P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
February 9, 2022

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

RE: CCN: 245201
Cycle Start Date: January 5, 2022

Dear Administrator:

On January 18, 2022, we notified you a remedy was imposed. On February 3, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 6, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 2, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 18, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 2, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 6, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
January 18, 2022

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

RE: CCN: 245201
Cycle Start Date: January 5, 2022

Dear Administrator:

On January 5, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 2, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 2, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 2, 2022.

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by February 2, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Fridley Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 2, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING ______ B. WING ______	C 01/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/5/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H5201117C (MN79771), with a deficiency cited at F600. The following complaint was found to be UNSUBSTANTIATED: H5201116C (MN79648) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		1/6/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 01/21/2022

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

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from sexual abuse for 1 of 2 residents (R2) reviewed for sexual abuse. This resulted in psychosocial harm for R2 when she was sexually abused by R1. Findings include: A nursing home incident report (NHIR) dated 12/29/21, at 4:00 p.m. indicated R1 was observed by nursing assistant (NA)-A in R2's room with his hands down R2's gown rubbing her chest and rubbing R2's inner thighs outside of her incontinent brief. R2's Face Sheet printed 1/5/22, indicated R1's diagnosis included Alzheimer's disease and mild cognitive impairment. R2's significant change Minimum Data Set (MDS) dated 11/10/21, indicated R2 had a severe cognitive impairment, utilized a wheelchair, and required extensive assistance with activities of daily living. R2's care plan dated 12/22/21, indicated R2 was a vulnerable adult (VA) due to care planned dependencies. The care plan directed safety monitoring would be implemented as needed to ensure residents safety (i.e., 15 min checks, 1:1,	F 600	R2 discharged from facility on 1/11/2022. R1 remains on increased monitoring with no further incidents. All facility residents remain free from abuse and neglect. Staff education initiated on 1/5/2022 on Monarch Healthcare Management Abuse Prohibition/Vulnerable Adult Plan Policy and facilities procedure on increased monitoring of residents. The facility will quiz 5 staff members per week for 4 weeks, then 5 staff members per month for 2 months and then PRN to ensure staff's competency on abuse and increased monitoring of residents. The facility will interview or complete skin assessments of 5 residents per week for 4 weeks, then 4 residents per month for 2 months and then PRN to ensure residents are free from abuse. The facility will audit accuracy of increased monitoring of resident documentation on any resident(s) who are on increased monitoring weekly for 4 weeks, then monthly for 2 months and then PRN. The facility's QAPI Committee will review the updated education, revised policy and	

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F 600	Continued From page 2	F 600		

etc.), and the local Ombudsman, Adult Protection, Police, and/or state/financial agencies would be notified of any suspected abuse or financial exploitation as needed.

R1's Face Sheet printed 1/5/22, indicated R2 had diagnosis including hemiplegia and hemiparesis (muscle weakness or partial paralysis) following non-traumatic intracranial hemorrhage (brain bleed) affecting right side, and dementia.

R1's quarterly MDS dated 10/1/21, indicated R1 had a mild cognitive impairment, utilized a wheelchair, and was independent with transfers and locomotion on and off the unit. The MDS also indicated R1 had behaviors not directed towards others 1-3 days in the assessment period.

R1's care plan dated 8/28/21, indicated R1 had history of unsolicited touching of female residents and following females around. Staff interventions included educating R1 on unwanted touching of female residents, encourage R1 in activities related to interests, increased supervision for any signs of or increased risk of inappropriate behavior with female residents (i.e. stalking, inappropriate touching, invasion of privacy), re-direct R1 if found to be attempting to enter any female's room. 15 minutes checks were initiated on 7/19/21, and titrated as appropriate. Mood and behavior charting initiated 7/19/21.

On 12/29/21, at 6:34 p.m. R1's progress note indicated NA-A came out of the shower room at 3:05 p.m. and saw R1 in R2's room, with his hand down the front of her gown, rubbing her chest. NA-A immediately attempted to separate R1 from R2, but R1 would not comply. R1 continued rubbing R2's chest and her inner thighs. NA-A

Provider's plan of correction (F 600): procedure, and plan of correction and determine frequency.

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F 600	Continued From page 3	F 600		

called additional staff to the room, and staff immediately separated the two residents. R1 was escorted to his room, and the director of nursing (DON) was notified. The DON immediately ensured R2 was alone in her room with the door shut, and R1 was in his room. The DON explained to R1 his behavior was inappropriate, and R1 responded by repeatedly shaking his head and saying, "No." R1 was verbally unable to describe or talk about the incident due to dysphasia, and ability to understand impacted by diagnosis. Providers and families of R1 and R2 were updated. R1 was placed on 15-minute checks, and all clinical staff were informed to observe R1 when out of his room, especially when near R2's room. R2's door was being kept shut. Every shift mood/behavior charting was started on both residents.

R1's Physician Orders dated 12/29/21, indicated an order for 15 minute checks due to recent sexually inappropriate touching of a female resident, and mood/behavior charting while monitoring for sexually inappropriate behavior.

R1's 15 minute check documents dated 12/29/21, through 1/5/22, indicated 15-minute checks were not completed and R1 was unaccounted for on the following dates and times:
12/29/21: from 4:00 p.m. to 10:00 p.m.
12/30/21: from 12:15 a.m. to 5:45 a.m. and from 4:00 p.m. to 12:00 a.m.
12/31/21: from 12:15 a.m. to 5:45 a.m. and from 10:45 p.m. to 12:00 a.m.
1/1/22: no 15-minute check document could be located by facility.
1/2/22: no 15-minute check document could be located by facility.
1/3/22: no 15-minute check document could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 4 located by facility. 1/4/22: from 12:15 a.m. - 5:45 a.m. R1's NA task sheet printed 1/5/22, lacked indication of R1's 15-minute checks, behavior charting, or other increased supervision as outlined in R1's care plan. On 1/5/22, from 9:00 a.m. to 10:00 a.m. R1 was continuously observed propelling his wheelchair from his bedroom into the hallway outside of his room. Staff were not observed performing 15 minute checks on R1. On 1/5/21, at 9:57 a.m. NA-B was interviewed and stated she was not aware R1 required increased supervision which included 15-minute checks. NA-B stated she was not aware of any behavioral concerns for R1. NA-B stated R1 was her resident, but she was not familiar with R1 as she was supposed to be in training, but was working the floor due to staffing concerns. On 1/5/22, at 10:10 a.m. trained medication aide (TMA)-A was interviewed and stated she was not aware R1 was on 15 minute checks, and stated R1 had behaviors of "touching the women's breasts." TMA-A reviewed R1's chart and verified 15 minute checks were in place, and stated she checked R1's location when she passed his medications. TMA-A further stated the nursing assistants were supposed to complete the 15 minute checks, and would need to be told again to complete them. On 1/5/21, at 10:26 a.m. family member (FM)-A was interviewed. FM-A stated the DON had called him and stated another resident (R1) had gotten into R2's room and was rubbing R2's chest. FM-A	F 600		

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F 600	Continued From page 5 stated he was not informed R1 was also rubbing R2's inner thighs. FM-A stated he felt that behavior was an "invasion of privacy" and "almost rape." FM-A stated R2 had dementia and was not aware of what was going on, however, he felt if R2 could comprehend the situation, she would be "very upset." FM-A stated the only intervention the DON relayed was keeping R2's door closed, which was not satisfactory to him. FM-A stated the DON had not informed him they would be doing frequent checks on R1. FM-A also stated no other interventions were offered. FM-A stated he felt the family checked on R2 more frequently than the staff and had on-going safety concerns for R2 at the facility and would like alternative placement. On 1/5/21, at 10:40 a.m. registered nurse (RN)-A stated R1 was on "strict 15-minute checks" which were completed and documented by the nurses, but all staff were to "keep an eye out" for R1. RN-A stated she was not aware of any other interventions besides 15 minute checks for R1, which she stated were working. RN-A stated she was not aware of any interventions for R2 other than keeping the door to her room closed when she was in her room. On 1/5/22, at 11:02 a.m. NA-A was interviewed and stated she was the staff who had observed R1 in R2's room rubbing her chest under her clothes. NA-A stated R2 was lying in bed awake but not speaking or moving. NA-A stated she attempted to remove R1 unsuccessfully, and requested assistance from other staff who successfully separated the residents. NA-A stated interventions included keeping R2's room door closed at all times. NA-A was not aware of R1's 15 minute checks, but stated staff "have eyes on	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 6 him." NA-A stated R1 wandered at night and should not be allowed into other residents' rooms. On 1/5/21, at 12:54 p.m. the administrator stated the facility had implemented interventions which included R1 was on 15 minute checks, R1's medications were reviewed with no changes, R1 was on behavior monitoring, and the facility was seeking alternate placement for R1. The administrator stated they were unable to change R1's room as there were no open male beds. The administrator stated R2's interventions included behavior monitoring, skin check, and keeping the door to R2's room closed. The administrator stated a room change was not offered to R2. The administrator verified 15 minute checks for R1 were not being completed consistently, and stated the expectation was for staff to complete and document the checks as ordered by R1's physician. The facility Abuse Prohibition/Vulnerable Adult Plan policy revised 8/26/21, identified sexual abuse as a form of abuse. The policy indicated the investigation team will review all incident reports regarding residents including those that indicate abuse. Plans are developed and measures taken to minimize risks, and submit any reports required by the State.	F 600		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2022

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

Re: Event ID: TPW311

Dear Administrator:

The above facility survey was completed on January 5, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: ______ B. WING ______	C **01/05/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/5/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/21/22

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2 000	Continued From page 1 UNSUBSTANTIATED: H5201116C (MN79648). The following complaint was found to be SUBSTANTIATED: H5201117C (MN79771), however, NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		