside the door to the room, in the hallway.

On 5/8/18, at 8:42 a.m. R244 was observed lying in bed and the pillow under R244's head was observed with stains of dried blood.

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21695	Continued From page 6 On 5/8/18, at 1:41 p.m. during a random observation, R244 was lying in bed asleep with the door to room wide open and under R244's head was a long pillow which was observed with multiple dried blood stains. On 5/9/18, at 7:36 a.m. a long blood stained pillow was observed lying on top of R244's made bed and the pillow was visible when standing in the hallway outside R22's room. At 7:38 a.m. R244 was observed to wheel down the hallway and go into his room. At this time licensed practical nurse (LPN)-A came into R244's room and asked R244 if she could help with transfers but R244 stated "I can do it, Thank you." LPN-A assisted to pull the blanket off the bed. At 7:39 a.m. NA-A came to the room and stated, "That pillow, we don't know what to do to it", when asked about the dried blood on the pillow. LPN-A then asked NA-A to help R244 get into bed and LPN-A left. -At 7:43 a.m. NA-A explained that R244's family had brought the pillow to the facility and R244 did not care how soiled the pillow looked. When asked how the pillow and soiled linen was to be cleaned, NA-A stated she did not know and she had asked registered nurse (RN)-B what to do and was waiting for an answer. NA-A further stated she would usually put soiled linen/clothing in a plastic bag and was going to do the same for the pillow until she got word what to do. -At 7:48 a.m. NA-A was observed to come out of R244's room with the soiled pillow in a biohazard red bag and went into the soiled utility room. On 5/9/18, at 1:49 p.m. the director of nursing stated the staff should have removed the soiled pillow from the room and bagged it and should have not left it in the room.	21695		

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21695	Continued From page 7 The facility Infection Control policy dated 1/1/2000, directed staff to remove soiled linen from the units to keep the areas infection free. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could ensure a residents linens and personal items are appropriately cleaned on a routine basis. The facility could create policies and procedures, educate staff and monitor to assure compliance. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in	21800		6/14/18

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21800	Continued From page 8 residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to submit 4 of 4 residents (R1, R15, R20, R46) denial letters to the fiscal intermediary for reconsideration of medicare denial for residents who were on Medicare and continued to reside in the facility. In addition the facility billed the residents or their secondary insurance after the residents requested Medicare reconsideration. Findings include: R1's 30-day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 12/29/17, indicated R1 was cognitively intact and was receiving physical and occupational therapy. R1's MDS indicated R1 was on a medicare stay that had started on 12/2/17. On 1/23/18, R1 was given Notice of Medicare Non-Coverage for last date for covered services was 1/25/18, and the notices was signed on	21800	Corrected.	

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21800	Continued From page 9	21800		

1/23/18, by the R1. R1 remained the facility for two more days and was given the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) notice dated 1/23/18, and signed by resident on 1/23/18, which indicated resident had MA however had requested the bill to be submitted to Medicare for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision."

On 5/9/18, at 12:53 p.m. Business office manager (BOM) provided R1's billing information that indicated from 1/26/18, through 2/8/18, facility billed Medicaid for R1's stay. BOM verified R1 had Medicare days remaining on 1/25/18.

During interview on 5/9/18 at 1:23 p.m. BOM verified facility did not submit a demand bill for reconsideration and continued to bill Medical Assistance for R1's stay.

R20's quarterly MDS dated 3/23/18 indicated R20 was cognitively intact and had received physical and occupational therapy during the seven day assessment period.

On 2/21/18, R20's power of attorney (POA) was notified by phone of last day of Medicare coverage for R20 was 2/24/18. Note indicated the notices were going to be sent to POA to sign and return which included the SNFABN because R20

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21800	Continued From page 10	21800		

was remaining in the facility. The POA returned the Notice of Medicare Non-Coverage for last date for covered services was 2/24/18, and the notice was signed on 3/5/18. The POA also returned the SNFABN which POA signed on 3/5/18 and indicated R20's POA had requested the bill to be submitted to Medicare for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision."

On 5/9/18, at 12:53 p.m. BOM provided R20's billing information that indicated the facility billed Medica for R20's continued stay in the facility from 2/25-2/28/18

During interview on 5/9/18 at 1:23 p.m. BOM verified facility did not submit a demand bill for reconsideration and billed Medica for R20's stay.

R15's 5-day Prospective Payment System (PPS) MDS dated 3/8/18, indicated R15 was cognitively intact and was receiving physical and occupational therapy. R15's MDS indicated R15 was on a Medicare stay that had started on 3/2/18.

R15 Notice of Medicare Non-Coverage for last date for covered services was 3/20/18, and the notice was signed on 3/16/18. by the resident. Then the resident remained at the facility and was given the SNFABN notice date 3/16/18, signed by

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21800	Continued From page 11	21800		

resident 3/16/18, which indicated resident had requested the bill to be submitted for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision."

On 5/9/18, at 12:53 p.m. BOM provided R15's billing information that indicated from 3/1 to 3/20/18, the facility billed Medicare. From 3/21-4/19/18 the facility billed Medica.

During interview on 5/9/18 at 1:23 p.m. BOM verified facility did not submit a demand bill for reconsideration and billed Medica for R15's stay.

R46's significant change of condition MDS dated 12/26/17, indicated R46 was cognitively intact and was receiving physical and occupational therapy. R46's MDS indicated R46 was on a Medicare stay that had started on 12/5/17.

R46 was given a Notice of Medicare Non-Coverage with last date of covered services of 12/25/17, and the notices was signed on 12/22/17, by the resident. The resident remained at the facility and was given the SNFABN notice dated 12/22/17, and was signed by resident on 12/22/17, which indicated resident had requested the bill to be submitted for review, "Option 1. Yes I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is

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21800	Continued From page 12 submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision." During interview on 5/9/18, at 1:50 p.m. BOM verified facility did not submit a demand bill for reconsideration and billed Medical assistance for R46's stay from 12/26/17, until death 2/11/18. The BOM indicated the facility was not aware the residents had requested Medicare to review the decision to discontinue Medicare coverage. Registered nurse (RN)- indicated the residents signed the requests for Medicare reconsideration in error and appeals were not sent. RN- stated was not aware that the residents had requested an appeal. On 5/10/18, at 10:23 a.m. the Adminstrator stated the facility was to follow the regulations regarding the processing of requests for Medicare review and were not to bill the residents or their insurance company until the results of the appeal were known. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing	21800		

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21800	Continued From page 13 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		