Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 30, 2022

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

RE: CCN: 245201
Cycle Start Date: October 12, 2022

Dear Administrator:

On October 25, 2022, we notified you a remedy was imposed. On November 17, 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 October 28, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 9, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 25, 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 November 9, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 28, 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 Therefore, the NATCEP prohibition is rescinded.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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 30, 2022

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

Re: Reinspection Results
Event ID: ZGP912 and HKFR12

Dear Administrator:

On November 17, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 12, 2022 and October 25, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 7, 2022

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

RE: CCN: 245201
Cycle Start Date: October 12, 2022

Dear Administrator:

On October 25, 2022, we informed you of imposed enforcement remedies.

On October 25, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 9, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 9, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 9, 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.

As we notified you in our letter of October 25, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 9, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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).

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 April 12, 2023 (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.

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/ 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 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	C 10/25/2022

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 10/24/22 through 10/25/22, 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 complaint was found to be SUBSTANTIATED: H52015121C (MN87530), with a deficiency cited at F684. As a result of the investigation, additional deficiencies were cited at F623, F625, and F677 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 677	ADL Care Provided for Dependent Residents	F 677		10/28/22

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

Electronically Signed — 11/09/2022

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 677 SS=D	Continued From page 1 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R2), who were dependent on staff were toileted in accordance with the care plan. Findings include: R2's quarterly Minimal Data Set (MDS) dated 10/18/22, indicated R2's diagnosis included dementia. Further, MDS indicated R2 required extensive assistance by two staff for toileting and was always incontinent of urine. Review of nursing assistant (NA) care sheet dated 10/24/22, indicated R2 required assistance of 2 staff for toileting and check and change incontinent product every 2-3 hours. On 10/24/22, at 1:37 p.m. R2 was observed laying in bed in her room. Continuous observation until 5:26 p.m. R2 remained in the same position in her room in bed and no nursing staff were observed to assist R2 with incontinent cares every 2-3 in accordance with the care plan. On 10/24/22, at 5:28 p.m. R2 was observed in her bed. R2 stated she did not like to "bother" the nursing staff to assist with incontinent care and would wait for the nursing staff to come into her room to check on her rather than using the call light.	F 677	Resident has discharged from facility Full house audit completed to ensure all residents had a bowel and bladder assessment in the past year and that toilet plan is on care plan and NAR guide All nursing staff will be educated to the bowel and bladder policy and education regarding following NAR guides Audit- audit 5 residents weekly x 2 months to ensure toilet schedule was followed	

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F 677	Continued From page 2 On 10/24/22, at 5:37 p.m. licensed practical nurse (LPN)-B stated nursing staff have access to each resident's care plan or staff utilize the NA care guide sheets. Further, LPN-B indicated R2 required assistance of two staff for activities of daily living (ADLs) such as toileting and incontinent care every 2-4 hours. On 10/24/22, at 6:10 p.m. NA-A stated R2 required assistance of two staff for ADLs such as toileting. Further, NA-A indicated R2 was incontinent of both bowel and bladder and staff were expected to check and change incontinent brief every 2 hours. NA-A stated R2 typically alerted staff when she needed assistance, but staff were still expected to check on R2 every two hours. NA-A stated she was R2's care giver for the evening. NA-A stated she "didn't know" when the last time R2 was checked and changed but it had not been within two to three hours. In addition, NA-A stated checking and changing incontinent products timely were important to prevent skin breakdown. On 10/25/22, at 10:58 a.m. assistant director of nursing (ADON) and regional nurse consultant (RNC) stated R2 required staff assistance with incontinent cares and staff would be expected to check and change every two hours based on R2's care plan and NA care guide sheet due to R2 not being able to alert staff and make her needs known all the time. Further, ADON and RNC indicated staff were expected to follow each resident's plan of care for toileting to prevent skin breakdown and provide comfort. Review of facility policy titled Activities of Daily Living (ADLS), Supporting dated 3/18, directed	F 677		

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F 677	Continued From page 3 residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs and residents who are unable to carry out ADLS independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 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 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow physician orders to relieve urinary retention and for ureteral stent removal, failed to comprehensively assess intake and output, and failed to consistently monitor for signs and symptoms of urinary tract infection for 1 of 1 resident (R1) who had history of urinary sepsis. The deficient practice resulted in harm when R1 was re-admitted to the hospital for urinary sepsis. Findings include: R1's admission Minimal Data Set (MDS) dated 10/18/22, indicated R1 had diagnoses which included, renal failure, and urinary tract infection (UTI) (last 30 days). Further, MDS indicated R1 required extensive assist by two staff for toileting.	F 684	Resident has discharged from facility. All dictations from the past 2 months from both inhouse and outside providers have been reviewed to determine orders and to ensure they were followed. All admits/readmission orders for the past 2 months have been reviewed to ensure accuracy. Residents with DX related to urine retention care plans were updated to add risk for urinary tract infections and/or history of urinary sepsis with interventions to prevent urinary tract infections Resident with DX related to urine retention were reviewed to determine if MD wishes for specific monitoring orders All future dictation from both inhouse and	10/28/22

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F 684	Continued From page 4 R1's pain care plan dated 5/19/2021, identified R1 had a history of flank pain related to kidney stones. Corresponding interventions included directions for pain management and follow up with renal specialist for renal stone management. R1's hospital discharge summary dated 8/4/22, indicated R1 was admitted to the hospital on 7/29/22 with severe sepsis secondary to complicated urinary tract infection (UTI) due to E.Coli (type of bacteria). Further found to have obstructive left ureter stone with hydronephrosis (buildup of urine in the kidneys) Additionally noted, R1 was at a higher risk for re-hospitalization related to infections secondary to renal stones. During the hospital course R1 had a ureteroscopy with stone basketing (procedure to break up stones) and a stent was placed in the left ureter. The discharge summary included an order for staff to remove urinary foley catheter in one week. The summary also included instructions for after foley removal. R1's physician orders included order dated 8/4/22 complete infection note for UTI in progress note every shift (stop date 8/27/22) R1's care plan did not identify R1's risk for urinary tract infections and/or history of urinary sepsis nor include interventions to prevent urinary tract infections. Further the care plan did not identify R1's ureteral stent placement. Although R1's record identified ongoing vital sign monitoring it was not evident R1's urine integrity was being consistently monitored for changes or monitoring for symptoms specifically related to bladder infections (examples: frequency, urgency,	F 684	outside providers will be reviewed to ensure accuracy with orders. All future admission/readmission orders will be triple checked by a clinical leader to ensure accuracy and provide reeducation as needed All licensed nurses have been educated to the medication order policy and triple check process Clinical leadership has been educated regarding reviewing dictations. Audits are being completed for 5 residents new orders weekly x 6 weeks to determine orders were followed. Audits are being completed on all admissions/readmissions ordrers for 6 weeks to ensure accuracy and that triple checks completed Audits will be completed on 3 residents with urinary DX weekly x 6 wks to ensure monitoring is occurring	

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F 684	Continued From page 5 burning/pain during urination). R1's urology visit note dated 8/9/22, indicated visit related to follow up after URS (ureteroscopy; thin flexible scope used to treat small to medium kidney stones) for ureter stone and stent placement. The note indicated a 3 mm (millimeter) left ureter stone that was treated. Note identified R1 had large stone burden in the left kidney; stones were non-obstructing. URS and ESWL (extracorporeal shock wave lithotripsy; non-invasive treatment to break up stones) would unlikely clear the stones. Options of treatment were discussed with R1, R1 preferred observation. We will remove the ureteral stent in about 1-2 weeks. Review of R1's current physician orders printed 10/25/22, included schedule outpatient urology appointment dated 8/11/22, and schedule patient for follow up visit with urology within the next two weeks to discuss left ureteral stent removal which had an order date of 8/25/22. R1's record does not identify the appointment was scheduled nor evidence R1's stent was removed. R1's hospital discharge summary dated 8/16/22, identified R1 was admitted to the hospital on 8/11/22 for cardiac complications. R1 discharged back to the facility on 8/16/22. Discharge orders directed staff to insert straight catheter every six hours as needed for no urination or if high post void residual greater than 400 ml on bladder scan if able to use bladder scan. R1's physician orders did not identify the hospital discharge summary orders for straight catheterization or bladder scan. There was no evidence R1 was catheterized or bladder scans	F 684		

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F 684	Continued From page 6 completed according to physician's orders between 8/16/22 and 10/2/22 other than when the NP ordered. Medication administration record (MAR) identified an order on 9/1/22 to perform sterile catheterization and collect urine sample; according to the record this was not completed. R1's record was reviewed between 8/16/22 to 9/4/22 it was not evident ongoing fluid monitoring and assessments of intake and output were completed and further lacked and ongoing comprehensive bladder assessments were completed to rule out urinary retention. R1's Bladder Evaluation dated 9/4/22, identified R1 had recently had a foley catheter removed. Indicated after foley removal, R1 reported he was not always aware of urge to void or when he was incontinent of urine. The evaluation indicated R1 was on a scheduled toileting plan of check and change every 2-3 hours. The evaluation did not identify the hospital discharge instructions for straight catheterizing R1. R1's bowel and bladder care plan was revised on 9/4/22 identified R1 was incontinent of bladder with a history of BPH (benign prostate hypertrophy (enlarged prostate)). Care plan identified the findings of evaluation dated 9/4/22. Care plan identified R1 did not always have urge to void or presence of urinary incontinence. The care plan identified the follow interventions: assist 1-2 with toileting, check and change every 2-3 hours and as need, and was dependent on staff for incontinent cares. R1's care plan lacked revision to identify R4 required straight catheterization or bladder scans	F 684		

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F 684	Continued From page 7 for urinary retention management as per the hospital discharge summary. Even though the 9/4/22 bladder evaluation and the care plan identified R1 was not always aware of the urge to void, it was not evident interventions were developed or implemented to rule out urinary retention. Further R1's type of incontinence was not identified or assessed. R1's record was reviewed from 9/4/22 to 10/2/22, it was not evident ongoing fluid monitoring assessments of intake and output, and ongoing comprehensive bladder assessments were completed to rule out urinary retention. Further the record continued to lack evidence of monitoring for signs and symptoms of urinary tract infection. On 9/6/22, MAR identified an order to bladder scan one time and report results to NP. The record indicated was completed however, the results were not evident. MAR also included an order on 9/15/22 to perform catheterization for urine sample, further directed if output was greater than 450 ml to insert foley catheter. MAR identified the order was completed, corresponding progress note identified 200 ml of yellow urine was obtained. Physician visit note dated 9/21/22, indicated visit was related to abdominal discomfort. Note identified history of R1's hospitalizations and was seen by urology for left ureteral stent placement. NP-A ordered schedule R1 a follow-up visit with Urology as soon as possible to discuss left ureteral stent removal as "this was supposed to have happened BEFORE 9/6/22".	F 684		

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 10/25/2022

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

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F 684	Continued From page 8 R1's progress note dated 10/2/22, indicated R1 was found in bed having difficulty breathing and difficult to arouse. R1 was sent to the hospital. During an interview on 10/25/22, at 9:42 a.m. hospital social worker (HSW) indicated R1 was admitted to the hospital related to UTI and kidney stone. R1 had a CT scan which showed left mid ureter stone that was blocking and causing infection. R1 was bladder scanned and 750 ml of urine was obtained, and a foley catheter was placed. R1's hospital discharge summary dated 10/14/22, identified R1 was admitted to the hospital on 10/2/22. The summary indicated R1 presented with lethargy. Further identified imaging studies were concerning for left ureteral stone causing hydronephrosis an UTI. Blood cultures grew pseudomonas aeruginosa and Providencia stuartli (both types of bacteria). Urology was consulted and performed left nephrostomy tube (thin plastic tube that is passed from the back through the skin and then through the kidney to the point where the urine collects) placement on 10/4/22. On 10/24/22, at 5:37 p.m. licensed practical nurse (LPN)-B indicated R1 had a history of UTI's and had foley catheter placed for a short period of time until it was removed. LPN-B indicated staff were monitoring output while catheter was in place, but not once the catheter was removed. LPN-B indicated facility had a bladder scanner to utilize for urinary retention if needed, but does recall R1 requiring the need to be bladder scanned. On 10/25/22, at 8:51 a.m. registered nurse	F 684		

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F 684	Continued From page 9 (RN)-A indicated R1 was incontinent of bladder and was unsure how nursing staff were monitoring output of urine due to R1 wearing an incontinent brief "it was difficult to tell", but RN-A stated they were not aware of any concerns regarding change in R1's urine that would indicate a UTI or urinary retention. During an interview on 10/25/22, at 10:58 a.m. assistant director of nursing (ADON) and regional nurse consultant (RNC) stated the stent removal "never happened" due to nursing entering orders instead of HUC who sets up the appointment. ADON and RNC confirmed they were not aware R1's urology follow-up appointments were not scheduled until surveyor requested urology notes. ADON and RNC confirmed R1 had not seen urology since 8/9/22. ADON and RNC stated R1 had a ureteral stent placed to open the tubes in the kidney to allow the stone to pass. In addition, ADON and RNC confirmed R1 returned to the facility following hospitalization on 8/16/22, with orders to straight cath or bladder scan R1 every 6 hours if R1 did not urinate. ADON and RNC confirmed this order was not processed and the nursing staff were not monitoring R1's voiding as expected. When asked how staff are expected to monitor R1's output, RNC stated by following physician orders of straight cathing or bladder scanning to ensure R1's urine was not being retained and cause an infection. On 10/25/22, at 11:52 a.m. NP-A indicated NP-A seen R1 on 8/9/22, 8/23/22, and 9/21/22, and wrote orders for to schedule R1 a follow-up appointment with urology. NP-A was unsure if ureteral stent was ever removed and stated, "it was not talked about" and "I doubt it". NP-A stated R1 had orders to be seen for a follow-up	F 684		

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 684	Continued From page 10 with urology related to the risk of infection due to new placement of a ureteral stent. NP-A stated the ureteral stent could have been causing the abdominal symptoms R1 had been experiencing and there were concerns related to R1 not emptying his bladder, however R1 would be "vague" related to symptoms when asked. On 10/25/22, at 12:36 p.m. family member (FM)-A indicated R1 had orders to remove the ureteral stent but stated "it didn't happen" and facility was not monitoring R1's output as ordered. Further, FM-A stated R1 was re-admitted to the hospital on 10/2/22, for sepsis. Facility policy for transcribing physician orders was requested and not received. Review of facility policy titled Bowel and Bladder Assessment dated 3/24/22, did not address procedures for monitoring intake and output with urinary retention	F 684		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245201	A. BUILDING: _____ B. WING _____	10/25/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245201	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/25/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 2 of 2 residents (R1,R2) or resident representative, were provided a notice of transfer to the hospital.

Findings include:

R1's admission Minimal Data Set (MDS) dated 10/18/22, indicated R1's diagnoses included coronary artery disease, renal failure, and urinary tract infection in the last 30 days.

R1's record revealed R1 was hospitalized 7/29/22 through 8/4/22, 8/11/22 through 8/16/22, and 10/2/22 through 10/14/22.

Review of R1's Bed-Hold Notice for Hospital Transfer dated 8/11/22, indicated R1 was being transferred to Mercy hospital on 8/11/22 and R1 gave verbal consent, however document lacked evidence of reason for transfer to the hospital.

R2's quarterly MDS dated 10/18/22, indicated R2 had a diagnosis of dementia.

R2's record revealed R2 transferred to the emergency department on 8/5/22.

On 10/15/22, at 10:29 a.m. registered nurse (RN)-A indicated before a resident was transferred to the hospital a bed hold form was required to be signed, but RN-A was unaware of a transfer notice. Further, RN-A indicated she was not trained as an agency nurse on where the form was located at the facility.

On 10/25/22, at 10:33 a.m. licensed practical nurse (LPN)-A indicated a transfer notice must be signed by resident before a resident was transferred to the hospital. Further, LPN-A indicated if the resident at the time of transfer was unable to sign the form a verbal consent was required, and social services would follow-up with the resident or family.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245201	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/25/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 On 10/25/22, at 10:58 a.m. assistant director of nursing (ADON) and regional nurse consultant (RNC) were both unaware of a transfer notice requirement. ADON and RNC confirmed R1 and R2's record lacked evidence of a transfer notice for their hospitalizations. On 10/25/22, administrator confirmed a transfer notice was not completed for R1's transfer to the hospital on 7/29/22 and 10/2/22. On 10/26/22, at 4:08 p.m. administrator confirmed a transfer notice was not completed for R2's transfer to the hospital on 8/5/22. Review of facility policy titled Transfer or Discharge, Emergency dated 8/18, direct staff to prepare a transfer form to send with the resident if necessary to make an emergency transfer or discharge to a hospital.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written copy of the bed hold policy for 2 of 2 residents (R1, R2) who were transferred to the hospital. Findings include: R1's admission Minimal Data Set (MDS) dated 10/18/22, indicated R1's diagnoses included coronary artery disease, renal failure, and urinary tract infection in the last 30 days.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245201	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/25/2022

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 3

R1's record revealed R1 was hospitalized 7/29/22 through 8/4/22, 8/11/22 through 8/16/22, and 10/2/22 through 10/14/22.

R2's quarterly MDS dated 10/18/22, indicated R2 had a diagnosis of dementia.

R2's record revealed R2 transferred to the emergency department on 8/5/22.

On 10/15/22, at 10:29 a.m. registered nurse (RN)-A indicated before a resident was transferred to the hospital a bed hold form was required to be signed. Further, RN-A indicated she was not trained as an agency nurse on where the forms were located at the facility.

On 10/25/22, at 10:33 a.m. licensed practical nurse (LPN)-A indicated a bed hold form must be signed by resident before a resident was transferred to the hospital. Further, LPN-A indicated if the resident at the time of transfer was unable to sign the form a verbal consent was required, and social services would follow-up with the resident or family.

On 10/25/22, at 10:58 a.m. assistant director of nursing (ADON) and regional nurse consultant (RNC) indicated when a resident was transferred to the hospital, a bed form document must be completed with either the resident or their representative. Further, ADON and RNC indicated if the resident at the time of transfer to the hospital was unresponsive, the facility staff would need to follow up with the resident or representative the next day to complete the bed hold form. ADON and RNC confirmed R1 and R2's record lacked evidence of a bed hold for their hospitalizations.

On 10/25/22, administrator confirmed a bed hold notice was not completed for R1's transfer to the hospital on 7/29/22 and 10/2/22.

On 10/26/22, at 4:08 p.m. administrator confirmed a bed hold notice was not completed for R2's transfer to the hospital on 8/5/22.

Review of facility policy titled Bed-Holds and Returns dated 3/17, indicated prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: the right and limitations of the resident regarding bed holds, the reserve bed payment policy as indicated by the stat plan; the facility per diem rate required to hole a bed or to hold a bed beyond the state bed hold person, and the details of the transfer.

Electronically delivered
November 7, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: HKFR11

Dear Administrator:

The above facility was surveyed on October 24, 2022 through October 25, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	C 10/25/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/24/22 through 10/25/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H52015121C (MN87530) with a licensing orders issued at 0830 and 0920. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow physician orders to relieve urinary retention and for ureteral stent removal, failed to comprehensively assess intake and output, and failed to consistently monitor for signs and symptoms of urinary tract infection for 1 of 1 resident (R1) who had history of urinary sepsis. The deficient practice resulted in harm when R1 was re-admitted to the hospital for urinary sepsis.	2 830	Corrected	10/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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2 830	Continued From page 3 Findings include: R1's admission Minimal Data Set (MDS) dated 10/18/22, indicated R1 had diagnoses which included, renal failure, and urinary tract infection (UTI) (last 30 days). Further, MDS indicated R1 required extensive assist by two staff for toileting. R1's pain care plan dated 5/19/2021, identified R1 had a history of flank pain related to kidney stones. Corresponding interventions included directions for pain management and follow up with renal specialist for renal stone management. R1's hospital discharge summary dated 8/4/22, indicated R1 was admitted to the hospital on 7/29/22 with severe sepsis secondary to complicated urinary tract infection (UTI) due to E.Coli (type of bacteria). Further found to have obstructive left ureter stone with hydronephrosis (buildup of urine in the kidneys) Additionally noted, R1 was at a higher risk for re-hospitalization related to infections secondary to renal stones. During the hospital course R1 had a ureteroscopy with stone basketing (procedure to break up stones) and a stent was placed in the left ureter. The discharge summary included an order for staff to remove urinary foley catheter in one week. The summary also included instructions for after foley removal. R1's physician orders included order dated 8/4/22 complete infection note for UTI in progress note every shift (stop date 8/27/22) R1's care plan did not identify R1's risk for urinary tract infections and/or history of urinary sepsis nor include interventions to prevent urinary tract infections. Further the care plan did not identify	2 830		

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2 830	Continued From page 4 R1's ureteral stent placement. Although R1's record identified ongoing vital sign monitoring it was not evident R1's urine integrity was being consistently monitored for changes or monitoring for symptoms specifically related to bladder infections (examples: frequency, urgency, burning/pain during urination). R1's urology visit note dated 8/9/22, indicated visit related to follow up after URS (ureteroscopy; thin flexible scope used to treat small to medium kidney stones) for ureter stone and stent placement. The note indicated a 3 mm (millimeter) left ureter stone that was treated. Note identified R1 had large stone burden in the left kidney; stones were non-obstructing. URS and ESWL (extracorporeal shock wave lithotripsy; non-invasive treatment to break up stones) would unlikely clear the stones. Options of treatment were discussed with R1, R1 preferred observation. We will remove the ureteral stent in about 1-2 weeks. Review of R1's current physician orders printed 10/25/22, included schedule outpatient urology appointment dated 8/11/22, and schedule patient for follow up visit with urology within the next two weeks to discuss left ureteral stent removal which had an order date of 8/25/22. R1's record does not identify the appointment was scheduled nor evidence R1's stent was removed. R1's hospital discharge summary dated 8/16/22, identified R1 was admitted to the hospital on 8/11/22 for cardiac complications. R1 discharged back to the facility on 8/16/22. Discharge orders directed staff to insert straight catheter every six hours as needed for no urination or if high post void residual greater than 400 ml on bladder scan	2 830		

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2 830	Continued From page 5 if able to use bladder scan. R1's physician orders did not identify the hospital discharge summary orders for straight catheterization or bladder scan. There was no evidence R1 was catheterized or bladder scans completed according to physician's orders between 8/16/22 and 10/2/22 other than when the NP ordered. Medication administration record (MAR) identified an order on 9/1/22 to perform sterile catheterization and collect urine sample; according to the record this was not completed. R1's record was reviewed between 8/16/22 to 9/4/22 it was not evident ongoing fluid monitoring and assessments of intake and output were completed and further lacked and ongoing comprehensive bladder assessments were completed to rule out urinary retention. R1's Bladder Evaluation dated 9/4/22, identified R1 had recently had a foley catheter removed. Indicated after foley removal, R1 reported he was not always aware of urge to void or when he was incontinent of urine. The evaluation indicated R1 was on a scheduled toileting plan of check and change every 2-3 hours. The evaluation did not identify the hospital discharge instructions for straight catheterizing R1. R1's bowel and bladder care plan was revised on 9/4/22 identified R1 was incontinent of bladder with a history of BPH (benign prostate hypertrophy (enlarged prostate)). Care plan identified the findings of evaluation dated 9/4/22. Care plan identified R1 did not always have urge to void or presence of urinary incontinence. The care plan identified the follow interventions: assist 1-2 with toileting, check and change every 2-3	2 830		

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2 830	Continued From page 6 hours and as need, and was dependent on staff for incontinent cares. R1's care plan lacked revision to identify R4 required straight catheterization or bladder scans for urinary retention management as per the hospital discharge summary. Even though the 9/4/22 bladder evaluation and the care plan identified R1 was not always aware of the urge to void, it was not evident interventions were developed or implemented to rule out urinary retention. Further R1's type of incontinence was not identified or assessed. R1's record was reviewed from 9/4/22 to 10/2/22, it was not evident ongoing fluid monitoring assessments of intake and output, and ongoing comprehensive bladder assessments were completed to rule out urinary retention. Further the record continued to lack evidence of monitoring for signs and symptoms of urinary tract infection. On 9/6/22, MAR identified an order to bladder scan one time and report results to NP. The record indicated was completed however, the results were not evident. MAR also included an order on 9/15/22 to perform catheterization for urine sample, further directed if output was greater than 450 ml to insert foley catheter. MAR identified the order was completed however, output was not reflected on MAR. Physician visit note dated 9/21/22, indicated visit was related to abdominal discomfort. Note identified history of R1's hospitalizations and was seen by urology for left ureteral stent placement. NP-A ordered schedule R1 a follow-up visit with Urology as soon as possible to discuss left	2 830		

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2 830	Continued From page 7 ureteral stent removal as "this was supposed to have happened BEFORE 9/6/22". R1's progress note dated 10/2/22, indicated R1 was found in bed having difficulty breathing and difficult to arouse. R1 was sent to the hospital. During an interview on 10/25/22, at 9:42 a.m. hospital social worker (HSW) indicated R1 was admitted to the hospital related to UTI and kidney stone. R1 had a CT scan which showed left mid ureter stone that was blocking and causing infection. R1 was bladder scanned and 750 ml of urine was obtained, and a foley catheter was placed. R1's hospital discharge summary dated 10/14/22, identified R1 was admitted to the hospital on 10/2/22. The summary indicated R1 presented with lethargy. Further identified imaging studies were concerning for left ureteral stone causing hydronephrosis an UTI. Blood cultures grew pseudomonas aeruginosa and Providencia stuartli (both types of bacteria). Urology was consulted and performed left nephrostomy tube (thin plastic tube that is passed from the back through the skin and then through the kidney to the point where the urine collects) placement on 10/4/22. On 10/24/22, at 5:37 p.m. licensed practical nurse (LPN)-B indicated R1 had a history of UTI's and had foley catheter placed for a short period of time until it was removed. LPN-B indicated staff were monitoring output while catheter was in place, but not once the catheter was removed. LPN-B indicated facility had a bladder scanner to utilize for urinary retention if needed, but does recall R1 requiring the need to be bladder scanned.	2 830		

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2 830	Continued From page 8 On 10/25/22, at 8:51 a.m. registered nurse (RN)-A indicated R1 was incontinent of bladder and was unsure how nursing staff were monitoring output of urine due to R1 wearing an incontinent brief "it was difficult to tell", but RN-A stated they were not aware of any concerns regarding change in R1's urine that would indicate a UTI or urinary retention. During an interview on 10/25/22, at 10:58 a.m. assistant director of nursing (ADON) and regional nurse consultant (RNC) stated the stent removal "never happened" due to nursing entering orders instead of HUC who sets up the appointment. ADON and RNC confirmed they were not aware R1's urology follow-up appointments were not scheduled until surveyor requested urology notes. ADON and RNC confirmed R1 had not seen urology since 8/9/22. ADON and RNC stated R1 had a ureteral stent placed to open the tubes in the kidney to allow the stone to pass. In addition, ADON and RNC confirmed R1 returned to the facility following hospitalization on 8/16/22, with orders to straight cath or bladder scan R1 every 6 hours if R1 did not urinate. ADON and RNC confirmed this order was not processed and the nursing staff were not monitoring R1's voiding as expected. When asked how staff are expected to monitor R1's output, RNC stated by following physician orders of straight cathing or bladder scanning to ensure R1's urine was not being retained and cause an infection. On 10/25/22, at 11:52 a.m. NP-A indicated NP-A seen R1 on 8/9/22, 8/23/22, and 9/21/22, and wrote orders for to schedule R1 a follow-up appointment with urology. NP-A was unsure if ureteral stent was ever removed and stated, "it was not talked about" and "I doubt it". NP-A	2 830		

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2 830	Continued From page 9 stated R1 had orders to be seen for a follow-up with urology related to the risk of infection due to new placement of a ureteral stent. NP-A stated the ureteral stent could have been causing the abdominal symptoms R1 had been experiencing and there were concerns related to R1 not emptying his bladder, however R1 would be "vague" related to symptoms when asked. On 10/25/22, at 12:36 p.m. family member (FM)-A indicated R1 had orders to remove the ureteral stent but stated "it didn't happen" and facility was not monitoring R1's output as ordered. Further, FM-A stated R1 was re-admitted to the hospital on 10/2/22, for sepsis. Facility policy for transcribing physician orders was requested and not received. Review of facility policy titled Bowel and Bladder Assessment dated 3/24/22, did not address procedures for monitoring intake and output with urinary retention SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review protocals for urinary retention and hospital admission orders. DON/designee could then provide education on protocals for assessments and monitoring for urinary retention as well as UTI's. In addition provide education on ensuring appointments are not missed. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure	2 830		

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2 830	Continued From page 10 compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R2), who were dependent on staff were toileted in accordance with the care plan. Findings include: R2's quarterly Minimal Data Set (MDS) dated 10/18/22, indicated R2's diagnosis included dementia. Further, MDS indicated R2 required extensive assistance by two staff for toileting and was always incontinent of urine. Review of nursing assistant (NA) care sheet dated 10/24/22, indicated R2 required assistance of 2 staff for toileting and check and change incontinent product every 2-3 hours. On 10/24/22, at 1:37 p.m. R2 was observed laying in bed in her room. Continuous observation until 5:26 p.m. R2 remained in the same position	2 920	Corrected	10/28/22

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2 920	Continued From page 11 in her room in bed and no nursing staff were observed to assist R2 with incontinent cares every 2-3 in accordance with the care plan. On 10/24/22, at 5:28 p.m. R2 was observed in her bed. R2 stated she did not like to "bother" the nursing staff to assist with incontinent care and would wait for the nursing staff to come into her room to check on her rather than using the call light. On 10/24/22, at 5:37 p.m. licensed practical nurse (LPN)-B stated nursing staff have access to each resident's care plan or staff utilize the NA care guide sheets. Further, LPN-B indicated R2 required assistance of two staff for activities of daily living (ADLs) such as toileting and incontinent care every 2-4 hours. On 10/24/22, at 6:10 p.m. NA-A stated R2 required assistance of two staff for ADLs such as toileting. Further, NA-A indicated R2 was incontinent of both bowel and bladder and staff were expected to check and change incontinent brief every 2 hours. NA-A stated R2 typically alerted staff when she needed assistance, but staff were still expected to check on R2 every two hours. NA-A stated she was R2's care giver for the evening. NA-A stated she "didn't know" when the last time R2 was checked and changed but it had not been within two to three hours. In addition, NA-A stated checking and changing incontinent products timely were important to prevent skin breakdown. On 10/25/22, at 10:58 a.m. assistant director of nursing (ADON) and regional nurse consultant (RNC) stated R2 required staff assistance with incontinent cares and staff would be expected to check and change every two hours based on R2's	2 920		

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2 920	Continued From page 12 care plan and NA care guide sheet due to R2 not being able to alert staff and make her needs known all the time. Further, ADON and RNC indicated staff were expected to follow each resident's plan of care for toileting to prevent skin breakdown and provide comfort. Review of facility policy titled Activities of Daily Living (ADLS), Supporting dated 3/18, directed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs and residents who are unable to carry out ADLS independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		