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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 64RL

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: **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 11/04/2021 (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):

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 11/17/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/17/2021 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2021

CMS Certification Number (CCN): 245201

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Dear Administrator:

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 October 25, 2021 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2021

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: CCN: 245201
Cycle Start Date: September 16, 2021

Dear Administrator:

On October 8, 2021, we notified you a remedy was imposed. On November 4, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 25, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 22, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 22, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 25, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 64RL

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5. Validation 6. Complaint
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(L9) **03/01/2017**

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

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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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):

17. SURVEYOR SIGNATURE — Date :
Mary Capes, HFE NE II — 11/04/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 11/12/2021 (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)

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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
October 8, 2021

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: CCN: 245201
Cycle Start Date: September 16, 2021

Dear Administrator:

On September 16, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 22, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 22, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 22, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 22, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Fridley Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 22, 2021. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
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: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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 - Health Regulation Division 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 Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 March 16, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 09/16/2021

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 On 9/13/21, through 9/16/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (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	E 041		10/25/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/15/2021

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 _____	C 09/16/2021

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 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 [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	E 041		

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 _____	C 09/16/2021

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 2 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. (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 a review of available documentation and staff interview, the facility failed to test and inspect the generator per 2012 edition of the Life Safety Code NFPA 101 section 9.1.3.1 and NFPA	E 041	Facility completed test and inspection of generator on 10/8/2021 for weekly generator inspection. Facility completed test and inspection of generator on	

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E 041	Continued From page 3 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.4, and NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4..1 and 8.4.2.1. This deficient practice had the potential to affect all 42 residents residing at the facility. Findings include: On 9/14/2021, at 9:00 a.m. to 2:00 p.m., it was revealed that seven monthly generator tests were not completed of the last 12 months. In addition, it was revealed that 45/52 weekly generator inspections were not completed between September 2020 to September 2021. On 9/14/21, these concerns were verified by the facilities manager, facilities supervisor and the administrator.	E 041	9/14/2021 for monthly generator inspection. Maintenance Director and Maintenance Assistant education initiated regarding Hospital CAH and LTC Emergency Power specific to weekly and monthly testing/inspection of the generator. Facility will complete weekly audits of the generator inspection weekly for 4 weeks, then monthly for 3 months. Facility will complete monthly audits of the generator inspection/test monthly for 3 months, quarterly for 2 quarters. Findings will be reported to QA team to determine continuation and frequency of audits. Maintenance Director and/or Designee will be responsible.	
F 000	INITIAL COMMENTS On 9/13/21 through 9/16/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5201099C/MN54498 H5201101C/MN53198 H5201102C/MN62820 However NO deficiencies were cited due to actions implemented by the facility prior to survey.	F 000		

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F 000	Continued From page 4 The following complaints were found to be UNSUBSTANTIATED: H5201095C/MN63348 H5201096C/MN62320 H5201097C/MN57192 H5201098C/MN56710,MN56930 H5201100C/MN64248 H5201103C/MN63565 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R31) observed to self-administer a nebulizer. Findings include:	F 554	Resident has had a self-administration of medication assessment completed. Physician's order was obtained and the care plan has been updated for nebulizer treatment. An audit of all residents who receive nebulizer treatments was conducted to	10/25/21

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F 554	Continued From page 5 R31's diagnoses included Alzheimer's disease, dementia, Parkinson's disease and chronic obstructive pulmonary disease (COPD) obtained from the admission record dated 9/16/21. R31's physician orders dated 9/12/12, directed to administer ipratropium-albuterol solution 3 milligrams (mg) per 3 milliliters (ml) (Duoneb, a respiratory medication) via nebulizer 3 ml inhale orally two times a day for bronchi muscle spasm. The physician's orders did not identify R31 could self-administer medications, including the nebulizer treatment. R31's care plan dated 7/29/21, identified resident had an alteration in oxygen/gas exchange, respiratory status related to acute cough and diagnoses of COPD. The care plan directed staff to adhere to medication regime as ordered per the physician. On 9/13/21, at 3:03 p.m. to 3:14 p.m. during a random observation, R31 was observed seated on the wheelchair in her room with door wide open to the hallway. During the observation an audible noise of a nebulizer machine was heard when standing at the hallway outside of R31's shared room. R31 was observed holding a handheld nebulizer chamber (a inhalation treatment device). Also, during the observation R31 was observed and heard coughing and two staff went past R31's room which included registered nurse (RN)-A who was assigned to R31 that shift. At 3:14 p.m., RN-A stated she thought she had turned it off. RN-A then asked R31 if she had shortness of breath and R31 stated it was better then. RN-A also stated R31 was not supposed to be left with nebulizer on alone.	F 554	establish the need for self-administration of medication. Assessments have been completed as needed. Nurses and TMAs have been educated on self-administration of medication requirements. Daily audits will be conducted for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Findings will be reported to the QA team to determine continuation and frequency of audits. DON and/or designee will be responsible.	

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F 554	Continued From page 6	F 554		

On 9/14/21, at 8:01 a.m. during a random observation the trained medication aide (TMA)-A was observed administer oral medications to R31 then TMA-A was observed set up the nebulizer handed it to R31, turned it on, left the room as she shut the door and returned to the medication cart which was located approximately 54 feet from the room.

On 9/14/21, at 8:06 a.m. licensed practical nurse (LPN)-A nurse manager verified R31 nebulizer was running. LPN-A reviewed the medical record and verified R31 did not have an order and SAM assessment completed before being allowed to do the SAM alone after setting up. LPN-A stated all residents who self-administered any medications were supposed to have an assessment to see if they were capable and then the nurse was to get an order for it which would be specific to the medication.

During interview on 9/14/21, at 8:12 a.m. the director of nursing (DON) stated for a resident to be able to self-administer the medication, the nurse would complete an assessment, teach the resident about the medication(s) and make sure they demonstrated doing the SAM and then they would get an order for the SAM. The DON stated she was going to follow up with this surveyor.

During interview on 9/14/21, at 8:18 a.m. TMA-A stated she was going by the guidelines from Covid recommendations that when a nebulizer was started in the room, they were to leave the room, shut the door behind and would return when it was completed. TMA-A stated she did not know if R31 had an order to SAM and had not been told R31 was not to be left alone before.

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F 554	Continued From page 7 TMA-A further stated after the concern was brought up by surveyor she had asked the nurse to follow up. The facility Self-Administration of Medications policy revised December 2016, indicated "As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident..."	F 554		
F 570 SS=B	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the surety bond contained sufficient funds to insure and protect the residents' trust fund, which had the potential to affect 24 of 42 residents who kept personal funds with the facility. Findings include: The facility Residents Trust Fund Report, dated 9/16/21, noted the current balance of the fund at $49,509.78 dollars. The facility's surety bond (legally binding contract protecting the trust fund), active from 10/20/20, to 10/31/21, contained a sum of $35,000 dollars. A sum which was inadequate to cover the current	F 570	The facility has increased the surety bond to ensure sufficient funds to insure and protect the resident trust fund. Business Office Manager and Administrator education initiated regarding surety bond and security of personal funds. The facility will complete weekly audits for 4 weeks, then monthly for 3 months to ensure the surety bond is greater than the total amount in the resident trust account. Findings will be reported to the QA team to determine continuation and frequency of audits.	10/25/21

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F 570	Continued From page 8 amount of the resident trust fund. On 9/16/21, at 7:45 a.m. the business office manager (BOM) and administrator interim provided a surety bond through Hartford Insurance Group for 35,000 dollars. The administrator stated the company had an umbrella surety bond but was not available at the time because the company was in transition to another insurance company which will go in effect October 1st 2021. The administrator further stated because the county was not renewing medical assistance for residents it caused the balance in the trust account to go up and then some of the residents had stimulus money in the account which added to the increasing balance. On 9/16/21, at 8:56 a.m. the interim administrator stated she had checked with the staff at the facility and all had indicated they had not sent the surety bond to Minnesota Department of Health (MDH) but she was going to reach out to corporate to see if they had. During interview on 9/16/21, at 9:14 a.m. the BOM reviewed the monthly running balances for the last 11 months and acknowledged the balance in the trust account had increased and should have been noted and the bond to be adjusted accordingly.	F 570	Administrator and/or designee will be responsible.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		10/25/21

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F 677	Continued From page 9 by: Based on observation, interview and document review, the facility failed to ensure facial hair removal was offered and/or provided for 1 of 1 resident (R28) who was dependent upon staff assistance for activities of daily living (ADLs). Findings include: R28's diagnoses included osteoarthritis of knee, type 2 diabetes mellitus and generalized anxiety disorder obtained from the quarterly Minimum Data Set (MDS) dated 8/10/21. In addition, the MDS indicated R28 had intact cognition, had no behaviors, which included refusal of care, and required extensive assistance with activities of daily living including personal hygiene and getting dressed. R28's care plan for dated 3/3/21, identified resident had a self-care deficit related to bilateral osteoarthritis of the knees and directed the staff to assist R28 with personal hygiene and provide assistance of 1 with getting dressed and bathing. During interview on 9/13/21, at 12:40 p.m. R28 stated "they are supposed to help me with the shaving, my mother and sister had this problem and I have one of those razors to do it but I cannot do it myself." During the interview R28 was observed to have multiple white/gray facial hairs on the lower chin approximately half inch long. During observations on 9/14/21, from 8:36 a.m. to 8:50 a.m. R28 was observed lying in bed and had completed eating breakfast. At 8:38 a.m. registered nurse (RN)-B went to room and took the breakfast tray out then R28 put the call light	F 677	Resident has had chin facial removed. Care plan has been reviewed and updated as appropriate. A full facility audit of all females has been completed to observe for facial/chin hair. Education has been completed for all nursing staff, therapy, and culinary on observation for facial hair on female residents with interactions and on the reporting chain of command. Audits will be completed daily for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Findings will be reported to the QA team to determine continuation and frequency of audits. DON and/or designee will be responsible.	

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F 677	Continued From page 10	F 677		

on, and licensed practical nurse (LPN)-A went into the room. At this time R28 stated she wanted to be changed. At 8:40 a.m. both RN-B and LPN-A were observed to check and change R28 then repositioned her and both never offered to remove the facial hairs which were visible as staff were observed standing over R28 during the cares as she lay in bed.

During care observations on 9/14/21, at 10:35 a.m. to 10:41 a.m. nursing assistants (NA)-A and NA-B were observed to provide and assist R28 with pericares and changed the incontinent pad however during the observation both never acknowledged or offered to remove the facial hairs for R28.

On 9/15/21, at 1:06 p.m. to 1:22 p.m. NA-B and NA-C who was assigned to R28 for the shift were observed standing over R28 prior to assisting her to be seated on the edge of the bed to transfer her to the wheelchair using a E-Z Stand (mechanical lift). During the observation, both NA's worked together to apply the lift sheet around R28's torso then secured her legs to the machine before lifting her up and onto the wheelchair. The NA's were over R28 the entire observation however never offered to remove the visible white/gray facial hairs on R28's chin.
-At 1:16 p.m. NA-C wheeled R28 out of the room never offered to remove the facial hairs and down the hallway into the dining room where an activity was going on.
-At 1:22 p.m. NA-C verified R28 had multiple facial hairs and then stated it did not cross her mind to ask or offer the resident to remove the facial hairs. NA-C further stated the staff was supposed to offer and assist resident with removing the facial hairs and if they refused, they

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F 677	Continued From page 11 were to report to the nurse. NA-C further stated R28 did not refuse cares. During interview on 9/15/21, at 1:31 p.m. trained medical assistant (TMA)-A stated the nursing assistants were responsible to make sure all the residents they were assigned were well groomed and if a resident refused cares, staff were to re-approach and then let the nurse know if the resident refused cares. During interview on 9/15/21, at 3:00 p.m. the director of nursing (DON) stated if a resident needs assistance with grooming, the staff should provide it on regular basis unless someone declines, and the nurse should be made aware. On 9/16/21, at 8:53 a.m. LPN-A stated she had observed the facial hairs on R28 and she was getting supplies to remove them. LPN-A stated the staff was supposed to remove it for resident. The facility Activities of Daily Living (ADLs) Supporting policy revised March 2018, indicated "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..."	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		10/25/21

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F 695	Continued From page 12 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident's (R18) Continuous Positive Airway Pressure (CPAP) mask was properly cleaned related to respiratory care. Findings include: R18's diagnoses included respiratory failure, anxiety, obstructive sleep apnea, chronic obstructive pulmonary disease (COPD) and obesity, obtained from the admission record printed on 9/15/21. R18's quarterly Minimum Data Set (MDS) dated 7/23/21, indicated intact cognition. R18's care plan initiated 9/17/18, indicated use of the CPAP nightly and R18 had frequent bronchitis and COPD exacerbations, however the care lacked directions on who, when and how the CPAP mask/machine was to be cleaned. On 9/13/21, at 1:16 p.m. R18 indicated she did not recall when the CPAP mask was cleaned last. At this time, the CPAP masked was observed to have a yellowish/white crust build up on the mask that was approximately the size of a dime. On 9/14/21, at 8:06 a.m. R18 was observed sitting in the recliner chair, dressed for the day, while the CPAP mask continued to have a yellowish/white crust build up on the mask. Review of the September 2021, treatment administration record (TAR) revealed R18's CPAP mask and tubing was to be cleaned weekly on	F 695	Resident's CPAP mask has been cleaned. All residents using CPAP/BIPAP have had their masks cleaned as needed and audited. Education has been provided to licensed staff and TMAs on the daily CPAP/BIPAP mask cleaning requirements. Audits will be completed on mask cleanliness daily for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Audit findings will be reported to QA team. QA team will determine the continuation and frequency of audits. DON and/or designee will be responsible.	

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F 695	Continued From page 13 Sundays with warm soapy water and to be rinsed with clear water and air dry, dated 9/20/20. On 9/14/21, at 8:11 a.m. nursing assistant (NA)-C stated she had assisted R18 that morning with cares and that R18 was wearing her CPAP. NA-C further indicated wiping R18's CPAP mask and oxygen tubing down that morning. On 9/14/21, at 8:17 a.m. licensed practical nurse (LPN)-B indicated R18 wore her CPAP every night. LPN-B further indicated the CPAP was to be cleaned by the overnight staff. LPN-B verified the yellowish/white crust that was approximately the size of a dime and stated it appeared to be food. On 9/14/21, at 8:20 a.m. director of nursing (DON) indicated a CPAP mask/tubing should be wiped down every day, and soaked every week. The facility policy CPAP/BiPAP Support dated March 2015, directed masks, nasal pillows and tubing should be cleaned daily by placing in warm, soapy water and soaking/agitating for 5 minutes. The policy further directed to rinks with warm water and allow to air dry between uses.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		10/25/21

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F 812	Continued From page 14 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to label opened containers of food in the kitchen refrigerators. This had the potential to affect all 42 of 42 residents in the facility who ate food from the kitchen. Findings include: During the tour of the kitchen on 9/13/21, at 11:50 a.m. the following foods were observed in the refrigerator and were not labeled to indicated were opened or use by dates on them which was confirmed by the dietary manager. -A large container of canned peaches, less than half full -A large container of pickles, approximately half full -A large container with several slices of lunch meat -A five pound plastic tub of taco pasta salad less than half full -A five pound plastic tub of non-fat yogurt less than half full -A five pound plastic tub of Italiano pasta salad, less than half full	F 812	The facility has labeled all open food containers of food in the kitchen refrigerators. Education has been provided to culinary staff on the facility's policy titled "Food Receiving and Storage" specific to labeling of opened containers. The facility will complete audits weekly for 4 weeks, then monthly for 3 months to ensure open containers of food are labeled. Audit findings will be reported to the QA team to determine the continuation of frequency of audits. Culinary Director and/or designee will be responsible.	

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	245201	A. BUILDING _____ B. WING _____	C 09/16/2021

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F 812	Continued From page 15 -11 individual cups of vanilla pudding prepared by kitchen staff. During an interview with the dietary manager on 9/13/21, at 11:57 a.m. she stated all food items should be labeled with an open date. During an interview with the cook on 9/14/21, at 10:00 a.m. stated all food items should be dated when they open them to be placed in the refrigerator. Facility policy titled Food Receiving and Storage revised date of October 2017, indicated "All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date)." This policy further states "Other opened containers must be dated and sealed or covered during storage."	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		10/25/21

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F 880	Continued From page 16	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 17 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission COVID-19 related to when staff wore a cloth type mask, rather than surgical face mask; failed to ensure appropriate utilization of personal protective equipment (PPE) during routine testing for not vaccinated staff and failed to ensure masks were offered and social distancing was adhered to for not vaccinated residents in the hallways/units. This had the potential to affect all 42 residents residing at the facility reviewed for infection control. Findings include: Cloth mask use: On 9/13/21, at 3:12 p.m. to 3:40 p.m. registered nurse (RN)-A was observed standing outside in the hallway by the medication cart outside room 121. RN-A was observed to be wearing a Gucci brown cloth mask. During the observation RN-A was observed go into R31, R28 and R291's rooms passing medications and turning the nebulizer machine off. When asked about the mask, RN-A stated she had a doctors order to wear a cloth mask because the medical grade	F 880	Cloth Mask Use: RN-A was educated on the appropriate surgical mask to wear and she stated full understanding and complied with the rule. An audit was completed on the following shifts to ensure no cloth masks were being worn. All staff have complied to the rule. Education was immediately performed with all staff regarding PPE requirements. Audits to be completed daily for 2 weeks, then weekly for 4 weeks, then monthly for 3 months and then PRN. Director of Nursing will be responsible and report to the QA team who will determine if further auditing is required. COVID Testing: RN-C has been educated on the proper PPE to wear and was corrected immediately.	

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F 880	Continued From page 18 mask made her face to break out. RN-A stated the facility was aware she was using a cloth mask and had been using this cloth mask for a while now. On 9/15/21, at 7:50 a.m. RN-A was observed standing by the medication cart across from the nursing station and the director of nursing (DON) was standing right next to her at this time. At 8:00 a.m. to 8:50 a.m. RN-A was observed setting up medications and administering them to multiple residents including insulin with still wearing a cloth mask. During interview on 9/15/21, at 2:21 p.m. the infection control preventionist (ICP) stated she was not aware RN-A was using a cloth mask when working as the nurse at the facility. The ICP stated stated cloth masks at this time were not approved to be used. The ICP then left the area and went to the nursing station and verified RN-A was wearing a cloth mask. -At 2:23 p.m. the ICP stated RN-A had not come to talk to her about using the cloth mask and she had been in the role since January 2021. During the interview, RN-C (nurse manager) also stated he was not aware RN-A was wearing a cloth mask and not the surgical mask as recommended by CDC. The ICP stated she had offered RN-A both N95 and regular surgical masks but RN-A had refused. The ICP further stated she was wondering how RN-A would have gone into isolation rooms. During interview on 9/15/21, at 2:51 p.m. the DON stated she had seen RN-A wearing a cloth mask and RN-A had told her she had spoken to the surveyors that she had a doctors note. The DON then stated "I saw her today and I told her	F 880	Other nurses who frequently swab for COVID were questioned and educated about proper PPE to wear while swabbing staff and residents. Education has been completed with RN-C, as well as all staff in the facility regarding the use of proper PPE while performing COVID testing. Audits on COVID testing will be performed on all testing days at least weekly for 6 weeks, biweekly for 4 weeks, then PRN. Director of Nursing will be responsible and report to the QA team who will determine if further auditing is required. Social Distancing and Mask Use for Unvaccinated Residents: R2 and R13 were provided with masks to wear and moved away from other residents. Audits were completed on all unvaccinated residents to ensure that all unvaccinated residents were wearing masks and were socially distanced. Education was completed with all staff about unvaccinated residents needing to wear masks when they are outside of their rooms. A list of unvaccinated residents was posted at the nursing desk and all resident's COVID status was put onto the banner of their electronic chart in PCC.	

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F 880	Continued From page 19 she needs to get a note. I did not know up to that she had been wearing a cloth mask. I asked her about the N95 and if she had reacted and she said yes. Am sure there is another things out there she can use that are hypoallergenic. I will be following up with [human resource] HR maybe she told someone." On 9/16/21, at 11:00 a.m. no additional information was provided concerning RN-A cloth mask use. Testing: During a random observation on 9/15/21, at 2:04 p.m. RN-C was observed doing a nasal swab to test for Covid-19 in the nursing office. During the observation, NA-C was seated on the chair as RN-C stood over on the other side of the desk as he completed the procedure. RN-C was observed only wearing goggles, and a blue surgical mask without a gown. After completing the swab RN-C inserted the swab into the packet and set it on the desk on top of a sheet of paper. There was no barrier across the desk and after the desk was not cleaned. RN-C then cleansed his hands as NA-C left the office. During interview on 9/15/21, at 2:19 p.m. the ICP stated the staff doing Covid-19 testing for both staff and residents was supposed to have on a gown, gloves, face shields and N95 mask. The ICP then stated although RN-C was doing a rapid test on NA-C he was still supposed to wear the appropriate PPE both for staff and residents. The ICP stated NA-C was unvaccinated and with that the staff involved were supposed to have weekly Covid-19 testing completed. During interview on 9/16/21, at 8:35 a.m. RN-C	F 880	Audits on unvaccinated resident mask wearing will be done daily for 2 weeks, weekly for 4 weeks, monthly for 3 months, then PRN. Director of Nursing will be responsible and report to the QA team who will determine if further auditing is required.	

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F 880	Continued From page 20	F 880		

stated, "I did not know I was supposed to use an N95 and gown when testing. I signed off on the education and now I know what am supposed to do."

Social distancing and mask use for un-vaccinated residents:
On 9/15/21, at 8:20 a.m. R13 was observed walking down the hallway. R13 came all the way to the nursing station not wearing a mask which was approximately 50 feet. During the observation although there was no other residents in the hallway there was several staff however none intervened and offered R13 a mask or redirected her.
-At 8:23 a.m. as R13 stood by the nursing station talking and visibly started to get teary, the DON approached R13 and then re-directed her back to her room at this time.

During interview on 9/15/21, at 2:32 p.m. the ICP verified R13 was not vaccinated at this time and then stated the staff were supposed to re-direct R13 when out of the room without the mask or offer a mask as R13 was confused.

On 9/15/21, at 8:55 a.m. after breakfast R2 was observed seated on the wheelchair outside room 103 without a mask and R2's wheelchair was parked into R37's back of her wheelchair. R37 wheelchair was slightly tilted and so was R37 as R2 sat right behind R37's back with no social distance at all between the two residents. During the observation, the ICP and RN-A walked past the area and RN-A remained standing next to R37's wheelchair as she set up medication but never moved R2 and offered a mask.
-At 8:57 a.m. as the ICP walked past surveyor

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F 880	Continued From page 21	F 880		

intervened and then the ICP moved R2 from behind R37 and then offered a mask to R2. The ICP verified R2 was not vaccinated and there was no proper social distancing between the residents.
-At 8:57 a.m. RN-A stated she did not know R2 was unvaccinated and she thought R2 was vaccinated and so was R37 and thus social distancing was not required.
-At 9:10 a.m. trained medication aide (TMA)-A stated she was aware R2 was not vaccinated and three other residents and when residents were not vaccinated, the staff was supposed to make sure the residents had a mask when out of the rooms and the residents were supposed to be re-directed. TMA-A further stated the staff was to make sure to keep them 6 feet when they are out here.

During interview on 9/15/21, at 2:28 p.m. the ICP stated "they should be masked and be kept 6 feet from each other apart. They kept him on top of her. The staff know all that." The ICP stated she was not certain the staff remembered all the residents who were not vaccinated however for R2 they should know because the responsible representative were very vocal about vaccination at the facility.

During interview on 9/15/21, at 2:54 p.m. the DON stated the residents who were not vaccinated should wear the mask and staff was supposed to follow the social distancing recommendations. The DON stated when asked if she was aware of R13 not being vaccinated "At the time I was walking with her she was having behaviors and I was more concerned about her state than the mask."

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/18/2021

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

By email to:
FM.HC.Inspections@state.mn.us

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

The Estates at Fridley is a 1-story building with a partial basement and was determined to be of Type II (111) construction. The 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

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K 000	Continued From page 2 automatic fire department notification. Since the original building and additions are of conforming construction, the facility will now be surveyed as one building. The facility has a capacity of 50 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct sensitivity testing of the smoke detectors of the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), National Fire Alarm Code, section 14.4.5.3.5. This deficient condition could have a patterned impact on the residents within the facility. Findings include:	K 345	Facility completed an inspection and sensitivity test of the fire alarm system on 09/17/2021 Maintenance Director and Maintenance Assistant have been provided education regarding Fire Alarm System-Testing and Maintenance specific to the fire alarm system inspection and testing requirement Facility will complete audits of the fire alarm inspection/testing every two years.	10/25/21

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K 345	Continued From page 3 On 09/14/2021 between 09:00 AM to 02:00 PM, it was revealed the sensitivity report printed on 08/2/2019 stated that two smoke detectors in resident rooms failed, there is no supporting documentation that they have been replaced, and no updated sensitivity has been completed. This deficient condition was verified by the Facilities Manager, Facilities Supervisor, and Administrator.	K 345	Findings will be reported to the QA team to determine continuation and a frequency of audits Maintenance Director and/or designee will be responsible	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 edition of the Life	K 353	Facility has removed all data cables and low voltage wires from sprinkler pipes located in the basement corridor and	10/25/21

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K 353	Continued From page 4 Safety Code (NFPA 101), section 9.7.5, and NFPA 25 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/14/2021, between 09:00 AM to 02:00 PM, it was revealed that several data cables and low voltage wires were lying on multiple sprinkler pipes in the basement corridor and the maintenance office. This deficient condition was verified by the Facilities Manager, Facilities Supervisor, and Administrator.	K 353	Maintenance office Maintenance Director and Maintenance Assistant have been provided education regarding the Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems Facility will complete audits of the sprinkler pipes and system weekly for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters to ensure the data cables and low voltage wires continue to be secured. Findings will be reported to QA team to determine continuation and frequency of audits Maintenance Director and/or designee will be responsible	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct several fire drills in	K 712	Facility completed a fire drill on 09/24/21 at 1:30pm on AM shift to fulfill fire drill	10/25/21

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	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2021**

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K 712	Continued From page 5 accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC), sections 19.7.1.4 through 19.7.1.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/14/2021 between 09:00 AM to 02:00 PM, it was revealed the facility did not perform the following fire drills and DACT testing: 1) Fire drills were not performed for the following time frames: -First Shift Second Quarter of 2021 -Third Shift of the Third Quarter of 2021 -First and Third Shift of the Fourth Quarter of 2020 2) Fire drill reports did not document the integrity of the alarm transmission for the following time frames: -First and Second Shift of the Second Quarter of 2021 -Third Shift of the Third Quarter of 2021 -First and Third Shift of the Fourth Quarter of 2020 3) Drill times did not vary when drills were completed in the nursing home. -Second shift drills were done at 3:17pm, 4:00pm, 3:50pm and 4:58pm These deficient conditions were verified by the Facilities Manager, Facilities Supervisor, and Administrator.	K 712	requirement Maintenance Director and Maintenance Assistant education regarding transmission of the fire alarm signal and simulation of emergency fire conditions has been initiated specific to frequency of fire drills Facility will complete fire drill audits monthly for 3 months, then quarterly for 4 quarters. Drills will be performed on all shifts each month and then on all shifts each quarter. Findings will be reported to QA team to determine continuation and frequency of audits Maintenance Director and/or designee will be responsible	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101	K 753		10/25/21

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K 753	Continued From page 6 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to restrict flammable decorations as required by the Life Safety Code (NFPA 101) 2012 edition section 19.7.5.6. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/14/2021, between 09:00 AM to 02:00 PM, observations revealed the entrance door to resident room 115 was covered by approximately 75 percent of the surface with pictures and drawings. This deficient condition was verified by the Facilities Manager, Facilities Supervisor, and Administrator.	K 753	Facility has removed flammable/combustible decorations from room 115□s door. Facility will initiate the use of a flame retardant chemical on room 115□s door and then continuing as necessary within the facility Facility staff have been provided education regarding combustible decorations and what is/is not prohibited Facility will complete audits of 4 resident room doors/facility doors weekly for 4 weeks, then monthly for 3 months. Findings will be reported to QA team to determine continuation and frequency of audits Administrator, Maintenance Director	

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K 753	Continued From page 7	K 753	and/or designee will be responsible	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to ensure the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99, 2012 Edition, Health Care Facilities Code Chapter 4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/14/2021 between 09:00 AM to 02:00 PM, it was revealed that the required risk assessment was not completed in its entirety per NFPA 99, missing Chapters 10 and 11. This deficient condition was verified by the Facilities Manager, Facilities Supervisor, and Administrator.	K 901	Facility completed a full risk assessment, including Chapters 10 and 11 Maintenance Director and Maintenance Assistant education regarding the requirements detailed within the Health Care Facilities Code Chapter 4 has been initiated Facility will review this risk assessment annually. Facility will update the facility utility risk assessment as room changes occur. Findings will be reported to QA team to determine continuation and frequency of audits Maintenance Director and/or designee will be responsible	10/25/21
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		10/25/21

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K 918	Continued From page 8 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and	K 918	Facility completed test and inspection of generator on 10/8/2021 for weekly	

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K 918	Continued From page 9 inspect the generator per 2012 edition of the Life Safety Code NFPA 101 section 9.1.3.1 and NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.4, and NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1) On 09/14/2021, between 09:00 AM to 02:00 PM, it was revealed that seven monthly generator tests were not completed in the last 12 months. 2) On 09/14/2021 between 09:00 AM to 02:00 PM, it was revealed that 45 of 52 weekly generator inspections were not completed between 09/2020 to 09/2021. These deficient conditions were verified by the Facilities Manager, Facilities Supervisor, and Administrator.	K 918	generator inspection. Facility completed test and inspection of generator on 9/14/2021 for monthly generator inspection. Maintenance Director and Maintenance Assistant education initiated regarding Hospital CAH and LTC Emergency Power specific to weekly and monthly testing and inspection of the generator. Facility will complete generator inspection/testing audits weekly for 4 weeks, then monthly for 3 months. Facility will complete generator inspection/testing audits monthly for 3 months, then quarterly for 2 quarters. Findings will be reported to the QA team to determine continuation and frequency of audits. Maintenance Director and/or designee will be responsible.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2021

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Re: State Nursing Home Licensing Orders
Event ID: 64RL11

Dear Administrator:

The above facility was surveyed on September 13, 2021 through September 16, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
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: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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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: On 9/13/21 through 9/16/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	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.	

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5201099C/MN54498 H5201101C/MN53198 H5201102C/MN62820 The following complaints were found to be UNSUBSTANTIATED: H5201095C/MN63348 H5201096C/MN62320 H5201097C/MN57192 H5201098C/MN56710,MN56930 H5201100C/MN64248 H5201103C/MN63565	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	2 920		10/25/21

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2 920	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facial hair removal was offered and/or provided for 1 of 1 resident (R28) who was dependent upon staff assistance for activities of daily living (ADLs). Findings include: R28's diagnoses included osteoarthritis of knee, type 2 diabetes mellitus and generalized anxiety disorder obtained from the quarterly Minimum Data Set (MDS) dated 8/10/21. In addition, the MDS indicated R28 had intact cognition, had no behaviors, which included refusal of care, and required extensive assistance with activities of daily living including personal hygiene and getting dressed. R28's care plan for dated 3/3/21, identified resident had a self-care deficit related to bilateral osteoarthritis of the knees and directed the staff to assist R28 with personal hygiene and provide assistance of 1 with getting dressed and bathing. During interview on 9/13/21, at 12:40 p.m. R28 stated "they are supposed to help me with the shaving, my mother and sister had this problem and I have one of those razors to do it but I cannot do it myself." During the interview R28 was observed to have multiple white/gray facial hairs on the lower chin approximately half inch long. During observations on 9/14/21, from 8:36 a.m. to 8:50 a.m. R28 was observed lying in bed and had completed eating breakfast. At 8:38 a.m. registered nurse (RN)-B went to room and took the breakfast tray out then R28 put the call light	2 920	Corrected	

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2 920	Continued From page 3 on, and licensed practical nurse (LPN)-A went into the room. At this time R28 stated she wanted to be changed. At 8:40 a.m. both RN-B and LPN-A were observed to check and change R28 then repositioned her and both never offered to remove the facial hairs which were visible as staff were observed standing over R28 during the cares as she lay in bed. During care observations on 9/14/21, at 10:35 a.m. to 10:41 a.m. nursing assistants (NA)-A and NA-B were observed to provide and assist R28 with pericares and changed the incontinent pad however during the observation both never acknowledged or offered to remove the facial hairs for R28. On 9/15/21, at 1:06 p.m. to 1:22 p.m. NA-B and NA-C who was assigned to R28 for the shift were observed standing over R28 prior to assisting her to be seated on the edge of the bed to transfer her to the wheelchair using a E-Z Stand (mechanical lift). During the observation, both NA's worked together to apply the lift sheet around R28's torso then secured her legs to the machine before lifting her up and onto the wheelchair. The NA's were over R28 the entire observation however never offered to remove the visible white/gray facial hairs on R28's chin. -At 1:16 p.m. NA-C wheeled R28 out of the room never offered to remove the facial hairs and down the hallway into the dining room where an activity was going on. -At 1:22 p.m. NA-C verified R28 had multiple facial hairs and then stated it did not cross her mind to ask or offer the resident to remove the facial hairs. NA-C further stated the staff was supposed to offer and assist resident with removing the facial hairs and if they refused, they were to report to the nurse. NA-C further stated	2 920		

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2 920	Continued From page 4 R28 did not refuse cares. During interview on 9/15/21, at 1:31 p.m. trained medical assistant (TMA)-A stated the nursing assistants were responsible to make sure all the residents they were assigned were well groomed and if a resident refused cares, staff were to re-approach and then let the nurse know if the resident refused cares. During interview on 9/15/21, at 3:00 p.m. the director of nursing (DON) stated if a resident needs assistance with grooming, the staff should provide it on regular basis unless someone declines, and the nurse should be made aware. On 9/16/21, at 8:53 a.m. LPN-A stated she had observed the facial hairs on R28 and she was getting supplies to remove them. LPN-A stated the staff was supposed to remove it for resident. The facility Activities of Daily Living (ADLs) Supporting policy revised March 2018, indicated "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service staff on completing routine grooming, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		10/25/21

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21375	Continued From page 5 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission COVID-19 related to when staff wore a cloth type mask, rather than surgical face mask; failed to ensure appropriate utilization of personal protective equipment (PPE) during routine testing for not vaccinated staff and failed to ensure masks were offered and social distancing was adhered to for not vaccinated residents in the hallways/units. This had the potential to affect all 42 residents residing at the facility reviewed for infection control. Findings include: Cloth mask use: On 9/13/21, at 3:12 p.m. to 3:40 p.m. registered nurse (RN)-A was observed standing outside in the hallway by the medication cart outside room 121. RN-A was observed to be wearing a Gucci brown cloth mask. During the observation RN-A was observed go into R31, R28 and R291's rooms passing medications and turning the nebulizer machine off. When asked about the mask, RN-A stated she had a doctors order to wear a cloth mask because the medical grade mask made her face to break out. RN-A stated the facility was aware she was using a cloth mask and had been using this cloth mask for a while	21375	Corrected	

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	00935	A. BUILDING: _____ B. WING _____	C 09/16/2021

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21375	Continued From page 6 now. On 9/15/21, at 7:50 a.m. RN-A was observed standing by the medication cart across from the nursing station and the director of nursing (DON) was standing right next to her at this time. At 8:00 a.m. to 8:50 a.m. RN-A was observed setting up medications and administering them to multiple residents including insulin with still wearing a cloth mask. During interview on 9/15/21, at 2:21 p.m. the infection control preventionist (ICP) stated she was not aware RN-A was using a cloth mask when working as the nurse at the facility. The ICP stated stated cloth masks at this time were not approved to be used. The ICP then left the area and went to the nursing station and verified RN-A was wearing a cloth mask. -At 2:23 p.m. the ICP stated RN-A had not come to talk to her about using the cloth mask and she had been in the role since January 2021. During the interview, RN-C (nurse manager) also stated he was not aware RN-A was wearing a cloth mask and not the surgical mask as recommended by CDC. The ICP stated she had offered RN-A both N95 and regular surgical masks but RN-A had refused. The ICP further stated she was wondering how RN-A would have gone into isolation rooms. During interview on 9/15/21, at 2:51 p.m. the DON stated she had seen RN-A wearing a cloth mask and RN-A had told her she had spoken to the surveyors that she had a doctors note. The DON then stated "I saw her today and I told her she needs to get a note. I did not know up to that she had been wearing a cloth mask. I asked her about the N95 and if she had reacted and she said yes. Am sure there is another things out	21375		

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21375	Continued From page 7 there she can use that are hypoallergenic. I will be following up with [human resource] HR maybe she told someone." On 9/16/21, at 11:00 a.m. no additional information was provided concerning RN-A cloth mask use. Testing: During a random observation on 9/15/21, at 2:04 p.m. RN-C was observed doing a nasal swab to test for Covid-19 in the nursing office. During the observation, NA-C was seated on the chair as RN-C stood over on the other side of the desk as he completed the procedure. RN-C was observed only wearing goggles, and a blue surgical mask without a gown. After completing the swab RN-C inserted the swab into the packet and set it on the desk on top of a sheet of paper. There was no barrier across the desk and after the desk was not cleaned. RN-C then cleansed his hands as NA-C left the office. During interview on 9/15/21, at 2:19 p.m. the ICP stated the staff doing Covid-19 testing for both staff and residents was supposed to have on a gown, gloves, face shields and N95 mask. The ICP then stated although RN-C was doing a rapid test on NA-C he was still supposed to wear the appropriate PPE both for staff and residents. The ICP stated NA-C was unvaccinated and with that the staff involved were supposed to have weekly Covid-19 testing completed. During interview on 9/16/21, at 8:35 a.m. RN-C stated, "I did not know I was supposed to use an N95 and gown when testing. I signed off on the education and now I know what am supposed to do."	21375		

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Social distancing and mask use for un-vaccinated residents:
On 9/15/21, at 8:20 a.m. R13 was observed walking down the hallway. R13 came all the way to the nursing station not wearing a mask which was approximately 50 feet. During the observation although there was no other residents in the hallway there was several staff however none intervened and offered R13 a mask or redirected her.
-At 8:23 a.m. as R13 stood by the nursing station talking and visibly started to get teary, the DON approached R13 and then re-directed her back to her room at this time.

During interview on 9/15/21, at 2:32 p.m. the ICP verified R13 was not vaccinated at this time and then stated the staff were supposed to re-direct R13 when out of the room without the mask or offer a mask as R13 was confused.

On 9/15/21, at 8:55 a.m. after breakfast R2 was observed seated on the wheelchair outside room 103 without a mask and R2's wheelchair was parked into R37's back of her wheelchair. R37 wheelchair was slightly tilted and so was R37 as R2 sat right behind R37's back with no social distance at all between the two residents. During the observation, the ICP and RN-A walked past the area and RN-A remained standing next to R37's wheelchair as she set up medication but never moved R2 and offered a mask.
-At 8:57 a.m. as the ICP walked past surveyor intervened and then the ICP moved R2 from behind R37 and then offered a mask to R2. The ICP verified R2 was not vaccinated and there was no proper social distancing between the residents.
-At 8:57 a.m. RN-A stated she did not know R2 was unvaccinated and she thought R2 was

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vaccinated and so was R37 and thus social distancing was not required.
-At 9:10 a.m. trained medication aide (TMA)-A stated she was aware R2 was not vaccinated and three other residents and when residents were not vaccinated, the staff was supposed to make sure the residents had a mask when out of the rooms and the residents were supposed to be re-directed. TMA-A further stated the staff was to make sure to keep them 6 feet when they are out here.

During interview on 9/15/21, at 2:28 p.m. the ICP stated "they should be masked and be kept 6 feet from each other apart. They kept him on top of her. The staff know all that." The ICP stated she was not certain the staff remembered all the residents who were not vaccinated however for R2 they should know because the responsible representative were very vocal about vaccination at the facility.

During interview on 9/15/21, at 2:54 p.m. the DON stated the residents who were not vaccinated should wear the mask and staff was supposed to follow the social distancing recommendations. The DON stated when asked if she was aware of R13 not being vaccinated "At the time I was walking with her she was having behaviors and I was more concerned about her state than the mask."

SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to ensure staff was wearing appropriate PPE during care as recommended by the State Agency to prevent the

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21375	Continued From page 10 spread of Covid-19. In addition the DON or designee will monitor the staff on ensuring the residents who are not vaccinated are following the recommendations for masking and social distancing. The DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R31) observed to self-administer a nebulizer. Findings include: R31's diagnoses included Alzheimer's disease, dementia, Parkinson's disease and chronic obstructive pulmonary disease (COPD) obtained from the admission record dated 9/16/21. R31's physician orders dated 9/12/12, directed to administer ipratropium-albuterol solution 3 milligrams (mg) per 3 milliliters (ml) (Duoneb, a	21565	Corrected	10/25/21

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respiratory medication) via nebulizer 3 ml inhale orally two times a day for bronchi muscle spasm. The physician's orders did not identify R31 could self-administer medications, including the nebulizer treatment.

R31's care plan dated 7/29/21, identified resident had an alteration in oxygen/gas exchange, respiratory status related to acute cough and diagnoses of COPD. The care plan directed staff to adhere to medication regime as ordered per the physician.

On 9/13/21, at 3:03 p.m. to 3:14 p.m. during a random observation, R31 was observed seated on the wheelchair in her room with door wide open to the hallway. During the observation an audible noise of a nebulizer machine was heard when standing at the hallway outside of R31's shared room. R31 was observed holding a handheld nebulizer chamber (a inhalation treatment device). Also, during the observation R31 was observed and heard coughing and two staff went past R31's room which included registered nurse (RN)-A who was assigned to R31 that shift.
At 3:14 p.m., RN-A stated she thought she had turned it off. RN-A then asked R31 if she had shortness of breath and R31 stated it was better then. RN-A also stated R31 was not supposed to be left with nebulizer on alone.

On 9/14/21, at 8:01 a.m. during a random observation the trained medication aide (TMA)-A was observed administer oral medications to R31 then TMA-A was observed set up the nebulizer handed it to R31, turned it on, left the room as she shut the door and returned to the medication cart which was located approximately 54 feet from the room.

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21565	Continued From page 12 On 9/14/21, at 8:06 a.m. licensed practical nurse (LPN)-A nurse manager verified R31 nebulizer was running. LPN-A reviewed the medical record and verified R31 did not have an order and SAM assessment completed before being allowed to do the SAM alone after setting up. LPN-A stated all residents who self-administered any medications were supposed to have an assessment to see if they were capable and then the nurse was to get an order for it which would be specific to the medication. During interview on 9/14/21, at 8:12 a.m. the director of nursing (DON) stated for a resident to be able to self-administer the medication, the nurse would complete an assessment, teach the resident about the medication(s) and make sure they demonstrated doing the SAM and then they would get an order for the SAM. The DON stated she was going to follow up with this surveyor. During interview on 9/14/21, at 8:18 a.m. TMA-A stated she was going by the guidelines from Covid recommendations that when a nebulizer was started in the room, they were to leave the room, shut the door behind and would return when it was completed. TMA-A stated she did not know if R31 had an order to SAM and had not been told R31 was not to be left alone before. TMA-A further stated after the concern was brought up by surveyor she had asked the nurse to follow up. The facility Self-Administration of Medications policy revised December 2016, indicated "As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically	21565		

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21565	Continued From page 13 appropriate for the resident..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils	21915		9/17/21

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21915	Continued From page 14 shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 42 residents' families who resided in the facility. Findings include: During interview on 9/15/21, at 10:11 a.m., the social service director confirmed the facility did not have an existing family council. The social service director further confirmed she had not formally attempted to organize a family council in the past year, and the last family council meeting was held in July of 2019. During interview on 9/16/21, at 9:20 a.m., the director of nursing and Administrator confirmed the Quality Assurance Performance Improvement committee had discussed it in the monthly meetings since July of 2019, but no attempt was made to organize a family council. SUGGESTED METHOD OF CORRECTION: The social service director or designee should ensure thorough attempts are made to develop a family council. The administrator or designee should develop monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915	Corrected	