Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 21, 2023

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

RE: CCN: 245201
Cycle Start Date: May 11, 2023

Dear Administrator:

On June 7, 2023, we notified you a remedy was imposed. On July 12, 2023, July 31, 2023, and August `4, 2023 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 July 29, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 7, 2023 be discontinued as of July 29, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 7, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 7, 2023. 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.

Your request for waiver of F727 has been approved based on the submitted documentation.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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
June 7, 2023

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

RE: CCN: 245201
Cycle Start Date: May 11, 2023

Dear Administrator:

On May 11, 2023, 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 July 7, 2023.

- 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 July 7, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 7, 2023.

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.

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 $11,995; 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 July 7, 2023, 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 July 7, 2023, 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 November 11, 2023 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 _____	05/11/2023

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
F 000	INITIAL COMMENTS On 5/8/23 - 5/11/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H5201123C (MN00082588), H52012147C (MN00086800), H52012148C (MN00087839), and H52012149C (MN00090886). 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		6/28/23

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

Electronically Signed | 06/16/2023

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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F 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to remove facial hair and maintain dignity for 1 of 3 residents (R4) reviewed for dignity. Findings include:	F 550	R4 facial hair was removed. R4's care plan and nursing aide care sheet has been updated to reflect grooming and personal hygiene preference. Dependent residents who need assistance with facial hair have the	

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F 550	Continued From page 2 R4's annual Minimum Data Set (MDS) dated 3/21/23, indicated R4 had severe cognitive impairment, and required one-person physical assistance for personal hygiene to include shaving. R4's diagnoses included schizoaffective disorder, obsessive compulsive disorder, intellectual disability, unspecified psychosis, and anxiety disorder. R4's care conference note dated 4/5/23, indicated, interdisciplinary team (IDT) met with family member (FM)-A for a quarterly conference. The note indicated, "The family has requested facila [sic] shaving to occur during her showers - need care notes updated." R4's care plan dated 3/21/23, indicated R4 was at risk for impaired ability to complete activities of daily living (ADLs) due to cognitive impairments and mental health and required supervision with set up for grooming and personal hygiene. R4's nursing aide care sheet lacked evidence of instruction for staff to remove R4's facial hair. During observation on 5/9/23 at 8:19 a.m., R4 had numerous long hair on chin and upper lip from 1/4 to 3/4 inches in length. During observation on 5/10/23 at 8:11 a.m., R4 continued to have numerous long chin and upper lip hairs. During interview on 5/10/23 at 9:33 a.m., FM-A stated being happy with most of the care R4 received at the facility, except for them not removing her facial hair even after being asked several times. FM-A stated, "It bothers me especially when I take her out to appointments...I	F 550	potential to be affected by this. Staff will be educated on ADL policy specific to grooming facial hair. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of 5 residents to ensure they are appropriately groomed to not have facial hair per their preference. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. DON or designee will be responsible party. Date of Completion: 6/28/2023	

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F 550	Continued From page 3 wonder if she will be shaved for her appointment today." FM-A further stated she provided a shaver some time ago and on the most recent care conference specifically requested R4 be shaved regularly. During interview on 5/10/23 at 9:57 a.m., nursing assistant (NA)-D stated if the NAs saw facial hair on a female resident, they were supposed to remove it on their shower day. During interview on 5/10/23 at 10:06 a.m., licensed practical nurse (LPN)-B stated the NAs were supposed to take care of the resident's facial hair unless they were on a blood thinner; then the nurses would do it. LPN-B stated R4 was not on a blood thinner and therefore, the NAs should have shaved her. LPN-B stated not being aware of any requests from R4's family regarding having facial hair removed particularly before an appointment. LPN-B stated R4 had a scheduled appointment today (5/10/23). During observation on 5/10/23 at 10:20 a.m., R4 continued to be unshaven. During interview on 5/10/23 at 10:38 a.m., NA-E stated R4 was supposed to be shaved on shower days and confirmed R4's shower day was Sunday day shift. NA-E further stated not being aware of any family requests for R4 to be shaved prior to appointments. During observation on 5/10/23 at 10:43 a.m., NA-E approached R4 with shaving supplies and offered to shave her. R4 accepted. NA-E confirmed R4 had numerous long chin and mustache hairs.	F 550		

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F 550	Continued From page 4 During observation and interview on 5/10/23 at 10:46 a.m., FM-A entered to pick up R4 for her appointment. FM-A stated staff were in the process of shaving R4, and she was very thankful. During interview on 5/10/23 at 11:12 a.m., social services (SS)-A stated she did not attend R4's most recent care conference. SS-A stated if requests or changes were agreed upon during the conference there would be an IDT approach as to who would follow up. If the change was nursing related such as personal hygiene or shaving, the nurse manager, director of nursing (DON), or the assistant DON (ADON) would ensure the appropriate follow up took place. In the case of shaving, the care plan, nurse aide care sheet and possibly a nursing order should be updated to reflect the change. During interview on 5/10/23 at 11:47 a.m., DON stated expectation was for nurse aide care sheets and care plan to be updated timely to reflect changes discussed during care conferences. DON further stated NAs should be shaving women's facial hair if the resident was not diabetic or on a blood thinner. Facility policy Activities of Daily Living (ADL)/Maintain Abilities dated 3/31/23, indicated the facility provided person centered care for ADLs to maintain good grooming and respects each resident's preferences, choices, values, and beliefs.	F 550		
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	F 554		6/28/23

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F 554	Continued From page 5 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 assess and determine safety for self-administration of medications (SAM) for 2 of 2 residents (R34 and R243) whom were observed to have medications in their rooms. Findings include: R34's admission Minimum Data Set (MDS) dated 4/22/23, identified R34 was cognitively intact and required assistance of 1-2 staff with activities of daily living (ADL's) including bed mobility, dressing and personal hygiene. R34's diagnoses included altered mental status, psychotic disorder with delusions, bipolar disorder and muscle weakness. R34's Order Summary Report dated 5/11/23, included Triamcinolone Acetonide External Cream 0.5% (a medication used to treat symptoms including itching, dryness, and inflammation caused by various skin conditions) topically for urticaria (hives). The physician orders lacked SAM orders. R34's care plan dated 4/18/23, failed to identify skin conditions and interventions that included SAM. During observation on 5/09/23 at 8:59 a.m., a tube of Triamcinolone 0.1% Cream was on R34's bedside table. R34 stated the staff left the cream in her room all the time and she applied the	F 554	R34 discharged from the facility on 5/16/2023. R243 has been assessed to be able to self-administer medication(s). Residents who self-administer medication(s) have been reviewed for appropriateness. The facilities Self-Administration of Medications policy was reviewed and remains current. Nursing staff educated on self-admin policy. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of 5 residents to ensure they have all appropriate documentation to self-administer medication(s). Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. DON or designee will be responsible party. Date of Completion: 6/28/2023	

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F 554	Continued From page 6 cream independently without staff assistance. During observation on 5/10/23 at 1:36 p.m., an opened and uncapped tube of Triamcinolone Cream 0.1% on R34's bedside table. During observation on 5/10/23 at 1:39 p.m., licensed practical nurse (LPN)-A removed an unlabeled tube of Triamcinolone Cream 0.1%, an unlabeled tube of Bactine 1.0% hydrocortisone cream and a labeled tube of Triamcinolone Cream 0.5% from R34's room. LPN-A stated the Triamcinolone Cream 0.1% and the Bactine were unlabeled and were not supplied by the facility pharmacy, although the Triamcinolone Cream 0.5% had a facility pharmacy label that identified it belonged to R34. LPN-A stated R34 did not have an order and had not been assessed for SAM and staff should not have left the medication in R34's room unattended. R243's admission record identified R243 was admitted on 5/5/23, and had diagnoses including osteomyelitis, diabetes mellitus type 2, protein C resistance and right below the knee amputation. R243's Order Summary Report dated 5/11/23, included Nystatin Powder (a topical medication used to treat fungal or yeast infections of the skin) apply topically twice daily for yeast/redness. R243's care plan dated 5/5/23, identified R243 was incontinent of urine and required assistance with toileting and personal hygiene. The plan failed to identify specific skin conditions and failed to identify interventions that included SAM. During observation on 5/09/23 at 10:55 a.m., an unlabeled bottle of Nystatin topical powder, usp	F 554		

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F 554	Continued From page 7 100,000 units per gram for topical use only, not for ophthalmic use, on R243's bedside table. R243 stated the staff leave the bottle in her room and apply the powder when needed. During observation on 5/10/23 at 1:11 p.m., R243 was seated in her wheelchair in her room. The same bottle of Nystatin Powder was on residents bedside table. During observation and interview on 5/10/23 at 1:30 p.m., the bottle of Nystatin powder was on R243's bedside table. LPN-A stated R243 had an order for medication, however, the order did not identify self administration and did not direct staff to leave the medication in the residents room. Further, LPN-A stated staff had not completed a SAM assessment that would identify if R243 was physically and mentally capable of applying the topical powder independently. During interview on 5/10/23 at 1:39 p.m., LPN-A stated medication nurses apply topical medications including creams and powders. The medications would be kept in the locked treatment cart and should not be kept in resident rooms. During joint interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/10/2023 at 2:56 p.m., the ADON stated the nursing SAM assessment included determination if the resident was able to administer the medication independently, and their understanding of the medication. Staff would then obtain an order from the physician, enter the order into the electronic medical record, and update care plan. The ADON further stated residents medications should be locked in the	F 554		

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	245201	A. BUILDING _____ B. WING _____	05/11/2023

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F 554	Continued From page 8 medication or treatment cart and should not be left at the bedside for residents unless they have a SAM order for a specific medication at which point the staff would bring the medication to the resident and return at a later time to be sure the resident took the medication appropriately. Both the ADON and the DON stated R34 and R243's medication should not have been left in their rooms and should have been locked in the medication or treatment cart. The facility Self Administration of Medication policy revised February 2021, identified residents have the right to self-administer medication if determined clinically appropriate and safe for the resident to do so. The SAM is periodically reassessed based on changes in the resident's medical and/or decision-making status. The facility would also obtain an order from the provider indicating which medications the resident could self administer. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		6/28/23

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F 561	Continued From page 9 care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to timely follow up on a resident requested medication change for 1 of 2 residents (R17) reviewed for choices. Findings include: R17's quarterly Minimum Data Set (MDS) dated 3/8/23, identified she had intact cognition and had not rejected cares. R17 had a diagnosis of end stage renal disease. R17 required supervision for dressing and limited assist for hygiene. R17's medication orders included: -start date of 12/7/2022, cetirizine hcl (hydrocloride) (an antihistamine) oral tablet five mg (milligrams) by mouth every 24 hours as needed related to allergic rhinitis.	F 561	R17 had no adverse effects. R17 physician has been followed up with, orders have been updated to reflect preference. All residents have the potential to be affected. All residents reviewed as to requests for changes to their medications and if they have been followed up in a timely manner. Nurses will be educated to put in a progress note in PCC for appropriate follow-up of provider communication. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of	

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F 561	Continued From page 10 R17's Communication Form dated 4/14/23, identified a request of R17 for Zyrtec (brand name for cetirizine) to be scheduled, as the medication was PRN (as needed) at this time. The provider's written response on 4/17/23, was "pls [please] re-ask the question." During an observation and interview on 5/09/23 at 9:09 a.m., R17 had dry, red eyes and rubbed her nose. R17 stated "I have such bad allergies, it's year round." R17 stated she wanted stronger allergy medication, she mentioned it to her provider already but no follow up was done. R17's medical record reviewed 5/9/22, lacked any follow up on R17's request to have her allergy medication scheduled (25 days after the original request). During an interview on 5/10/23 at 1:32 p.m., licensed practical nurse (LPN)-B stated she worked with R17 frequently. LPN-B stated R17 had allergies and was prescribed oral pills and eye drops to help manage the symptoms. LPN-B stated R17's providers were at the facility at least two times per week. LPN-B reviewed R17's request in the medical record and agreed it should have been followed up on and had not been. During a follow up interview on 5/10/23 at 2:43 p.m., R17 stated her allergies were still bothering her and no one had followed up yet. During an interview on 5/11/23 at 9:30 a.m., the assistant director of nursing (ADON) stated resident requests to the provider could easily be followed up on within a week or less. The ADON reviewed R17's request in the medical record and	F 561	5 residents to ensure appropriate follow-up of provider communication. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. DON or designee will be responsible party. Date of Completion: 6/28/2023	

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F 561	Continued From page 11 stated it should have been followed up on more timely for R17's comfort. A policy for physician's orders was requested and not provided.	F 561		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 657	R29 care plan has been updated to	6/28/23

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F 657	Continued From page 12 review, the facility failed to revise care plan interventions with recommended behavioral approaches for 1 of 1 residents (R29) reviewed for mood and behavior. Findings include: R29's quarterly Minimum Data Set (MDS) dated 3/1/22, identified he had intact cognition and had rejected cares one to three days in the look back period. R29 was independent with ambulation and toileting. R29 had a diagnosis of encephalopathy (brain disease, damage, or malfunction that can cause an altered mental state.) R29's Associated Clinic of Psychology (ACP) visit note dated 4/5/23, identified it was important for staff to replace R29's linens when they removed items. Further, it was important to replace the items as soon as possible to help decrease R29's concerns of items were stolen. R29's mood and behavior care plan dated 4/10/23, lacked the recommended intervention to replace any removed linens. During an observation on 5/9/23 at 11:07 a.m., R29 was yelling loudly in the hallway for staff to give him back his towels and linens. During an interview on 5/9/23 at 11:24 a.m., R29 stated he had towels and linens in his laundry basket in preparation to take a shower. R29 stated he then left his room, staff made his bed and took his linens out of the basket. R29 held his empty basket which now only contained soap and lotion. R29 stated staff had not replaced the towels and linen and he would have wanted them	F 657	reflect behavioral recommendations per ACP. SSD will meet with ACP Clinicians, each week when onsite, to review current resident needs, behaviors, and any changes as well as discuss new residents/referrals. Residents who see ACP will have behavioral recommendations reviewed and reflected in their plan of care. Previously, ACP Visit Notes were faxed to the facility and immediately uploaded into residents documents. This process has been changed to any ACP Visit Notes will be given directly to the SSD. The SSD and IDT will then review the recommendations and SSD will integrate the recommendations into the care plans as appropriate. Once the recommendations have been integrated into the care plan, the SSD will initial Visit Notes and they will be uploaded to the residents documents. The facilities Care Planning Policy was reviewed and remains current. Director of Social Services and clinical leadership educated to the care planning policy specific to revising residents care plan with behavioral interventions. DSS and clinical leadership educated to review ACP notes weekly to follow-up on recommendations. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of	

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F 657	Continued From page 13 to. R29 stated staff stole clothing and linen from him. During an interview on 5/9/23 at 11:58 a.m., licensed practical nurse (LPN)-A- stated staff had to remove soiled linens from R29's room earlier today. LPN-A stated R29 would hang up urine soaked linens to dry in his room and they had to remove the items to try and reduce malodor. During an interview on 5/10/23 at 12:36 p.m., housekeeper (H)-A stated housekeeping would remove soiled linens when found. H-A stated R29 would hang up clothing, briefs, linens and towels which were urine soaked to dry, which resulted in malodor. Housekeeping cleaned the room daily and fully deep cleaned every three days. H-A stated she was not aware any removed items should be replaced. During an interview on 5/10/23 at 12:49 p.m., nursing assistant (NA)-A and NA-C stated the urine odor was strong in R29's room and every day he required a bed change. NA-A and NA-C stated they were not aware they were supposed to replace other linens or towels that were removed. During a follow up interview on 5/10/23 at 12:57 p.m., LPN-B reviewed R29's care plan and confirmed the intervention to replace removed linens was not listed. During an interview on 5/10/23 at 1:25 p.m., the director of social services (DSS) stated ACP visited residents often in the building. The recommendations were then faxed to the facility or emailed and then social services would discuss as an IDT and revise the care plan. The	F 657	5 residents to ensure ACP recommendations are care planned as necessary. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. SSD or designee will be responsible party. Date of Completion: 6/28/2023	

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F 657	Continued From page 14 DSS was not aware of the recommendation to replace linens that were removed, and stated it would be acceptable for R29 to keep a small amount of clean linens in his room. During an interview on 5/11/23 at 8:23 a.m., ACP social worker (SW)-B stated she was at the facility often to visit residents and had seen R29 the past six months. SW-B stated after her visits she would send recommendation notes to the facility within 24 hours and would expect the facility to follow up with them within a couple of days to help manage the resident's mental health needs. SW-B stated it was still a valid recommendation to replace any items that were removed. SW-B stated since R29 had hoarding tendencies, replacing some items might make removing the soiled or damaged items less distressing. A policy for care plan revision was requested while on survey and not provided.	F 657		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an	F 727		6/28/23

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F 727	Continued From page 15 average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight consecutive hours a day. This had the potential to affect all 44 residents who resided at the facility. Findings include: Review of the facility daily staffing hours and staff schedules from 4/1/23 through 4/30/23, revealed there was no RN scheduled on-site during the following weekends: - 4/1/23 through 4/2/23 - 4/8/23 through 4/9/23 - 4/15/23 through 4/16/23 - 4/22/23 through 4/23/23 - and 4/29/23 through 4/30/23. On 5/10/23 at 1:01 p.m., the administrator reviewed the daily staff posting and stated a "0" under the 'staff hours column' means there was no RN scheduled. A "1" in the 'number of staff column' indicates the DON would have covered. During interview on 5/11/23 at 9:13 a.m., the administrator stated there is always an RN in the facility Monday through Friday. The administrator stated at least one weekend a month, if not more, there is not an RN working in the building and the assistant director of nursing (ADON) or the director of nursing (DON) would be on-call. The administrator stated during 4/14/23 through 4/16/23, there was not an RN scheduled in the facility and this would have been the case during first quarter of 2023 when RN coverage triggered	F 727	June 20, 2023 To whom it may concern, I am writing this letter to request a waiver regarding federal regulation F727 for The Estates at Fridley in Fridley, MN license number 245201. We currently have several registered nurse positions open and are actively recruiting for them. Unfortunately, being in a small facility, registered nurses tend to be difficult to recruit. We are close to a clinic and hospital that also actively recruits registered nurses, making recruitment even more difficult. We currently employ one interim full-time Director of Nursing, one interim full-time Assistant Director of Nursing, and one full-MDS nurse that travels between two Monarch facilities. We have found it to be difficult to fulfill our 8 hours of RN coverage seven days a week, most notably on the weekends. Over the last year we have received 7 registered nursing applications, 8 of which were eligible for review. We offered two applicants' employment at our facility and both declined employment, and 2 did not show up for interview, 2 no response to interview invites and 1 shifts available did not work out. We currently have several efforts in place to recruit registered nurses such as sign-on bonuses, retention bonuses for current staff, staff referral bonuses, wage increases for the first full year of employment, and tuition	

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F 727	Continued From page 16 on the PB&J report. During interview on 5/11/23 at 10:04 a.m., trained medication aide (TMA) stated during the week there was an RN working in the facility. During evenings, nights and weekends there was either one TMA and one licensed practical nurse (LPN) or two LPN's working. The ADON/DON was on-call. The daily staffing policy was requested and not provided.	F 727	reimbursement for our LPNs looking to further their nursing credentials. Please see the current RN job postings attached to this letter. Knowing that it will become even more difficult for us to fulfill our 8 hours per day of RN coverage, we do, and will continue to, consider the acuity of our current residents as well as those who we review for admission if our request was approved. The health and safety of our residents is our top priority. We have a strong relationship with the hospital located in the next town and being in a small community. The physicians employed by that hospital have a strong understanding of the residents we care for at our facility. If the need were to arise, they would be able to respond to our call within minutes. We will continue to put forth every effort to have a registered nurse in the building for 8 hours, 7 days a week by altering work schedules when possible and ensuring we always have a registered nurse on call. After May 30th, 2023, it will become increasingly difficult to maintain 8 hours of RN coverage. This leaves approximately 4 days a month without any RN coverage on-site. We are requesting this waiver to be granted until we can employ two full-time registered nurses in an attempt to preserve the currently employed registered nurses here at our facility. Thank you for your consideration. Cindy Thao	

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F 727	Continued From page 17	F 727	Administrator 763-762-1104	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		6/28/23

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F 756	Continued From page 18 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacy recommendations were addressed for 1 of 1 resident (R4) reviewed for antipsychotic medication side effects. Findings include: R4's annual Minimum Data Set (MDS) dated 3/21/23, indicated R4 had severe cognitive impairment, and had received antipsychotics 7 of the 7 days during the lookback period. R4's diagnoses included schizoaffective disorder, obsessive compulsive disorder, intellectual disability, unspecified psychosis, and anxiety disorder. R4's provider orders indicated Risperdal tablet 1mg (milligram). Give 1 mg by mouth every morning and at bedtime for schizoaffective disorder. R4's care plan dated 3/21/23, indicated R4 had potential for psychotropic drug ADR's (adverse drug reactions) related to daily use of psychotropic medication. R4's consultant pharmacist medication regimen review (MRR) recommendation dated 11/3/22, indicated, "This resident takes Risperidone, a medication that can cause metabolic abnormalities including hyperlipidemia or elevated blood glucose. I was unable to locate a recent	F 756	R4 had no adverse effects. R4 pharmacy recommendation has been completed. Residents who have a pharmacy recommendations has the potential to be affected. DON educated to contact providers within 30 days of receipt, contact Medical Director if primary providers do not respond within 30 days. Director of Nursing or designee will be responsible party. Date of Completion: 6/28/2023	

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F 756	Continued From page 19 fasting lipid panel or A1c." The provider response section of the MRR lacked evidence of provider response. R4's consultant pharmacist recommendation dated 12/6/22, indicated, "Note Text: MRR See report for recommendation-This resident takes the antipsychotic Risperdal the last AIMS assessment in PCC is from May 22--A reminder that an AIMS assessment is due, please complete now and at least q 6 months for monitoring." R4's consultant pharmacist recommendation dated 1/3/23, indicated, "NOTE: Reissued recommendation from 11/2/22, and 12/6/22. This resident takes Risperidone, a medication that can cause metabolic abnormalities including hyperlipidemia or elevated blood glucose. I was unable to locate a recent fasting lipid panel or A1c." The provider response section of the MRR lacked evidence of provider response. R4's consultant pharmacist recommendation dated 2/2/23, indicated "MRR. See report for recommendation--Reissued recommendation from 11/2/22, 12/6/22. and 1/3/23 -- this resident takes Risperidone, a medication that can cause metabolic abnormalities including hyperlipidemia or elevated blood glucose. I was unable to locate a recent fasting lipid panel or A1c." Provider order dated 2/14/23, indicated, "lipid panel and A1c related to risperidone Rx [prescription]. recommendation from Polaris and approved by MD signed." During interview on 5/11/23 at 8:08 a.m., consultant pharmacist (CP) stated she originally	F 756		

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F 756	Continued From page 20 made the lab recommendation for R4 in November and reissued the same recommendation in December, January, and February. CP stated she spoke to the director of nursing (DON) and medical director (MD) to expedite the lab order. CP further stated expectation was for the recommendations to be addressed within a month and four months was too long for a response regarding R4's lab draw. During interview on 5/11/23 at 8:57 a.m., DON stated expectation was for MRRs to be addressed in a timely manner and sooner than four months. Facility policy Consultant Pharmacist Reports dated August 2019, indicated the CP worked with the facility to establish a system whereby the CP recommendations regarding residents' medication therapies were communicated to those with authority to implement the recommendations and were responded to in an appropriate and timely fashion.	F 756		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own	F 776		6/28/23

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F 776	Continued From page 21 diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to timely arrange for an ordered urology examination 1 of 1 resident (R29) reviewed who required diagnostics services. Findings include: R29's quarterly Minimum Data Set (MDS) dated 3/1/22, identified intact cognition. R29 was independent with ambulation and toileting. R29's had a diagnosis of encephalopathy (brain disease, damage, or malfunction that can cause an altered mental state.) R29's orders dated 12/2/22, identified please schedule urology appointment to evaluate and treat for urinary incontinence- may need urodynamic studies. R29's physician visit notes identified the following: -12/16/22, R29 reported frequent urination and urinary incontinence. R29's room smelled of urine, but R29 did not smell of urine. R29 was asked about the urologist and R29 reported not seeing one yet. The note added a diagnosis of functional urinary incontinence and would discuss with staff a urology follow up. -1/23/23, R29 continued to report frequent urination and urinary incontinence. R29's room smelled of urine and R29 refused hygiene care from staff. Flomax (medication for enlarged prostate) was prescribed.	F 776	R29 was seen by urology specialist on 5/19/2023. Residents who have radiology/other diagnostic services ordered have the potential to be affected. Residents will have necessary medical appointments scheduled in a timely manner. HUC and Nursing staff educated on appointment referral orders for scheduling. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of resident ordered medical appointments to ensure they were/are scheduled in a timely manner. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Director of Nursing or designee will be responsible party. Date of Completion: 6/28/2023	

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F 776	Continued From page 22 R29's medical record reviewed 5/8/23, five months and six days after the original order, lacked mention of any past or upcoming urology appointments. During an observation on 5/8/23, at 7:30 p.m. R29's room had a strong urine smell. During an interview on 5/8/23 at 7:45 p.m., nursing assistant (NA)-B stated R29 had ongoing urinary continence issues and the urine smell was not new. NA-B stated R29 was independent with cares but the nursing staff helped with cleaning. During an interview on 5/9/23 at 11:24 a.m., R29 stated he had urinary continence issues and had talked to his doctor three times about it but he never got a response back. During an interview on 5/9/23 at 11:58 a.m., licensed practical nurse (LPN)-A stated R29 had ongoing urinary continence issues. LPN-A reviewed R29's medical record and agreed there was an order to schedule urology, however, no appointment was scheduled. During an interview on 5/10/23 at 10:07 a.m., the healthcare intern (HCI) viewed the order for R29's urology referral. The HCI stated he would schedule appointments and rides for residents after nursing gave him the referrals. The HCI stated he would need to check to see if this appointment was scheduled. During a follow up interview on 5/10/23 at 11:17 a.m., the HCI stated R29 had a urology appointment scheduled for the upcoming week. The HCI stated the appointment was set up last week.	F 776		

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F 776	Continued From page 23 During an interview on 5/11/23 at 9:30 a.m., the assistant director of nursing (ADON) stated R29's urology appointment was not followed up timely and should have been. A policy for resident appointments was requested and not provided.	F 776		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		6/28/23

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F 867	Continued From page 24 including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;	F 867		

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F 867	Continued From page 25 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		

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F 867	Continued From page 26 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance Assessment and Performance Improvement Plan (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys in regards infection control and self-administration of medications (SAM) which were also identified during this survey. This had the potential to effect all 44 residents residing in the facility. Findings include: Review of the facility CASPER Report dated 5/1/23, identified the facility was cited F880 for infection control on the surveys which exited 7/11/19 and 9/16/21. The facility was also cited F554 for SAM on the survey which exited 9/16/21. See F880: Based on observation, interview, and document review the facility failed to ensure staff wore appropriate personal protective equipment (PPE) appropriately for 1 of 2 residents (R31) who was on transmission based precautions (TBP). See F554: Based on observation, interview, and document review, the facility failed to assess the resident and determine safety for SAM for 2 of 2 residents (R34 and R243) observed who had medications in their room. The facility's QAPI meeting minutes dated 4/23,	F 867	The facility initiated a Quality Assurance Assessment and Performance Improvement (QAPI) committee to effectively sustain ongoing compliance of citations. All residents have the potential to be affected. The facilities Quality Assurance Assessment and Performance Improvement Plan (QAPI) policy was reviewed and remains current. Administrator and IDT educated on QAPI policy specifically on ensuring citations have sustainable plans in place to eliminate repeat citations. The facility will complete a monthly audit for 4 months, then annually to ensure sustainability of citations through the QAPI process. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Administrator or designee will be responsible party. Date of Completion: 6/28/2023	

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F 867	Continued From page 27 lacked ongoing data related to the above repeat citations. Additional QAPI meeting minutes were requested and not provided on survey. During an interview on 5/11/23, at 10:53 a.m. the administrator stated the facility discussed infection control at QAPI as it pertained to active infections and not related to previous repeat citations, however there were no action plans in place. QAPI policy undated, identified an objective to establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome.	F 867		
F 880 SS=D	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 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		6/28/23

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F 880	Continued From page 28 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. §483.80(e) Linens.	F 880		

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F 880	Continued From page 29 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 ensure staff wore appropriate personal protective equipment (PPE) appropriately for 1 of 2 residents (R31) who was on transmission based precautions (TBP). Findings include: R31's significant change Minimum Data Set (MDS) dated 4/27/23, identified R31 was cognitively intact and was frequently incontinent of bowel and bladder. The assessment identified R31 required extensive assist from one or more staff for toileting, bed mobility, transfers, and personal hygiene. R31's diagnoses included diabetes mellitus, heart disease, peripheral vascular disease, and methicillin resistant staphylococcus aureus (MRSA) infection. The assessment lacked diagnosis of urinary tract infection with vancomycin-resistant enterocolitis (VRE - an infection in the urine that is resistant to vancomycin antibiotics, is usually spread from person to person through contact with infected people or people who carry the bacteria without it causing infection within themselves). R31's care plan dated 3/28/23, identified R31 had a current urinary tract infection with VRE. Staff interventions included isolation precautions per facility protocol, and update the physician with	F 880	F880: Infection Prevention and Control Corrective Action: Personal Protective Equipment (PPE) All residents have the potential to be affected by this deficient practice. Facility leadership will ensure that there is proper donning/doffing of PPE. DON reviewed policies and procedures regarding donning/doffing PPE, mask, gown, and standard and transmission-based precautions. Policies remain current. The facility's Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, with Governing Body completed a root cause analysis on 6/16/2023 to help identify the problems that resulted in this deficiency and developed interventions to prevent reoccurrence. Facility provided education for all staff providing direct care to residents, and all staff entering resident's rooms on standard infection control practices, including but not limited to	

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F 880	Continued From page 30 any changes. The plan identified R31 was incontinent of bowel and bladder and wore incontinent briefs. During observation on 5/10/23 at 7:44 a.m., R31's room had a personal protective equipment (PPE) bin outside the room. There was a sign posted on the door which indicted contact precautions were in place which included the need to wear gloves and gown with resident contact. The sign on the door directed staff/visitors to wash hands upon entrance/exit, wear gloves, gown, and keep the door closed. During observation and interview on 5/10/23 at 9:05 a.m., nursing assistant (NA)-A was in R31's room standing next to and leaning over the residents bed. The bottom to mid-waist of NA-A's scrub top was in full contact and touched R31's bed for approximately two minutes. NA-A wore a face mask and gloves but did not wear a gown. NA-A stated R31's bedsheets and brief were wet. During observation on 5/10/23 at 9:11 a.m., NA-A left R31's room and walked to the medication cart where licensed practical nurse (LPN)-A was standing. LPN-A asked NA-A if she had put on a gown prior to entering R31's room and NA-A reported she had not because she didn't know she was supposed to. LPN-A informed NA-A R31 was on contact precautions and staff were supposed to wear a gown and gloves when working with the resident. - At 9:14 a.m., NA-A verified earlier when she was changing R31's brief she had been leaning over the residents wet bed and wet brief, her scrub top had been touching the residents bed and she had not been wearing a gown. NA-A stated she should have worn a gown upon entering the room	F 880	transmission-based precautions, appropriate PPE use, and donning and doffing of PPE with a competency testing of staff. Residents and their representatives will receive education on the facility's Infection Prevention Control Program for residents on transmission-based precautions. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet Precautions. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met; audits will continue until 100% compliance is met for staff, visitors and residents. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoing with the Quality Assurance Program Improvement (QAPI) program.	

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F 880	Continued From page 31 and while caring for R31. Infection Prevention and Control Program policy, revised 3/13/23, defined the infection control program as comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. The Monitoring Employee Health section, #3 included those employees with potential direct exposure to blood or body fluids were trained in and required to use appropriate precautions and personal protective equipment provided by the facility. A policy for contact precautions and personal protective equipment use was requested but not provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		6/28/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 32 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R2 and R35) were offered or received the pneumococcal vaccine in accordance with the Center for	F 883	R2 discharged from the facility on 5/12/2023. R35 was offered the pneumococcal vaccination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 33 Disease Control (CDC) recommendations. Findings include: The CDC's Pneumococcal Vaccine Timing for Adults dated 3/15/23, identified adults 65 years or older who had not previously received any pneumococcal vaccine, one dose of PCV15 or PCV20 (pneumococcal conjugate vaccines) should be administered. If PCV15 was used, this should be followed by a dose of PPSV23 (pneumococcal polysaccharide vaccine) at least 1 year later. R2's face sheet undated, identified he was 73 years old and admitted on 4/25/23. R2 had no allergies to vaccines or contraindications to vaccines listed. R2's immunization record undated, lacked documentation of the pneumococcal vaccine. R2's Resident Vaccine Administration Consent form undated, identified he declined the influenza and COVID-19 vaccines but lacked documentation of the pneumococcal vaccine. R35's face sheet undated, identified she was 66 years old and admitted on 12/29/22. R35 had no allergies to vaccines or contraindications to vaccines listed. R35's immunization record undated, lacked documentation of the pneumococcal vaccine. R35's Resident Vaccine Administration Consent form dated 2/14/23, identified she declined the influenza vaccine but lacked documentation of the pneumococcal vaccine.	F 883	Facility will offer pneumococcal immunizations to residents who fit the criteria. The facilities Pneumococcal Policy was reviewed and remains current. Nursing staff educated to Pneumococcal Policy specifically to vaccine being offered and received. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months on 5 new admits assessing for current immunization status and if eligible. If resident is eligible, vaccine will be administered within 30-day. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months on new admits for completion of Resident Vaccine Administration Consent Form of 5 residents. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Director of Nursing or designee will be responsible party. Date of Completion: 6/28/2023	

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F 883	Continued From page 34 During an interview on 5/11/23 at 9:30 a.m., the assistant director of nursing (ADON) stated vaccines should be provided as required and documented if declined. The facility's Pneumococcal Policy dated 4/6/22, identified prior to or upon admission to the facility (within 5 days), all residents would be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident would be offered the vaccine, when indicated, unless the resident had already been vaccinated or the vaccine was medically contraindicated.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident,	F 887		6/28/23

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F 887	Continued From page 35 resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the COVID-19 vaccination timely to 1 of 1 resident (R37) whom	F 887	R37 will receive COVID-19 vaccination per request.	

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F 887	Continued From page 36 requested to be vaccinated. Findings include: R37's significant change Minimum Data Set (MDS) dated 3/24/32, identified intact cognition. R37 required limited assistance with dressing and hygiene. R37's diagnoses included stroke with paralysis on one side of the body and pulmonary disease. R37's face sheet undated, identified she was 69 years old and was admitted on 2/1/23. R37 had no allergies to vaccines or contraindications to vaccines listed. R37's immunization sheet undated, identified she had one dose of a COVID-19 vaccine on 8/11/21. R37's Resident Vaccine Administration Consent Form dated 2/7/23, identified the COVID-19 vaccine would be completed by the facility. During an interview on 5/9/23 at 4:00 pm., R37 stated staff offered the COVID-19 vaccine when she was admitted but it had not been administered yet and she still wanted the vaccine. During an interview on 5/11/23 at 9:30 a.m., with the administrator and the assistant director of nursing (ADON), the ADON stated vaccines should be provided as required. The administrator stated the facility process was: the admission nurse would fill out the vaccine form and send the request to the pharmacy. Vaccines could usually be administered within a day or two of the request, and this particular request must have gotten overlooked.	F 887	Facility will offer COVID-19 immunizations to residents per preference. The facilities COVID-19 was reviewed and remains current. Nursing staff educated to COVID-19 policy specifically to vaccine being offered and received. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months on 5 new admits assessing for current immunization status and if eligible. If resident is eligible, vaccine will be administered within 30-days. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months on 5 new admits for completion of Resident Vaccine Administration Consent Form. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Director of Nursing or designee will be responsible party. Date of completion: 6/28/2023	

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F 887	Continued From page 37 Facility policy COVID-19 Infection Prevention and Control dated 3/13/23, identified prior to or upon admission to the facility (within 5 days), all residents would be assessed for current immunization status and eligibility to receive the COVID vaccine. Within 30 days of admission, resident would be offered the vaccine, when indicated, unless the resident had already been vaccinated or the vaccine was medically contraindicated.	F 887		

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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		06/16/2023

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

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K 000	Continued From page 1	K 000		

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

By email to:
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 44 at the time of the survey.	K 000		
K 211 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 05/10/2023 at 11:22 AM, it was revealed by observation that the exit corridor in the basement had a table with cardboard boxes obstructing the path of egress.	K 211	Basement table has been removed from corridor, housekeeping carts and power wheelchairs have been relocated and therapy stairs moved into therapy gym. Items will not be placed to obstruct path of egress. Staff educated to maintain a clear path of egress. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months to	6/28/23

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K 211	Continued From page 3 2. On 05/10/2023 at 11:56 AM, it was revealed by observation that the exit corridor in by the southwest corridor had housekeeping carts and battery powered wheelchair obstructing the path of egress. 3. On 05/10/2023 at 12:34 AM, it was revealed by observation there are therapy stairs being stored in the sunshine room. According to the Physical Therapist(MB) she stated that "they have been there a month or so and are used a few times a week". An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 211	ensure aisles, passageways, corridors, exit discharges, exit locations and access to ensure compliance. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is responsible party. Date of Completion: 6/28/2023	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress stair enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.1.3.2.3 and 7.2.2.5.3.1. This deficient finding could have patterned impact on the residents within the facility.	K 225	Basement table has been removed from corridor, housekeeping carts and power wheelchairs have been relocated and therapy stairs moved into therapy gym. Items will not be placed to obstruct path of egress.	6/28/23

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K 225	Continued From page 4 Findings include: On 05/10/2023 between 11:06 AM, it was revealed by observation that there was a time clock and 32 gallon garbage can and employee information in the basement stairwell. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 225	Staff educated to maintain a clear path of egress. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months to ensure aisles, passageways, corridors, exit discharges, exit locations and access to ensure compliance. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is responsible party. Date of Completion: 6/28/2023	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		6/28/23

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K 321	Continued From page 5 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/10/2023 at 11:16 AM, it was revealed by observation that the door to the maintenance shop has a 5/8 inch gap at the op of the door and a 1/2 inch gap on the side of the door. 2. On 05/10/2023 at 12:09 PM, it was revealed by observation that a combustible storage room by resident room 103 did not have door closers. 3. On 05/10/2023 at 12:12 PM, it was revealed by observation that a soiled utility room C-4 has 2 small holes in the door where hardware has been removed and a 1/4 inch gap from the gram on the hardware side. An interview with the Administrator, Maintenance Director and Regional Maintenance Director	K 321	Spring hinges added to combustible storage room door located near resident room 103, maintenance door and soiled utility room door replaced. Facility will maintain hazardous storage rooms doors per regulation. Staff educated on informing maintenance director via TELS of any needed maintenance repairs to facility doors. Maintenance Director educated on monitoring doors to maintain hazardous storage room doors per regulation The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of 5 doors to ensure they maintain hazardous storage room door regulation. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is responsible party.	

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K 321	Continued From page 6 verified this deficient findings at the time of discovery.	K 321	Date of Completion: 6/28/2023	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Fire Safety Based on observation and staff interview, the facility failed to install an automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.7.4.1.1.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 351	Sprinkler head by room 110 will be fixed to meet regulation. Facility will ensure sprinkler heads are appropriately installed/placed. Maintenance Director educated on NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler systems, section 8.7.4.1.1.1.	6/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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
K 351	Continued From page 7 On 05/10/2023 at 2:45 PM., it was revealed by observation that a fire sprinkler head in the South corridor by room 110 is 1 inch from the deflector and 1 1/2 inches from the fusible link from the ceiling above the smoke compartment doors. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient findings at the time of discovery.	K 351	The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of 5 sprinkler heads to ensure they meet regulation. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is responsible party. Date of Completion: 6/28/2023	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.8.1 and 7.3.1.1.1. This deficient finding could have an patterned impact on the residents within the facility. Findings include: 1. On 05/10/2023 at 9:02 AM, it was revealed by observation and document review that the fire extinguisher by the North nurses station was expired.	K 355	corrected	6/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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
K 355	Continued From page 8 2. On 05/10/2023 9:02 AM, it was revealed by observation that the fire extinguisher by the North nurses station was mounted at 66 inches. 3. On 05/10/2023 3:00 PM, it was revealed by observation that the fire extinguisher near the restrooms in the southwest corridor was mounted at 66 inches. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		6/28/23

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	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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

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K 363	Continued From page 9 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Fire Safety Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1. This deficient finding could have an patterned impact on the residents within the facility. Findings include: 1. On 05/10/2023 at 12:00 PM, it was revealed by observation resident room 102 did not positively latch when tested. 2. On 05/10/2023 at 12:02 PM, it was revealed by observation resident room 106 door did not close properly from the floor when tested and hardware for door handle is loose. An interview with the Administrator, Maintenance	K 363	Expired fire extinguishers has been services. Fire extinguishers have been lowered to meet standards. The facility has ensured fire extinguishers are not expired and are mounted at appropriate height. Maintenance Director educated on monitoring and mounting of fire extinguishers per regulation. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of 5 fire extinguishers to ensure they are not expired and are at the appropriate height. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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THE ESTATES AT FRIDLEY LLC	**5700 EAST RIVER ROAD** **FRIDLEY, MN 55432**

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K 363	Continued From page 10 Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 363	responsible party. Date of Completion: 6/28/2023	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement smoking regulations per NFPA 101 (2012 edition), Life Safety Code,	K 741	Discarded cigarettes in concrete, mulch and generator enclosure have been cleaned up.	6/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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

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K 741	Continued From page 11 section 19.7.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/10/2023 at 09:02 AM, it was revealed by observation that the designated smoking area in the front of the building was unkept, with discarded cigarettes on the concrete and in the mulch. 2. On 05/10/2023 at 1:50 PM, it was revealed by observation in the area of the generator there are cigarette butts in the generator enclosure. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 741	The facilities Resident Smoking Policy and employee handbook as been reviewed and remains current. Staff and residents educated on appropriate places to discard cigarettes along with designated smoking areas. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months of smoking areas and other areas of the facilities grounds to ensure no cigarettes are inappropriately discarded. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is responsible party. Date of Completion: 6/28/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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	K 918		6/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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
K 918	Continued From page 12 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 maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/10/2023 at 9:50 AM, it was revealed by a review of available documentation that the facility could not provide a letter of reliability from the gas company that supplies natural gas to their	K 918	A letter of reliability from the gas company was received. The 4-hour generator load bank was completed. All residents have the potential of being affected by this. The Maintenance Director has been educated to ensure the letter of reliability from the gas company is present. The Maintenace Director has been educated on completing the 4-hour generator load bank test. Facility company is requiring 3 years 4-hour load bank testing to be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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K 918	Continued From page 13 generator. 2. On 05/10/2023 at 9:55 AM, it was revealed by a review of available documentation that the facility could not provide documentation of a 36-Month 4 hour generator load bank test. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified these deficient finding at the time of discovery.	K 918	and will be in TELS as a scheduled recurring task. Maintenance Director or designee is responsible party. Date of Completion: 6/28/2023	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		6/28/23

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	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2023**

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

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K 923	Continued From page 14 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain storage of an oxygen tank per NFPA 99 (2012 edition), Health Care Facilities Code, 11.6.2.3. This deficient finding could have an patterned impact on the residents within the facility. Findings include: On 05/10/2023 at 12:04 PM, it was revealed by observation in resident room 101, one oxygen tank size MM was stored in the resident room and was not secured for tip resistance. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 923	Oxygen tank was removed from resident room and relocated to designated oxygen room. All other oxygen tanks were ensured to be maintained in storage per regulation Staff educated on proper oxygen tank storage. The facility will complete a weekly audit for 4 weeks, then monthly for 3 months to ensure oxygen tanks are being appropriately stored. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Maintenance Director or designee is responsible party. Date of Completion: 6/28/2023	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245201	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **5/10/2023**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	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: Fire Safety Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, 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 finding could have a isolated impact on the residents within the facility. Findings include: On 05/10/2023 at 11:09 AM, it was revealed that one data cable wire was lying on a sprinkler pipe in the basement corridor by the maintenance office. An interview with the Administrator, Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents