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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WGSA

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245201**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **03/09/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Name Changed. This facility previously operated under the name of Golden Livingcenter Lynwood.

17. SURVEYOR SIGNATURE — Date :
Amy Charais, HFE NE II — 04//07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/11/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 27, 2017

Ms. Lynn Hogendorn, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: Project Number S5201026

Dear Ms. Hogendorn:

On March 9, 2017, a standard 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 9, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5201052 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 18, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 18, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by June 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

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 September 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 _____	03/09/2017

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 The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. During the recertification survey on 3/6/17, through 3/9/17, complaint investigation(s) were also conducted at the time of the standard survey. An investigation of complaint, H5201052 was completed. The complaint was not substantiated.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state	F 164		4/18/17

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

Electronically Signed | 04/07/2017

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 _____	03/09/2017

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 164	Continued From page 1 laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R4) was provided privacy during cares. Findings include: R4's communication Care Area Assessment (CAA) dated 5/19/16, indicated resident spoke slowly and clearly, and resident was able to express needs/wants. The care plan dated 8/30/16, indicated resident had impaired vision	F 164	Resident #4 is provided privacy during cares as outlined in individual care plan. All residents will continue to be provided with privacy during cares. Nurses and nursing assistants will be re-educated on resident rights, specific to privacy. Audit of resident privacy during resident	

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 _____	03/09/2017

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 164	Continued From page 2 related to glaucoma, cataracts and macular degeneration. The care plan directed staff to assist with placement and cleaning with glasses as needed, provide set up and cueing as necessary. R4's care plan dated 11/16/16, indicated resident had a physical functioning deficit related to self-care impairments due to impaired mobility, degenerative changes, bilateral lower extremity range of motion impairments and dementia. Care plan indicated resident was dependent on staff, unable to ambulate and used a mechanical maxi lift for all transfers. The care plan directed staff to provide extensive to total assist with activities of daily living (ADLs). R4's diagnoses included macular degeneration, glaucoma, major depressive disorder, dementia, anxiety state, osteoporosis, urinary incontinence and personality disorder obtained from the quarterly Minimum Data Set (MDS) dated 1/30/17. The care plan printed 2/27/17, indicated R43 had an alteration in cognition related to dementia, anxiety, depression and personality disorder. The care plan directed staff to "Please help me make safe choices..." On 3/8/17, at 7:18 a.m. R4 was observed lying in bed on her back when approached and asked how she had slept R4 stated "am tired." When asked if she had told the nursing assistant (NA)-B, R4 stated "mm, hmm." NA-B was observed at that time go back and forth between the bathroom and resident room setting up all the supplies at bedside to stated she was going to get R4 ready for the day. At 7:20 a.m. NA-B approached R4's bedside asked how she has slept then stated to R4 "you look tired." R4 kept quiet. NA-B then took off the bedding then removed R43's gown and only covered R4's breast with a towel as R4 lay there wearing an	F 164	cares to be completed weekly x 4; then as needed. DNS or designee with be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 164	Continued From page 3	F 164		

incontinent pad. NA-B proceeded to wash R4's torso and armpits the privacy curtain was not pulled around. At 7:24 a.m. NA-A came to room opened the door wide open as R4 lay there uncovered able to see R4 when standing outside the hallway. NA-A applied gloves, approached the other side of the bed and was observed assist to get R4 ready. At 7:25 a.m. NA-C knocked at the door then as she came into the room opened door wide as resident laid there naked with no privacy curtain pulled. NA-C shut door and went over to R4's roommate side and was observed wheel R4's roommate towards the door. NA-C then came around closed the curtain at that time, wheeled R4's roommate out the door and then turned around with door half way open as R4 laid there naked to the left as NA's cued R4 to grab bed rail. At 7:27 a.m. NA-B was observed provide pericare and as she wiped R43's bottom smears of feces was observed on the wash towels. NA-B then pat dried R4's bottom using the same gloves applied a clean pad never removed the gloves. Both NA-A and NA-B then applied R4's pants, shirt and adjusted the clothing at 7:29 a.m. as NA-B still had the same gloves. NA-BA asked R4 how she was doing and R4 stated "tired." NA-B then told R4 "Two more turns then will leave you till breakfast" as both NAs finished adjusting the clothing. NA-B then took the basin of water dumped it in bathroom washed hands as other aide adjusted R4 pillow and covered resident back up. At 7:31 a.m. NA-B had finished left room stated she was going to get R4 water left then came back briefly. At 7:32 a.m. NA-B asked R4 if she was doing good then left room shut the door. At 7:37 a.m. resident laid in bed dressed eyes closed.

On 3/8/17, at 11:09 a.m. NA-B stated when asked

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 _____	03/09/2017

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 164	Continued From page 4 about resident being uncovered during care exposing her NA-B stated she was working on cleaning resident up from top to bottom and thought she had covered resident breast however she did not think resident was to be covered on the rest of the body as she had a incontinent pad on. On 3/9/17, at 3:48 p.m. DON stated she would expect the staff to follow the care plan. DON further stated she would expect the staff to provide privacy with cares. The facility Dignity policy revised 3/31/16, directed staff "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." In addition, the policy directed staff to maintain dignity when "Assisting residents in daily care in a dignified manner (e.g., pushing residents forward in wheelchairs, covering appliances attached to resident, ensuring residents are not exposed..."	F 164		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or	F 225		4/18/17

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 _____	03/09/2017

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 225	Continued From page 5	F 225		

misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect,

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 _____	03/09/2017

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 225	Continued From page 6 exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an elopement to the State agency for 1 of 1 resident (R18) reviewed for elopement. Findings include: R18's five-day Minimum Data Set (MDS) dated 11/12/16, indicated he was cognitively intact and required supervision for activities of daily living. R18's care plan dated 11/8/16, identified a short attention span exhibited by an inability to focus on anything for long, impaired neurological status related to a history of brain injury and short term memory impairments. A review of GL-Lynwood Progress Notes dated 1/1/17, going forward were reviewed and identified the following: On 1/23/17, at 10:00 a.m., R18 left the facility on a leave of absence (LOA) and stated he would be back the next day at 11:00 a.m. On 1/25/17, R18 had not returned to the facility. The facility nurse attempted to contact R18 by phone at 5:00 p.m. and 9:00 p.m. On 1/26/17, staff again attempted to contact R18 by phone. R18 called the facility back on 1/26/17, and stated that he got sick and	F 225	Resident #18 is discharged from the facility. New admissions/re-admits will be assessed for safety parameters during LOA's. All other resident's will be assessed to ensure safe LOA parameters are indicated within the physicians orders. Individual resident physician orders will be developed/revised to reflect resident's current LOA privileges. All facility staff will be re-educated on the Abuse Prevention/Vulnerable Adult Plan. Tracking and reporting of alleged incidents will be completed as incidents occur. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process	

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 _____	03/09/2017

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 225	Continued From page 7	F 225	based on compliance date.	

was in the hospital. R18 stated he would return to the facility after discharge from the hospital. R18 re-admitted to the facility on 1/28/17.

On 2/7/17, Progress Note indicated R18 again left the facility on a LOA with anticipated return of 2/8/17, at 11:00 a.m. A Progress Note dated 2/10/17, indicated R18 had not returned to the facility from his LOA. On 2/13/17, a Progress Note indicated: R18 had not contacted nor returned to the facility. The facility would discharge him due to not contacting facility to confirm bed hold. Another note dated 2/13/17, indicated R18's belongings would be packed up, CEP (A CEP is the county unit responsible for receiving oral reports of suspected maltreatment - physical, mental, emotional or sexual abuse; neglect (caregiver or self); or financial exploitation of vulnerable adults.) was called and a report was filed, six days after R18 left the facility. On 2/13/17, at approximately 9:30 a.m., a nurse from Hennepin County Medical Center called the facility to report R18 had shown up in the emergency department four nights in a row. Facility staff told the nurse at the hospital that R18 was discharged from the facility. On 2/17/17, Hennepin County Adult Protection called to confirm dates of R18's stay in the facility and reported R18 was currently hospitalized.

During an interview on 3/8/17, at 3:16 p.m., the director of nursing (DON) stated if a resident went out on an LOA and did not return, they follow the policy. She stated the facility would update the physician and herself. The DON stated the facility would attempt to call the resident. She stated she was not sure what the time frame was, but stated it should be by the next morning. The DON stated in regard to R18, she received a call from a hotel

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 _____	03/09/2017

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 225	Continued From page 8	F 225		

that he was there with no money and could not pay for the hotel or a cab, but she was not sure it was the first time he left or the second and she did not document it. She stated he was taken to the hospital and admitted. She stated R18 was intoxicated and stated "he's his own person."

During an interview on 3/8/17, at 3:28 p.m., the administrator stated she tried to call R18, but did not document it anywhere. She stated CEP was called on the day the facility discharged him due to leaving against medical advice. The administrator stated she did not consider R18 to be missing and stated the State agency was not notified because he did not elope from the facility.

While R18 was cognitively intact, his care plan indicated he had memory loss and a short attention span. And while R18 left the facility on a LOA, there was no evidence the facility attempted to contact R18 or his family for six days when the hospital contacted the facility to alert them of R18's status, even though a previous LOA resulted in R18 being hospitalized.

A facility policy titled Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, injuries of Unknown Source and Misappropriation of Resident Property, dated 9/27/16, was reviewed. The policy indicated it is the policy of the company to take appropriate steps to prevent the accordance of abuse, neglect, injuries of unknown origin and misappropriation of resident property. The director of nursing services shall notify the resident/s representative and reassure the resident's representative that and investigation has been initiated. This contact shall be documented. It is the responsibility of watch

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 _____	03/09/2017

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 225	Continued From page 9 employee to report to the executive director suspicion of neglect, abuse, injury of unknown origin and the executive director shall notify the appropriate State agency.	F 225		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226		4/18/17

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 _____	03/09/2017

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 226	Continued From page 10 prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize the abuse prohibition policies regarding ensuring 4 of 5 newly hired staff (licensed practical nurse (LPN)-B, nursing assistant (NA)-A, dietary aide (DA)-A, maintenance director) had evidence of dementia training reviewed for abuse prohibition. This had the potential to affect 36 of 36 residents who resided in the one level facility who had a diagnosis of dementia. In addition, the facility failed to operationalize their policy for elopement for 1 of 1 resident (R18) reviewed for elopement. Findings include: Golden Living Investigation and Reporting of alleged violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, injuries of unknown source and Misapproapriation of Resident's property policy revised 9/27/16, directed "During orientation, new employees shall be trained on the obligation to report alleged violations. Training shall include definitions of the alleged violations and examples of reportable incidents to assist staff in detection of such incidents. Training shall include appropriate interventions to deal with aggressive and/or catastrophic reactions of residents and caregiver stress..." Monarch Healthcare Management Abuse Prevention/Vulnerable Adult Plan revised 12/2016, directed "Monarch Healthcare Management provides corporate orientation to all new employees. At this time Resident's Rights and Vulnerable Adult Law Policies and	F 226	All 4 employees have received Dementia training. All new employees will receive Dementia training upon hire and all staff will receive Dementia training annually. All facility staff will be re-educated on Dementia training. All new hire employee files will be audited no later than 1 week after orientation to ensure Dementia training has been completed and documented. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 226	Continued From page 11	F 226		

Procedures are reviewed and staff receives an employment policy book which outlines these policies/procedures. All new employees receive training on how to report alleged abuse/neglect at this time. All employees of Monarch Healthcare Management receive annual in-service training on Resident's Rights and Vulnerable Adult Policies and Procedures. In addition to this, employees receive additional training and interventions to deal with aggressive residents and residents exhibiting catastrophic reactions..."

During review of the personnel files the following was revealed:
LPN-B's file revealed a hire date of 11/16/16, however file lacked evidence LPN-B had received dementia training even though LPN-B worked with residents who had dementia.

NA-A's file revealed a hire date of 1/2/17, however the file lacked NA-A had received dementia training.

DA-A's file revealed a hire date of 1/30/17, however the file lacked DA-A had received dementia training.

Maintenance director's file revealed a hire date of 2/13/17, however the file lacked evidence of the maintenance director ever 'had received dementia training.

On 3/9/17, at 12:00 p.m. the administrator reviewed the files and verified the files lacked evidence of dementia training. The administrator stated she was going to put a record request ticket as the training was done on-line and with the new company transition she was not able access the on-line training records for the staff

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 _____	03/09/2017

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 226	Continued From page 12	F 226		

provided by former company Golden Living Center.

On 3/9/17, at 3:43 p.m. the administrator stated she had found out if the staff had not completed the course evaluation after the on-line training she was not able to pull the certificate. Administrator further stated, "Am not able to pull the dementia training records at this time its super frustrating." The administrator acknowledged staff did not have evidence of dementia training as directed by the regulation.

A facility policy titled Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, injuries of Unknown Source and Misappropriation of Resident Property, dated 9/27/16, was reviewed. The policy indicated it is the policy of the company to take appropriate steps to prevent the accordance of abuse, neglect, injuries of unknown origin and misappropriation of resident property. The director of nursing services shall notify the resident/s representative and reassure the resident's representative that and investigation has been initiated. This contact shall be documented. It is the responsibility of watch employee to report to the executive director suspicion of neglect, abuse, injury of unknown origin and the executive director shall notify the appropriate state agency.

R18's five-day Minimum Data Set (MDS) dated 11/12/16, indicated he was cognitively intact and required supervision for activities of daily living. R18's care plan dated 11/8/16, identified a short attention span exhibited by an inability to focus on anything for long, impaired neurological status related to a history of brain injury and short term

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 _____	03/09/2017

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 226	Continued From page 13	F 226		

memory impairments.

A review of GL-Lynwood Progress Notes dated 1/1/17, going forward were reviewed and identified the following:
On 1/23/17, at 10:00 a.m., R18 left the facility on a leave of absence (LOA) and stated he would be back the next day at 11:00 a.m. On 1/25/17, R18 had not returned to the facility. The facility nurse attempted to contact R18 by phone at 5:00 p.m. and 9:00 p.m. On 1/26/17, staff again attempted to contact R18 by phone. R18 called the facility back on 1/26/17, and stated that he got sick and was in the hospital. R18 stated he would return to the facility after discharge from the hospital. R18 re-admitted to the facility on 1/28/17.

On 2/7/17, Progress Note indicated R18 again left the facility on a LOA with anticipated return of 2/8/17, at 11:00 a.m. A Progress Note dated 2/10/17, indicated R18 had not returned to the facility from his LOA. On 2/13/17, a Progress Note indicated R18 had not contacted nor returned to the facility. The facility would discharge him due to not contacting facility to confirm bed hold. Another note dated 2/13/17, indicated R18's belongings would be packed up, CEP (A CEP is the county unit responsible for receiving oral reports of suspected maltreatment - physical, mental, emotional or sexual abuse; neglect (caregiver or self); or financial exploitation of vulnerable adults.) was called and a report was filed, six days after R18 left the facility. On 2/13/17, at approximately 9:30 a.m., a nurse from Hennepin County Medical Center called the facility to report R18 had shown up in the emergency department four nights in a row. Facility staff told the nurse at the hospital that R18 was discharged from the facility. On 2/17/17,

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 _____	03/09/2017

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 226	Continued From page 14 Hennepin County Adult Protection called to confirm dates of R18's stay in the facility and reported R18 was currently hospitalized. During an interview on 3/8/17, at 3:16 p.m., the director of nursing (DON) stated if a resident went out on an LOA and did not return, they follow the policy. She stated the facility would update the physician and herself. The DON stated the facility would attempt to call the resident. She stated she was not sure what the time frame was, but stated it should be by the next morning. The DON stated in regard to R18, she received a call from a hotel that he was there with no money and could not pay for the hotel or a cab, but she was not sure it was the first time he left or the second and she did not document it. She stated he was taken to the hospital and admitted. She stated R18 was intoxicated and stated "he's his own person." During an interview on 3/8/17, at 3:28 p.m., the administrator stated she tried to call R18, but did not document it anywhere. She stated CEP was called on the day the facility discharged him due to leaving against medical advice. The administrator stated she did not consider R18 to be missing and stated the State agency was not notified because he did not elope from the facility. While R18 was cognitively intact, his care plan indicated he had memory loss and a short attention span. And while R18 left the facility on a LOA, there was no evidence the facility attempted to contact R18 or his family for six days when the hospital contacted the facility to alert them of R18's status, even though a previous LOA resulted in R18 being hospitalized.	F 226		
F 242	483.10(f)(1)-(3) SELF-DETERMINATION -	F 242		4/18/17

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 _____	03/09/2017

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 242 SS=D	Continued From page 15 RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (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. (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to offer choices for frequency of bathing for 1 of 3 residents (R19) reviewed for choices. In addition, the facility failed to accommodate waking preferences for 1 of 3 residents (R4) reviewed for choices. Findings include: R19's quarterly Minimum Data Set (MDS) dated 2/10/17, indicated she was cognitively intact and required extensive assistance for dressing and bathing. R19's care plan dated 2/14/17, identified a communication deficit related to English not being her first language and identified the use of an interpreter. The care plan further identified a physical functioning deficit related to hemiplegia (paralysis on one side of the body). During an initial interview on 3/7/17, at 12:28	F 242	Resident #19 was assessed for bathing preferences; Resident #4 was assessed for sleep preferences as outline in individual care plan. New admissions will continue to be interviewed for bathing and sleep preferences. All current residents will have their bathing and sleep preferences reviewed and individual care plan to be updated as indicated. Other residents will continue to be interviewed quarterly and as needed to determine bathing and sleep preferences. All staff will be educated on resident rights, specific to bathing and sleep	

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 _____	03/09/2017

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 242	Continued From page 16 p.m., R19 was asked (via interpreter) if she was able to choose how many baths she gets in a week. R19 replied she was getting one bath and would like two. She stated "I want to be clean, don't want to smell bad." During an observation on 3/7/17, at 3:41 p.m., R19 was sitting in her wheel chair. She had a strong urine odor. During a second observation on 3/9/17, at 8:26 a.m., R19 was sitting on the side of her bed. She again smelled strongly of urine. During an interview on 3/9/17, at 9:05 a.m., nursing assistant (NA)-E stated R19 gets one bath a week, on Wednesday. NA-E stated R19 would follow staff around on Wednesdays waiting for her bath. She stated R19 did have some urinary incontinence and would change her clothes three or four times per day. NA-E stated R19 had already changed her clothes since she got her up that morning. During an interview on 3/9/17, at 9:15 a.m., laundry aide (LA)-G stated R19 had a lot of laundry. LA-G stated if R19 got a little wet she would change her clothes. LA-G stated R19 had four pairs of pants and four shirts in the laundry for one day. During an interview on 3/9/17, at 12:54 p.m., the director of nursing (DON) stated the facility's standard of practice for bathing was one time per week unless the resident requests another one. The DON stated the activity director completed the assessment for preferences. She further stated R19 knew when her bath day was and would gather up all of her clothes and point to the shower. The DON stated R19 was incontinent of	F 242	preferences. Weekly audits of new admit resident bathing and sleep preferences to be completed weekly x 4; then as needed. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 242	Continued From page 17	F 242		

bladder and would bring staff a new pull up when she was wet.

During an interview on 3/9/17, at 3:10 p.m., the activity director (AD) stated he completed the assessment for resident preferences. He stated the assessment did not ask how many times a week a resident want a bath and he did not ask that question.

A facility policy for bathing pretences and choices was requested, but not received.

R4's diagnoses included macular degeneration, glaucoma, major depressive disorder, dementia, anxiety state, osteoporosis, urinary incontinence and personality disorder obtained from the quarterly MDS dated 1/30/17.

On 3/8/17, at 7:18 a.m. R4 was observed lying in bed on her back when approached and asked how she had slept R4 stated "am tired." When asked if she had told the NA-B, R4 stated "mm, hmm." NA-B was observed at that time go back and forth between the bathroom and resident room setting up all the supplies at bedside to stated she was going to get R4 ready for the day. At 7:20 a.m. NA-B approached R4's bedside asked how she has slept then stated to R4 "you look tired." R4 kept quiet. NA-B proceeded to get R4 ready for the day. NA-B asked R4 how she was doing and R4 stated "tired." NA-B then told R4, "Two more turns then will leave you till breakfast" as NA-B and NA-A finished adjusting the clothing. NA-B then took the basin of water dumped it in bathroom washed hands as other aide adjusted R4 pillow and covered resident back up. At 7:31 a.m. NA-B had finished left room stated she was going to get R4 water left then

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 _____	03/09/2017

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 242	Continued From page 18	F 242		

came back briefly. At 7:32 a.m. NA-B asked R4 if she was doing good then left room shut the door. At 7:37 a.m. resident laid in bed dressed eyes closed. NA-B did not ask the resident if the resident wanted to get dressed for the day, even after the aide was informed by R4 that they were "tired."

R4's communication Care Area Assessment (CAA) dated 5/19/16, indicated resident spoke slowly and clearly, and resident was able to express needs/wants. The care plan directed staff to provide extensive to total assist with activities of daily living (ADLs). The care plan printed 2/27/17, indicated R4 had an alteration in cognition related to dementia, anxiety, depression and personality disorder. The care plan directed staff to "Please help me make safe choices..." The plan of care lacked evidence of preferences for when the resident wanted to get up or when the resident wanted to go to bed.

R4's Preferences for Customary Routine and Activities assessment dated 5/19/16, indicated resident had indicated it was "Very important" for her to choose her bedtime however her waking up preferences had not been assessed.

On 3/8/17, at 11:09 a.m. NA-B stated when asked if she knew resident did not want to get up in the morning NA-B stated resident was not a morning person and never wanted to get out of bed and staff had always gotten her dressed in the morning and left her there until lunch. NA-B again repeated "she is not a morning person and is tired all the time."

On 3/9/17, at 7:33 a.m. R4 was approached and asked how she had slept. The resident stated

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 _____	03/09/2017

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 242	Continued From page 19 "okay." At the time resident appeared alert and was already dressed for the day. When asked if the staff had gotten her ready resident stated she was already up and staff had not woken her up. R4 also indicated she was not tired. On 3/9/17, at 1:55 p.m. NA-D stated resident liked to stay in bed in the morning when asked R4's morning routine and waking up preferences. On 3/9/17, at 3:48 p.m. the DON stated "It is care planned she doesn't like to get up in the morning and did not want to get dressed until after breakfast wants to get up around 10:00 and this was in the care card. She doesn't like to be bothered." On 3/9/17, at 2:00 p.m. a policy for resident preferences was requested but was never provided.	F 242		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 248	Resident #28 and #76 were assessed for	4/18/17

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 _____	03/09/2017

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 248	Continued From page 20 review, the facility failed to ensure activities were offered to 2 of 3 residents (R28, R76) reviewed for activities. Findings include: On 3/6/17, at 2:00 p.m. during an interview when asked if staff encouraged R28 to attend activities and provided assistance to attend them family member (F)-A stated "No. He lays there most of the time." On 3/6/17, at 3:24 p.m. R28 was observed lying in bed asleep as a music activity went on which had several residents in attendance in the dining room (DR) was never offered to attend. On 3/6/17, at 6:45 p.m. to 7:35 p.m. R28 was observed in his room agitated. The activity director (AD) was sitting in the room watching television (TV) with R28 and R28 was repeatedly asking to go outside. When approached and asked what he did for a living, R28 stated he worked for a construction company then went back to ask surveyor to take him outside. The AD sat there distracting R28 however was not successful. No other activities offered. On 3/7/17, at approximately 10:10 a.m., the AD was observed at the DR with six residents doing devotions and R28 laid in bed. On 3/7/17, at 4:20 p.m. the AD coordinated a card activity as R28 was observed lying in bed. On 3/8/17, at 7:06 a.m. R28 was observed sitting on wheelchair, which was tilted slightly. When approached asked how he had slept resident stated "well." On 3/8/17, at 2:00 p.m. R28 was observed lying in bed as Bingo was being called in the dining room. On 3/9/17, at 1:15 p.m. R28 laid in bed as the AD was observed to assist and invite several	F 248	resident activity preferences and care plans have been updated to reflect resident's preferences. New admissions will be assessed for activity preferences. Other resident's will be assessed quarterly and as needed to ensure their activity preferences are being met. Individual care plans will be developed/revised to reflect resident's activity preferences. Activity Director will be re-educated on ensuring all residents are assessed for activity preferences and participation logs are completed. Weekly audit of resident activity participation logs will be completed weekly x 4; then as needed. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 248	Continued From page 21	F 248		

residents into an activity in dining room.

R28's care plan dated 7/8/16, indicated "I sometimes have difficulty starting and staying involved in recreational activities as evidenced by: Short attention span. I am now on hospice care." Care plan directed staff "As I have a hard time with activities that last a long time, please include me in shorter duration activities, Call my name or gently touch my arm of hand to help me stay aware of the activity going on around me, If I become frustrated understanding or completing an activity, please help me with more instruction or by simplifying the activities, Offer me smaller group activities for more assistance at my highest level, Please give me assistance if I need it, using simple instructions, verbal and physical cuing and task segmentation during activities, Please help me participate in my favorite activities at my highest level."

R28's Recreational Service Assessment dated 7/14/16, indicated resident needed much encouragement to attend groups and to participate; family was very supportive with daily visits and was on hospice care at the time. The assessment indicated resident interests included "trivia, country western music, likes to go outside and get fresh air, activity preferences large group, small groups, and with family/friends."

R28's cognitive loss/dementia Care Area Assessment (CAA) dated 7/14/16, directed staff to keep resident at nurses station so that he can socialize with staff, peers and to included him in activities. The activities CAA dated 7/14/16, indicated resident needed much encouragement to attend groups and to participate and family was very supportive with daily visits.

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 _____	03/09/2017

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 248	Continued From page 22	F 248		

R28's diagnoses included dementia, psychotic disorder, depression, seizure disorder and cerebrovascular accident (CVA) obtained from the quarterly Minimum Data Set (MDS) dated 1/5/17. In addition, the MDS indicated R28 had severely impaired cognition, and did not exhibit any behavioral symptoms.

During review of the Recreation Participation Record the following were revealed:
-March 2017, log indicated resident had participated in activities on five of nine days of the month so far. With four days of no activities so far.
-February 2017, log indicated resident had only attended activities on 11 of 28 days, with no planned activities for 17 days.
-January 2017, log indicated resident had only attended activities on 17 of 31 days, with no activities for 14 days for that month.
-December 2016, log indicated resident had only attended activities for 18 of 31 days, with 13 days of no activities.
-November 2016, log indicated resident had only attended activities for 18 of 31 days, with 13 days of no activities.
-October 2016, log indicated resident had only attended activities for 10 of 31 days, with 21 days of no activities
-September 2016, log indicated resident had only attended activities for two of 31 days, with 29 days of no activities. The logs and medical record lacked documentation, R28 had refused activities offered and if resident had been re-assessed to ensure the interventions in place were effective.

On 3/9/17, at 2:44 p.m. the AD was interviewed about the observations made during the survey

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 _____	03/09/2017

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 248	Continued From page 23	F 248		

period. When reviewing the March 2017, Recreation Participation Record for R28 AD stated he was in the room daily between 10:15 to 10:45 a.m. doing the following activities "movie, church/Religious, music therapy, current events, trivia, reminiscing television/radio and visiting." All during that time as he had them marked for resident. When asked for a clarification as that was the same time frame in the facility calendar for "Daily devotions, current events, trivia and/or Did you know" AD then recanted it back and stated it was daily devotions time and he did go to multiple resident's room and did devotions with them. When asked about R28's activities attendance AD stated he would try to invite the resident to activities and resident had the choice to participate or not. When asked if he did document resident refusals anywhere he stated he did not. When asked about R28's most recent recreational assessment AD stated, "There would be none and would be the MDS and the care plan." When asked about the assessment dated 7/14/16,which was the only assessment that had been completed seven months AD stated he was not working at the facility at the time of the assessment and had never done another assessment. AD appeared surprised when told R28's interests/likes as indicated on the assessment dated 7/14/16. When asked if resident had been invited to attend the music on 3/6/17, 3/7/17, 3/8/17, and 3/9/17, AD stated he may have however, he stated he forgot to document a refusal and was not even sure if he had invited R28 to attend. When asked how many days resident had not received activities in the month of February 2017, AD verified resident had not had activities for "over half of the month." When asked who did activities, when he was not in the building AD stated "am a one man show."

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 _____	03/09/2017

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 248	Continued From page 24	F 248		

On 3/9/17, at 3:10 p.m. the administrator stated she would expect the activities director to assess resident activities, document participation accurately, document refusal and to involve R28 to activities more.

R76 was sitting on the edge of the bed on 3/6/17, at 4:51 p.m. and the TV was on. R76 stated there were not enough activities on the weekends and evenings. R76 said, "They could use a little bit more activities in the afternoon and after supper. They could mix it up a little bit. I get tired of watching TV in my room every night."

R76's admission MDS dated 12/30/16, indicated R76 was cognitively intact without behaviors and minimal signs of depression. R76's MDS indicate R76 participated in therapy six days a week for an average of an hour and 40 minutes each time. R76's MDS indicated R76 experienced daily pain that interfered with daily activities. R76's MDS indicated that it was somewhat important to do things with people and do favorite activities. R76's medical record lacked evidence of a comprehensive activity assessment being completed.

R76's care plan printed 2/28/17, instructed staff that R76 was still adjusting to new surroundings and desired to "be comfortable socializing with others and being involved in LivingCenter events. Activity care plan R76 anticipated only being at the facility for a short period of time and did not have interest in joining in facility programs and instructed staff to offer R76 activities later in the day after R76 was done with therapy. R76 care plan indicated R76 liked to keep busy with independent activities and visiting with family and

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 _____	03/09/2017

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 248	Continued From page 25	F 248		

friends but lacked details to help R76 achieve goals of being comfortable socializing with others.

During interview on 3/9/17, at 11:42 a.m. AD stated, "I do a recreation assessment in the first two weeks they [residents] are here. The assessment was done to determine what a resident likes to do." AD commented R76 liked coloring books, word searches, and in room activities. AD said, "[R76] had a lot of refusals to attend activities." AD verified there was no documentation of refusals to attend activities. AD verified there was no activity assessment in R76's medical record.

During interview on 3/9/17, at 12:57 AD verified there was not a documented assessment for activities in PCC (electronic health record) or on paper until requested by surveyor. AD verified the hand written assessment dated 12/16, was for period of time the facility was owned by Golden Living, but was written on a form provided by new owners. When asked when the form was written, AD said, "I wrote the assessment today."

During interview on 3/9/17, at 1:10 p.m. the executive director said, "I would expect R76's assessment to be done in December in PCC or on the Golden Living form." Verified MHM on the hand written assessment dated 12/16, stood for Monarch Health Management. The executive director reviewed the therapeutic recreation calendars for December 2016, January 2017, February 2017, and March 2017. Executive director verified there was one activity per week after supper. When the executive director was asked what was your expectation for evening activities? Executive director said, "Per company policy and regulation, that we have an effective

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 _____	03/09/2017

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 248	Continued From page 26 activity program." When asked what was in place for short stay residents, the executive director said, "In room activities. No activities if that is their preference but individualized to what the resident would like." Executive director said, "Assessments and care plan were to be completed and available." During interview on 3/9/17, at 2:20 p.m. R76 said, "They have a lot of stuff, but not in the evening. I would like some variety with the activities and I would really like something to do in the evening. They talked about doing movie nights, but I don't know what happened."	F 248		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		4/18/17

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 _____	03/09/2017

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 280	Continued From page 27	F 280		

right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(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.

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 _____	03/09/2017

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 280	Continued From page 28 (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 review, the facility failed to develop care planned interventions to reduce the risk of falls for 1 of 3 residents (R30) reviewed for accidents. Findings include: R30's significant change Minimum Data Set dated 1/30/17, indicated she was moderately cognitively impaired, required extensive assist of two staff for bed mobility, toileting and transfers, and was incontinent of bowel and bladder. A Care Area Assessment dated 2/6/17, identified a risk for falls due to a history of falls, psychosis, mobility impairments and a lack of safety awareness and judgement. R30's care plan dated 2/6/17, identified a physical functioning deficit related to mobility impairments, chronic pain and fatigue. The care plan further identified a risk for falls related to a history of falls. The care plan directed staff to keep her call light within reach,	F 280	Resident #30 has been assessed for all falls and interventions have been identified to ensure resident's safety per individual fall care plan. New admissions/re-admits will continue to be assessed for fall risk(s) and appropriate interventions will be initiated. Other resident's will continue to be assessed for fall risks quarterly and as needed and individual care plans will be updated. Nurses and nursing assistants will be re-educated on falls policy. Weekly audits of falls will be completed weekly x 4; then as needed. DNS or designee will be responsible	

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 _____	03/09/2017

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 280	Continued From page 29 encourage her to ask for assistance and checks every two hours. Review of facility documents titled Lynwood Progress Notes and correlating Minnesota Incident Report forms dated December 2016 through March 2017, identified the following falls: A Progress Note dated 1/2/17, indicated R30 was found sitting on the floor by the bed at 4:15 a.m. Reported attempting to self-transfer. There was no evidence the facility reviewed the fall in an effort to determine causal factors. A Progress Note dated 1/12/17, indicated as staff was walking into the facility at 6:05 a.m., R30 was heard yelling for help. R30 was found on the floor between her bed and her wheelchair. A Minnesota Incident Report dated 1/12/17, indicated R30 was impulsive and non-compliant with waiting for help and indicated R30 encouraged to wait for help. A Minnesota Incident Report dated 1/24/17, indicated R30 had a history of falls, did not ask or wait for help. Psychotropic medications were changed, would need time to adjust. R30 was again reminded to use call light and wait for assistance. A Progress Note dated 1/25/17, indicated the fall occurred on 1/25/17, and indicated the following: R30 yelling "help me, help me." Staff found her on the floor in front of her bed at 11:26 p.m. R30 stated she was trying to get up into her wheel chair. A Progress Note dated 2/15/17, indicated R30 was found on the floor. R30 stated she rolled out of bed attempting to self-transfer. A Minnesota Incident Report form indicated R30 fell at 6:08 a.m., the fall was reviewed on 3/9/17, 22 days after her fall and indicated R30 was encouraged to use her call light and staff to perform frequent checks. The incident report form further indicated a visit by the social worker for Associated Clinic of Psychology	F 280	party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 280	Continued From page 30	F 280		

(ACP). A review of the ACP progress note dated 2/15/16, indicated R30's cognitive functioning was in the severe range as well as her memory. The notes identified poor sleep with continued nightmares, but did not address the falls. A Minnesota Incident Report form dated 3/8/17, indicated R30 was again observed on her floor following a self-transfer attempt at 4:00 a.m. The incident report indicated staff again encouraged use of her call light.

During an observation on 3/8/17, R30 was sitting in her room in a standard wheel chair. Her head was tilted back, over the backrest and she appeared to be sleeping. At 9:41 a.m., R30 remained sleeping in the same position. She remained that way until 11:04 a.m. At 12:57 p.m., R30 was in bed, asleep. During an observation on 3/9/17, at 9:41 a.m., R30 was sitting in her wheel chair, her head was back, resting on the strap of her oxygen tank. She again appeared to be sleeping.

During an interview on 3/9/17, at 9:21 a.m., nursing assistant (NA)-C stated when R30 was weak she would self-transfer and fall and then will yell out for help. NA-C stated R30 fell the previous evening and stated, "The nurse takes care of it."

During an interview on 3/9/17, at 4:28 p.m., the director of nursing (DON) stated R30 was a "frequent faller." She stated R30 had nightmares and would sit up fast and slide to the floor. She stated when a resident falls, the staff fills out an incident report and she reviewed them with the interdisciplinary team (IDT) and come up with interventions. The DON stated, "We encourage her to use her call light." The DON stated most of

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 _____	03/09/2017

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 280	Continued From page 31 R30's fall occur on the night shift. She stated R30 did not like to be in bed or wait for help. She stated staff would bring her to the nurse's station or turn the bathroom light on for her. While R30 sustained five falls in a period of three months, there was no indication the facility reviewed her falls in an attempt to identify causative factors. Further, while R30's care plan indicated it had been revised on 2/6/17, there was no evidence any new interventions for falls had been added to the care plan since 4/19/16.	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R62) who received renal diet as ordered and that medication orders were followed and the facility failed to ensure 2 of 3 residents (R76, R28) were offered activities as directed by the plan of care. In addition, the facility failed to ensure the care plan was follow for a.m. care routine for 1 of 3 residents (R4). Findings include: Diet:	F 282	Resident #62 is discharged from the facility. Resident #28 and #76 were assessed for resident's activity preferences and care plans have been updated to reflect resident's preferences. Resident #4 is provided privacy during cares as outlined in individual care plan. New admissions/re-admits will continue to be provided physician prescribed diets and medications. New admissions will be assessed for activity preferences.	4/18/17

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 _____	03/09/2017

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 282	Continued From page 32 On 3/6/17, at 5:30 p.m. R62's dinner was cheese ravioli with meat sauce, green beans with tomatoes, bread sticks and lime fruited Jello. R62 had eight ounces of milk and a full cup of coffee to drink. On 3/8/17, at 7:38 a.m. breakfast was posted as steak and egg scramble and raisin bran and a spiced muffin. R62 received raisin bran and scrambled eggs. R62's tablemate's gave him two additional spiced muffins. R62 requested a second bowl of cereal and said he could not eat the eggs. R62 had an eight ounce glass of orange juice, milk and a cup of coffee to drink. R62's diet slip indicated diet was "CCHO-Reg Cons [Consistent Carbohydrate, regular consistency]." The Abbott North Western Discharge Orders dated 3/3/17, instructed staff R62 was to have a "diabetic and renal dialysis (or facility equivalent) diet." R62's Alteration Kidney Function Hemodialysis care plan dated 2/17, instructed staff R62 was on dialysis and that staff were to observe for signs of infection, bleeding, send a bag lunch with R62 to dialysis and "Follow diet as ordered." During interview on 3/8/17, at 12:48 p.m. dietician stated on 3/6/17, R62 should not have had the cheese ravioli, gelatin or cheese cake because of the phosphorus and sodium. The dietician stated orange juice would need to be limited due to potassium. Because of the phosphorous in raisin Bran two bowls would be a problem. The dietician said the nursing staff or dietary staff should have contacted me. This was a new diet on March third and we should have clarified if [R62] needed a fluid restriction. I have spoken with dialysis and am making changes."	F 282	Other resident's will continue to be provided physician prescribed diets and medications. Other resident's will be assessed to ensure their activity preferences are being met. Individual care plans will be developed/revised to reflect resident's activity preferences. All residents will continue to be provided with privacy during cares. Nurses will be re-educated on diet request form and dialysis communication form. Activity Director will be re-educated on ensuring all residents are assessed for activity preferences and participation logs are completed. Nurses and nursing assistants will be re-educated on resident rights specific to privacy. Weekly audits of physician prescribed diets, dialysis, resident activity participation logs and resident privacy will be completed weekly x 4; then as needed. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 282	Continued From page 33	F 282		

Medications:
During interview on 3/8/17, at 8:31 a.m. R62 said, "I have had dialysis three times in the hospital and three times over at Blaine. No one has told me what I can eat or what to do in case of an emergency. I expect them to know that here. I wished someone would provide me with information." R62 said, "You know what the worse thing about going to dialysis is, the last two times I have had to go number two so bad. Monday it was two times and on top of it they are giving me those pills to soften my stools. When asked did you get the stool softener this morning R62 said, "Yes. I don't want to be bound up, but I can't run to the bathroom at dialysis easily."

R62's Alteration Kidney Function Hemodialysis care plan dated 2/17, instructed staff R62 was on dialysis and that staff were to observe for signs of infection, bleeding, send a bag lunch with R62 to dialysis and "Follow diet as ordered." The hemodialysis care plan did not address medications. The diabetic care plan dated 2/17, instructed staff to give diet as ordered and administer insulin per doctor's order. Immediate Plan of Care at Risk for Cardiovascular Problems dated 2/24/17, instructed staff to "administer medications as prescribed." Immediate Plan of Care at Risk for Respiratory Problems dated 2/24/17, instructed staff to "administer medications as prescribed."

Dialysis/Nursing Facility Communication Form dated 3/8/17, instructed facility staff to start rena-vite 0.8 mg one tablet daily, "Please send recent med list. Second Request. Pt [patient] up to bathroom today at 1300. Please HOLD Senna-S."

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 _____	03/09/2017

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 282	Continued From page 34	F 282		

The Dialysis/Nursing Facility Communication Form dated 3/16/17, indicated R62 had been up to bathroom each treatment and instructed staff of new telephone order to hold Senna (a stool softener) prior to dialysis and no protein supplements day of dialysis. The form also requested facility please send a current medication sheet to dialysis.

During interview on 3/8/17, at 11:11 a.m. assistant director of nurses (ADON) said, "The nurse should be checking the communication binder for any communication and any orders." Reviewed March medication sheets and ADON verified all the blank and circled medications. ADON said, "I would expect the staff to give the medications and document it or document why they circled the medications." ADON verified two Senna-S 8.6-50 milligrams (mg) tablets were given to R62 on 3/8/17, prior to dialysis. ADON verified that metoprolol (a medication for hypertension) 150 mg, Senna-S 8.6-50 mg, Hydralazine (a medication for hypertension) 100 mg, amlodipine(a medication for hypertension) 10 mg, Breo Ellipta (a medication for respiratory difficulty), Bupropion (a medication for depression) 75 mg celexa (a medication for depression) 40 mg Plavix (a medication to prevent blood clots) 75 mg, lisinopril (a medication for hypertension) 10 mg Lantus (a medication for diabetes) 5 units and prednisone (a medication for respiratory difficulty) 40 mg were circled or blank without any explanation. ADON said, "This would indicate the medications were most likely not given prior to [R62] going to dialysis." ADON reviewed medication sheets and verified that the order to hold Senna-S prior to dialysis had not been transcribed. R62's plan of

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 _____	03/09/2017

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 282	Continued From page 35	F 282		

care was not followed as R62 did not receive the renal diet as ordered.

Activity:
R76 was sitting on the edge of the bed on 3/6/17, at 4:51 p.m. and the TV was on. R76 stated there were not enough activities on the weekends and evenings. R76 said, "They could use a little bit more activities in the afternoon and after supper. They could mix it up a little bit. I get tired of watching TV in my room every night."

R76's admission MDS dated 12/30/16, indicated R76 was cognitively intact without behaviors and minimal signs of depression. R76's MDS indicate R76 participated in therapy six days a week for an average of an hour and 40 minutes each time. R76's MDS indicated R76 experienced daily pain that interfered with daily activities. R76's MDS indicated that it was somewhat important to do things with people and do favorite activities. R76's medical record lacked evidence of a comprehensive activity assessment being completed.

R76's care plan printed 2/28/17, instructed staff that R76 was still adjusting to new surroundings and desired to "be comfortable socializing with others and being involved in LivingCenter events. Activity care plan R76 anticipated only being at the facility for a short period of time and did not have interest in joining in facility programs and instructed staff to offer R76 activities later in the day after R76 was done with therapy. R76 care plan indicated R76 liked to keep busy with independent activities and visiting with family and friends but lacked details to help R76 achieve goals of being comfortable socializing with others.

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 _____	03/09/2017

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 282	Continued From page 36	F 282		

During interview on 3/9/17, at 11:42 a.m. AD stated, "I do a recreation assessment in the first two weeks they [residents] are here. The assessment was done to determine what a resident likes to do." AD commented R76 liked coloring books, word searches, and in room activities. AD said, "[R76] had a lot of refusals to attend activities." AD verified there was no documentation of refusals to attend activities. AD verified there was no activity assessment in R76's medical record.

During interview on 3/9/17, at 12:57 AD verified there was not a documented assessment for activities in PCC (electronic health record) or on paper until requested by surveyor. AD verified the hand written assessment dated 12/16, was for period of time the facility was owned by Golden Living, but was written on a form provided by new owners. When asked when the form was written, AD said, "I wrote the assessment today."

During interview on 3/9/17, at 1:10 p.m. the executive director said, "I would expect R76's assessment to be done in December in PCC or on the Golden Living form." Verified MHM on the hand written assessment dated 12/16, stood for Monarch Health Management. The executive director reviewed the therapeutic recreation calendars for December 2016, January 2017, February 2017, and March 2017. Executive director verified there was one activity per week after supper. When the executive director was asked what was your expectation for evening activities? Executive director said, "Per company policy and regulation, that we have an effective activity program." When asked what was in place for short stay residents, the executive director said, "In room activities. No activities if that is

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 _____	03/09/2017

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 282	Continued From page 37	F 282		

their preference but individualized to what the resident would like." Executive director said, "Assessments and care plan were to be completed and available."

During interview on 3/9/17, at 2:20 p.m. R76 said, "They have a lot of stuff, but not in the evening. I would like some variety with the activities and I would really like something to do in the evening. They talked about doing movie nights, but I don't know what happened." R76 was not involved with activities as directed by the plan of care.

R28's was asked about activites on 3/6/17, at 2:00 p.m. During an interview when asked if staff encouraged R28 to attend activities and provided assistance to attend them, the family member (F)-A stated "No. He lays there most of the time."

On 3/6/17, at 3:24 p.m. R28 was observed lying in bed asleep as a music activity went on which had several residents in attendance in the dining room (DR) was never offered to attend. On 3/6/17, at 6:45 p.m. to 7:35 p.m. R28 was observed in his room agitated. The activity director (AD) was sitting in the room watching television (TV) with R28 and R28 was repeatedly asking to go outside. When approached and asked what he did for a living, R28 stated he worked for a construction company then went back to ask surveyor to take him outside. The AD sat there distracting R28 however was not successful. No other activities offered. On 3/7/17, at approximately 10:10 a.m., the AD was observed at the DR with six residents doing devotions and R28 laid in bed. On 3/7/17, at 4:20 p.m. the AD coordinated a card activity as R28

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 _____	03/09/2017

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 282	Continued From page 38	F 282		

was observed lying in bed. On 3/8/17, at 7:06 a.m. R28 was observed sitting on wheelchair, which was tilted slightly. When approached asked how he had slept resident stated "well." On 3/8/17, at 2:00 p.m. R28 was observed lying in bed as Bingo was being called in the dining room. On 3/9/17, at 1:15 p.m. R28 laid in bed as the AD was observed to assist and invite several residents into an activity in dining room.

R28's care plan dated 7/8/16, indicated "I sometimes have difficulty starting and staying involved in recreational activities as evidenced by: Short attention span. I am now on hospice care." Care plan directed staff "As I have a hard time with activities that last a long time, please include me in shorter duration activities, Call my name or gently touch my arm of hand to help me stay aware of the activity going on around me, If I become frustrated understanding or completing an activity, please help me with more instruction or by simplifying the activities, Offer me smaller group activities for more assistance at my highest level, Please give me assistance if I need it, using simple instructions, verbal and physical cuing and task segmentation during activities, Please help me participate in my favorite activities at my highest level."

R28's Recreational Service Assessment dated 7/14/16, indicated resident needed much encouragement to attend groups and to participate; family was very supportive with daily visits and was on hospice care at the time. The assessment indicated resident interests included "trivia, country western music, likes to go outside and get fresh air, activity preferences large group, small groups, and with family/friends."

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 _____	03/09/2017

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 282	Continued From page 39	F 282		

R28's cognitive loss/dementia Care Area Assessment (CAA) dated 7/14/16, directed staff to keep resident at nurses station so that he can socialize with staff, peers and to included him in activities. The activities CAA dated 7/14/16, indicated resident needed much encouragement to attend groups and to participate and family was very supportive with daily visits.

R28's diagnoses included dementia, psychotic disorder, depression, seizure disorder and cerebrovascular accident (CVA) obtained from the quarterly Minimum Data Set (MDS) dated 1/5/17. In addition, the MDS indicated R28 had severely impaired cognition, and did not exhibit any behavioral symptoms.

During review of the Recreation Participation Record the following were revealed:
-March 2017, log indicated resident had participated in activities on five of nine days of the month so far. With four days of no activities so far.
-February 2017, log indicated resident had only attended activities on 11 of 28 days, with no planned activities for 17 days.
-January 2017, log indicated resident had only attended activities on 17 of 31 days, with no activities for 14 days for that month.
-December 2016, log indicated resident had only attended activities for 18 of 31 days, with 13 days of no activities.
-November 2016, log indicated resident had only attended activities for 18 of 31 days, with 13 days of no activities.
-October 2016, log indicated resident had only attended activities for 10 of 31 days, with 21 days of no activities
-September 2016, log indicated resident had only

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 _____	03/09/2017

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 282	Continued From page 40	F 282		

attended activities for two of 31 days, with 29 days of no activities. The logs and medical record lacked documentation, R28 had refused activities offered and if resident had been re-assessed to ensure the interventions in place were effective.

On 3/9/17, at 2:44 p.m. the AD was interviewed about the observations made during the survey period. When reviewing the March 2017, Recreation Participation Record for R28 AD stated he was in the room daily between 10:15 to 10:45 a.m. doing the following activities "movie, church/Religious, music therapy, current events, trivia, reminiscing television/radio and visiting." All during that time as he had them marked for resident. When asked for a clarification as that was the same time frame in the facility calendar for "Daily devotions, current events, trivia and/or Did you know" AD then recanted it back and stated it was daily devotions time and he did go to multiple resident's room and did devotions with them. When asked about R28's activities attendance AD stated he would try to invite the resident to activities and resident had the choice to participate or not. When asked if he did document resident refusals anywhere he stated he did not. When asked about R28's most recent recreational assessment AD stated, "There would be none and would be the MDS and the care plan." When asked about the assessment dated 7/14/16,which was the only assessment that had been completed seven months AD stated he was not working at the facility at the time of the assessment and had never done another assessment. AD appeared surprised when told R28's interests/likes as indicated on the assessment dated 7/14/16. When asked if resident had been invited to attend the music on 3/6/17, 3/7/17, 3/8/17, and 3/9/17, AD stated he

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 _____	03/09/2017

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 282	Continued From page 41	F 282		

may have however, he stated he forgot to document a refusal and was not even sure if he had invited R28 to attend. When asked how many days resident had not received activities in the month of February 2017, AD verified resident had not had activities for "over half of the month." When asked who did activities, when he was not in the building AD stated "am a one man show." R28 was offered activites as care planned.

A.m. Cares:
R4's diagnoses included macular degeneration, glaucoma, major depressive disorder, dementia, anxiety state, osteoporosis, urinary incontinence and personality disorder obtained from the quarterly MDS dated 1/30/17.

On 3/8/17, at 7:18 a.m. R4 was observed lying in bed on her back when approached and asked how she had slept R4 stated "am tired." When asked if she had told the NA-B, R4 stated "mm, hmm." NA-B was observed at that time go back and forth between the bathroom and resident room setting up all the supplies at bedside to stated she was going to get R4 ready for the day. At 7:20 a.m. NA-B approached R4's bedside asked how she has slept then stated to R4 "you look tired." R4 kept quiet. NA-B proceeded to get R4 ready for the day. NA-B asked R4 how she was doing and R4 stated "tired." NA-B then told R4, "Two more turns then will leave you till breakfast" as NA-B and NA-A finished adjusting the clothing. NA-B then took the basin of water dumped it in bathroom washed hands as other aide adjusted R4 pillow and covered resident back up. At 7:31 a.m. NA-B had finished left room stated she was going to get R4 water left then came back briefly. At 7:32 a.m. NA-B asked R4 if she was doing good then left room shut the door.

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 _____	03/09/2017

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 282	Continued From page 42	F 282		

At 7:37 a.m. resident laid in bed dressed eyes closed. NA-B did not ask the resident if the resident wanted to get dressed for the day, even after the aide was informed by R4 that they were "tired."

R4's communication Care Area Assessment (CAA) dated 5/19/16, indicated resident spoke slowly and clearly, and resident was able to express needs/wants. The care plan directed staff to provide extensive to total assist with activities of daily living (ADLs). The care plan printed 2/27/17, indicated R4 had an alteration in cognition related to dementia, anxiety, depression and personality disorder. The care plan directed staff to "Please help me make safe choices..." The plan of care lacked evidence of preferences for when the resident wanted to get up or when the resident wanted to go to bed.

R4's Preferences for Customary Routine and Activities assessment dated 5/19/16, indicated resident had indicated it was "Very important" for her to choose her bedtime however her waking up preferences had not been assessed.

On 3/8/17, at 11:09 a.m. NA-B stated when asked if she knew resident did not want to get up in the morning NA-B stated resident was not a morning person and never wanted to get out of bed and staff had always gotten her dressed in the morning and left her there until lunch. NA-B again repeated "she is not a morning person and is tired all the time."

On 3/9/17, at 7:33 a.m. R4 was approached and asked how she had slept. The resident stated "okay." At the time resident appeared alert and was already dressed for the day. When asked if

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 _____	03/09/2017

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 282	Continued From page 43 the staff had gotten her ready resident stated she was already up and staff had not woken her up. R4 also indicated she was not tired. On 3/9/17, at 1:55 p.m. NA-D stated resident liked to stay in bed in the morning when asked R4's morning routine and waking up preferences. On 3/9/17, at 3:48 p.m. the DON stated "It is care planned she doesn't like to get up in the morning and did not want to get dressed until after breakfast wants to get up around 10:00 and this was in the care card. She doesn't like to be bothered." On 3/9/17, at 2:00 p.m. a policy for resident preferences was requested but was never provided. R4's care plan was not followed for getting sressed in the morning.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 309		4/18/17

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 _____	03/09/2017

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 309	Continued From page 44 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R62) received a renal diet as ordered and medication orders were followed. Findings include: Diet: On 3/6/17, at 5:30 p.m. R62's dinner was cheese ravioli with meat sauce, green beans with tomatoes, bread sticks and lime fruited Jello. R62 had eight ounces of milk and a full cup of coffee to drink. On 3/8/17, at 7:38 a.m. breakfast was posted as steak and egg scramble and raisin bran and a spiced muffin. R62 received raisin bran and scrambled eggs. R62's tablemate's gave him two additional spiced muffins. R62 requested a second bowl of cereal and said he could not eat the eggs. R62 had an eight ounce	F 309	Resident #62 is discharged from the facility. New admissions/re-admits will continue to be provided physician prescribed diets and medication. New admissions will be assessed for activity preferences. Other resident's will continue to be provided physician prescribed diets and medications. Nurses will be re-educated on diet request form and dialysis communication form. Weekly audits of physician prescribed diets and dialysis will be completed weekly x4; then as needed.	

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 _____	03/09/2017

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 309	Continued From page 45 glass of orange juice, milk and a cup of coffee to drink. R62's diet slip indicated diet was "CCHO-Reg Cons [Consistent Carbohydrate, regular consistency]." R62's admission Minimum Data Set dated 2/27/16, indicated R62's cognition, mood and behaviors had not been assessed. Dialysis Treatment Sheet for Facility Blaine dated 3/6/17, indicated R62 was alert and oriented. Admission Record printed 3/9/17, indicated R62's diagnosis included, diabetes, chronic kidney disease, major depression and congestive heart failure. R62's Alteration Kidney Function Hemodialysis care plan dated 2/17, instructed staff R62 was on dialysis and that staff were to observe for signs of infection, bleeding, send a bag lunch with R62 to dialysis and "Follow diet as ordered." During interview on 3/8/17, at 12:48 p.m. dietician stated on 3/6/17, R62 should not have had the cheese ravioli, gelatin or cheese cake because of the phosphorus and sodium. The dietician stated orange juice would need to be limited due to potassium. Because of the phosphorous in raisin Bran two bowls would be a problem. The dietician said the nursing staff or dietary staff should have contacted me. This was a new diet on March third and we should have clarified if [R62] needed a fluid restriction. I have spoken with dialysis and am making changes." Medications: On 3/6/17, at 4:31 p.m. R62 was observed sitting in a wheelchair in bedroom. R62 stated he had just returned from dialysis. R62's tee shirt had dried blood around neck of the tee shirt and on the left side of shirt over dialysis access.	F 309	DNS or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 309	Continued From page 46	F 309		

During interview on 3/8/17, at 8:31 a.m. R62 said, "I have had dialysis three times in the hospital and three times over at Blaine. No one has told me what I can eat or what to do in case of an emergency. I expect them to know that here. I wished someone would provide me with information." R62 said, "You know what the worse thing about going to dialysis is, the last two times I have had to go number two so bad. Monday it was two times and on top of it they are giving me those pills to soften my stools. When asked did you get the stool softener this morning R62 said, "Yes. I don't want to be bound up, but I can't run to the bathroom at dialysis easily."

R62's Alteration Kidney Function Hemodialysis care plan dated 2/17, instructed staff R62 was on dialysis and that staff were to observe for signs of infection, bleeding, send a bag lunch with R62 to dialysis and "Follow diet as ordered." The hemodialysis care plan did not address medications. The diabetic care plan dated 2/17, instructed staff to give diet as ordered and administer insulin per doctor's order. Immediate Plan of Care at Risk for Cardiovascular Problems dated 2/24/17, instructed staff to "administer medications as prescribed." Immediate Plan of Care at Risk for Respiratory Problems dated 2/24/17, instructed staff to "administer medications as prescribed."

Dialysis/Nursing Facility Communication Form dated 3/8/17, instructed facility staff to start rena-vite 0.8 mg one tablet daily, "Please send recent med list. Second Request. Pt [patient] up to bathroom today at 1300. Please HOLD Senna-S."

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 _____	03/09/2017

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 309	Continued From page 47	F 309		

The Dialysis/Nursing Facility Communication Form dated 3/16/17, indicated R62 had been up to bathroom each treatment and instructed staff of new telephone order to hold Senna (a stool softener) prior to dialysis and no protein supplements day of dialysis. The form also requested facility please send a current medication sheet to dialysis.

During interview on 3/8/17, at 11:11 a.m. assistant director of nurses (ADON) said, "The nurse should be checking the communication binder for any communication and any orders." Reviewed March medication sheets and ADON verified all the blank and circled medications. ADON said, "I would expect the staff to give the medications and document it or document why they circled the medications." ADON verified two Senna-S 8.6-50 milligrams (mg) tablets were given to R62 on 3/8/17, prior to dialysis. ADON verified that metoprolol (a medication for hypertension) 150 mg, Senna-S 8.6-50 mg, Hydralazine (a medication for hypertension) 100 mg, amlodipine(a medication for hypertension) 10 mg, Breo Ellipta (a medication for respiratory difficulty), Bupropion (a medication for depression) 75 mg celexa (a medication for depression) 40 mg Plavix (a medication to prevent blood clots) 75 mg, lisinopril (a medication for hypertension) 10 mg Lantus (a medication for diabetes) 5 units and prednisone (a medication for respiratory difficulty) 40 mg were circled or blank without any explanation. ADON said, "This would indicate the medications were most likely not given prior to [R62] going to dialysis." ADON reviewed medication sheets and verified that the order to hold Senna-S prior to dialysis had not been transcribed.

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 _____	03/09/2017

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 309	Continued From page 48 On 3/8/17, at 1:14 p.m. RN-B called and stated [R62] had to be taken off dialysis at 1 pm to go to the bathroom for stool. R62's plan of care was not followed as R62 did not receive the renal diet as ordered. Policy or procedure for care of patient on dialysis requested but not received.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		4/18/17

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 _____	03/09/2017

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 323	Continued From page 49 Based on observation, interview and document review, the facility failed to developed interventions to reduce the risk for falls for 1 of 3 residents (R30) reviewed for accidents. Findings include: R30's significant change Minimum Data Set dated 1/30/17, indicated she was moderately cognitively impaired, required extensive assist of 2 staff for bed mobility, toileting and transfers, and was incontinent of bowel and bladder. A Care Area Assessment dated 2/6/17, identified a risk for falls due to a history of falls, psychosis, mobility impairments and a lack of safety awareness and judgement. R30's care plan dated 2/6/17, identified a physical functioning deficit related to mobility impairments, chronic pain and fatigue. The care plan further identified a risk for falls related to a history of falls. The care plan directed staff to keep her call light within reach, encourage her to ask for assistance and checks every two hours. A review of facility documents titled Lynwood Progress Notes and correlating Minnesota Incident Report forms dated December 2016 through March 2017, identified the following: A Progress Note dated 1/2/17, indicated R30 was found sitting on the floor by the bed at 4:15 a.m. Reported attempting to self-transfer. There was no evidence the facility reviewed the fall in an effort to determine causal factors. A Progress Note dated 1/12/17, indicated as staff was walking into the facility at 6:05 a.m., R30 was heard yelling for help. R30 was found on the floor between her bed and her wheel chair. A Minnesota Incident Report dated 1/12/17,	F 323	Resident #30 has been assessed for all falls and interventions have been identified to ensure resident's safety per individual fall care plan. New admissions/re-admits will continue to be assessed for fall risk(s) and appropriate interventions will be initiated. Other resident's will continue to be assessed for fall risks quarterly and as needed and individual care plans will be updated. Nurses and nursing assistants will be re-educated on falls policy. Weekly audits of falls will be completed weekly x 4; then as needed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 323	Continued From page 50	F 323		

indicated R30 was impulsive and non-compliant with waiting for help and indicated R30 encouraged to wait for help.

A Minnesota Incident Report dated 1/24/17, indicated R30 had a history of falls, did not ask or wait for help. Psychotropic medications were changed, and would need time to adjust. R30 was again reminded to use call light and wait for assistance. A Progress Note dated 1/25/17, the day after the incident report was completed, indicated the fall occurred on 1/25/17, and indicated the following: R30 yelling "help me, help me." Staff found her on the floor in front of her bed at 11:26 p.m. R30 stated she was trying to get up into her wheel chair.

A Progress Note dated 2/15/17, indicated R30 was found on the floor. R30 stated she rolled out of bed attempting to self-transfer. A Minnesota Incident Report form indicated R30 fell at 6:08 a.m., the fall was reviewed on 3/9/17, (22 days after her fall) and indicated R30 was encouraged to use her call light and staff to perform frequent checks. The incident report form further indicated a visit by the social worker for Associated Clinic of Psychology (ACP). A review of the ACP progress note dated 2/15/16, indicated R30's cognitive functioning was in the severe range as well as her memory. The notes identified poor sleep with continued nightmares, but did not address falls.

A Minnesota Incident Report form dated 3/8/17, indicated R30 was again observed on her floor following a self-transfer attempt at 4:00 a.m. The incident report indicated staff again encouraged use of her call light.

During an observation on 3/8/17, R30 was sitting

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 _____	03/09/2017

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 323	Continued From page 51	F 323		

in her room in a standard wheel chair. Her head was tilted back, over the backrest and she appeared to be sleeping. At 9:41 a.m., R30 remained sleeping in the same position. She remained that way until 11:04 a.m. At 12:57 p.m., R30 was in bed, asleep.

During an observation on 3/9/17, at 9:41 a.m., R30 was sitting in her wheel chair, her head was back, resting on the strap of her oxygen tank. She again appeared to be sleeping.

During an interview on 3/9/17, at 9:21 a.m., nursing assistant (NA)-C stated when R30 was weak she would self-transfer and fall and then will yell out for help. NA-C stated R30 fell the previous evening and stated, "The nurse takes care of it."

During an interview on 3/9/17, at 4:28 p.m., the director of nursing (DON) stated R30 was a "frequent faller." She stated R30 had nightmares and will sit up fast and slide to the floor. She stated when a resident falls, the staff fills out an incident report and she reviewed them with the interdisciplinary team (IDT) and come up with interventions. The DON stated, "We encourage her to use her call light." The DON stated most of R30's fall occur on the night shift. She stated R30 did not like to be in bed or wait for help. She stated staff would bring her to the nurse's station or turn the bathroom light on for her. The DON further stated, "I feel like her falls are reducing." She stated she felt the basis of her falls was psychological but stated R30 had been referred to therapy.

During an interview on 3/9/17, at 1:35 p.m., occupation therapy assistant (OTA)-A stated R30

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 _____	03/09/2017

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 323	Continued From page 52 had not been on caseload recently for wheel chair positioning, she stated therapy had ordered a specialized wheel chair with a tilt option, but R30 no longer needed it due to improvement. OTA-A stated R30 had not been referred to therapy for falls. While R30 sustained five falls in a period of three months, there was no indication the facility reviewed her falls in an attempt to identify causative factors, and while the facility identified R30's falls all occurred at night, there was no evidence the facility made efforts to promote safety during the overnight hours. In addition, the facility continued to encourage R30 to use her call light, even though she was determined to be moderately to severely cognitively impaired and had demonstrated a lack of insight regarding use of the call light. A facility policy title Assessing Falls and Their Causes, dated 10/2010, indicated falls are the leading cause of morbidity and mortality among the elderly in nursing homes. The policy directed staff to complete an incident report following a fall and within 24 hours of a fall the nursing staff will begin to identify likely causes of the fall and evaluate the chain of events preceding the fall.	F 323		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (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	F 334		4/18/17

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 _____	03/09/2017

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 334	Continued From page 53	F 334		

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 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.

(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

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 _____	03/09/2017

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 334	Continued From page 54 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 implement the current standards of immunizations for pneumonia for 1 of 5 residents (R8). Findings include: The Center for Disease Control and Prevention identified adults 65 years of age or older who have not previously received PCV13 (pneumococcal 13-valent Conjugate Vaccine) and who have previously received one or more doses of pneumococcal polysaccharide vaccine 23 (PPSV23) should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R8's record indicated the 77 year old had resided at the facility since 9/7/11, the immunization	F 334	Resident #8 is being offered immunizations for pneumonia. New admissions will continue to be offered immunizations. Other resident's immunization history to be reviewed and will be offered immunizations per audit results including pneumonia. Nurses will be re-educated on pneumococcal Disease - prevention protocol. Weekly audits of immunizations for new admissions will be completed weekly x 4; then as needed.	

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 _____	03/09/2017

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 334	Continued From page 55 record documented R8 had received the Pneumococcal in 2006, and no PCV13 had been administered and/or offered since admit. On 3/9/17, at 4:25 p.m. the director of nursing (DON) verified R8 did not have the PCV13. Pneumococcal Disease-Prevention Protocol revised 11/2016, instructed staff; "it is the practice of the Health Care Facility to interview all residents to determine Pneumococcal vaccination status. If the resident has received vaccine, the date of the vaccination will be recorder in the resident's medical record. If the resident has not had vaccination or is uncertain of previous vaccination status, with informed consent from resident or family, the Pneumococcal vaccination will be encouraged." Pneumococcal Disease-Prevention Protocol does not differentiate between PCV13 and PPSV23.	F 334	DNS or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	
F 354 SS=C	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (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. (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. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 354		4/18/17

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 _____	03/09/2017

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 354	Continued From page 56 Based on interview and document review, the facility failed to consistently provide registered nurse coverage of eight hours daily, seven days a week. This had the potential to affect all 36 residents residing at the facility. Findings include: A review of facility documents titled Golden Living Center- Lynwood were reviewed and indicated the following: On 12/24/16, the facility staffed six licensed practical nurses (LPN)s and no registered nurses (RN)s for a 24 hour period. On 12/25/16, the facility staffed six LPNs and no RN's for a 24 hour period. On 1/1/17, the facility staffed six LPNs and no RN's for a 24 hour period. On 1/717 and 1/8/17, the facility again staffed six LPNs and no RNs for each 24 hour period. During an interview on 3/9/17, at 7:29 a.m., the director of nursing (DON) stated the facility had a manager on duty (MOD) on the weekends and holidays. She stated the MOD was required to be in the building for four hours each day. The DON stated she was the MOD on 12/24/16, and 12/25/16, and had an RN in the building on 1/1/17, but stated while she was on call on 1/7/17 and 1/8/17, there was no RN in the building on either of those days. During an interview on 3/9/17, at 3:55 p.m., the administrator stated she was aware the facility was required to have an RN in the building for	F 354	The Estates at Fridley has designated an RN for 8 hours per day to be in the facility. The facility will assure there is 8 hours of RN coverage per day at the facility. Weekly audits of facility staffing schedule weekly x 4; then as needed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 354	Continued From page 57 eight hours a day. She further stated she was aware the MOD was only in the building four hours a day on weekends and holidays. A facility policy for registered nurse coverage was requested, but not received.	F 354		
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpster to prevent attracting pests and rodents. This had the potential to affect all 36 residents residing at the facility. Findings include: On 3/8/17, at 1:57 p.m. during a tour of the only facility garbage dumpster located in a closed shade at the end of the parking lot, the entire ground all around the dumpster was observed extremely littered with multiple used turned inside out gloves, multiple cigarette butts on the back wall, empty water collapsed bottles, incontinent pad package, plastic clear bags and nets all littered the area. At 2:02 p.m. went outside with the dietary manager who verified the area was extremely littered and when asked if her staff used the area she acknowledged it and when asked who cleaned the area DM stated, "That I don't know." DM acknowledged both the dietary staff and other departments had used the dumpster during the last three days of the survey and nobody had brought to her attention to have the area cleaned. At 2:06 p.m. the facility policy	F 372	Garbage dumpster area has been cleaned. The facility will assure the dumpster area will remain clean. Weekly audits of dumpster area will be completed weekly x 4; then as needed. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	4/18/17

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 _____	03/09/2017

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 372	Continued From page 58 was requested and not provided. On 3/9/17, at 12:59 p.m. the administrator stated she did not find a policy and would expected the dumpster area be kept clean and free of litter. The administrator brought up the issue of snow however surveyor reminded the snow had melted for almost over two weeks now and she acknowledged it.	F 372		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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	F 441		4/18/17

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 _____	03/09/2017

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 441	Continued From page 59 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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	F 441	Resident #4 is receiving appropriate	

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 _____	03/09/2017

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 441	Continued From page 60 review, the facility failed to ensure proper hand hygiene and glove use was provided for 1 of 3 residents (R4) reviewed for activities of daily living. Findings include: On 3/8/17, at 7:18 a.m. to 7:25 a.m. nursing assistant (NA)-A and NA-B were observed to provide morning care to R4. At 7:27 a.m. NA-B was observed with pericare. NA-B wiped R4's bottom and feces was observed on the washcloths. NA-B then patted dry R43's bottom using the same soiled gloves, applied a clean incontinent product, and never removed the soiled gloves or washed their hands. Both NA-A and NA-B then applied R4's pants, shirt and adjusted the clothing at 7:29 a.m. as NA-B still wore the same soiled gloves. NA-B asked R4 how she was doing and R4 stated "tired." NA-B then told R4 "Two more turns then will leave you till breakfast" as both NAs finished adjusting the clothing. NA-B then took the basin of soiled water, dumped it in bathroom, and then washed the hands. At 7:31 a.m. NA-B had finished left room stated she was going to get R4 water left then came back briefly. On 3/8/17, at 11:09 a.m. NA-B acknowledged resident had smears when she had provided pericare and thought she should have changed her gloves. When asked what the facility policy was for hand washing and gloving NA-B asked surveyor what she thought and surveyor directed her to check with director of nursing (DON). On 3/9/17, at 3:54 p.m. the DON stated she would expected staff to remove gloves and don a clean pair before getting resident dressed if going	F 441	personal cares to prevent spread of infections based on universal precautions. New admission/re-admits will continue to receive appropriate personal cares to prevent the spread of infection based on universal precautions. Other resident's will continue to receive appropriate personal cares to prevent the spread of infections based on universal precautions. Nursing assistants will be re-educated on perineal care. Weekly audits of perineal care will be completed weekly x 4; then as needed. DNS or designee will responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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 _____	03/09/2017

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 441	Continued From page 61 to clean. The facility Infection Control - Hand Washing policy revised 3/29/16, directed staff to wash hands "After handling any soiled or contaminated equipment, cleaning cloths, utensils, dishes trays, soiled aprons or trash can lids. As often as as necessary to remove soil and contamination and to prevent cross-contamination..."	F 441		

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 _____	**03/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	**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 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 07, 2017. At the time of this survey, Golden Livingcenter Lynwood was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Golden Livingcenter Lynwood is a 1-story building with a partial basement and was determined to be of Type II (111) construction. Original year of construction was 1962 with additions being built in 1990 and in 2007 both buildings are of the same type of construction and only 1-story. The facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors and resident sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.