



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 17, 2025

Administrator
The Estates at Fridley LLC
5700 EAST RIVER ROAD
FRIDLEY, MN 55432

RE: CCN: 245201
Cycle Start Date: November 6, 2025

Dear Administrator:

On November 6, 2025, we notified you a remedy was imposed.

On December 9, 2025, the Minnesota Departments of Health completed a final revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 28, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 21, 2025, be discontinued as of November 28, 2025. (42 CFR 488.417 (b))

In our letter of November 6, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 21, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Holly Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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December 17, 2025

Administrator

The Estates at Fridley LLC

5700 EAST RIVER ROAD

FRIDLEY, MN 55432

Re: Reinspection Results

Event ID: 1D8631-H2

Dear Administrator:

On December 2, 2025, 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 survey completed on October 2, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 26, 2025

Administrator
The Estates at Fridley LLC
5700 EAST RIVER ROAD
FRIDLEY, MN 55432

RE: CCN: 245201

Cycle Start Date: October 27, 2025

Dear Administrator:

On November 6, 2025, we informed you of imposed enforcement remedies.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 21, 2025.
- Civil money penalty. (42 CFR 488.430 through 488.444)

On November 26, 2025, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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 21, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 21, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 21, 2025.

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 November 6, 2025, 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 21, 2025.

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:

Annette Winters, Regional Supervisor Federal RR

**Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558**

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 27, 2026 (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
202-795-7490

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 at (312) 353-1502.

Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/>

[form/NHDisputeResolution](#)

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Electronically delivered

November 26, 2025

Administrator
The Estates at Fridley LLC
5700 EAST RIVER ROAD
FRIDLEY, MN 55432

Re: State Nursing Home Licensing Orders

Event ID: 1D8631-H1

Dear Administrator:

The above facility survey was completed on November 26, 2025, 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 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:

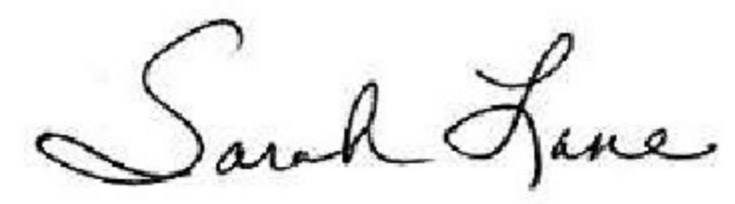
Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Fridley LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD , FRIDLEY, Minnesota, 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
F0000	<p>INITIAL COMMENTS</p> <p>From 9/30/25 to 10/2/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H52015282C (2630032) with no deficiencies issued.</p> <p>However, as a result of the investigation deficiencies were issued at F656 and F842.</p> <p>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.</p> <p>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.</p>	F0000		
F0656 SS = D	<p>Develop/Implement Comprehensive Care Plan</p> <p>CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p>	F0656	<p>Immediate Corrective Action:</p> <p>R1 discharged from the facility on 9/26/25.</p> <p>Corrective Action as it applies to others:</p> <p>All other residents who are at risk for elopement and/or are on civil commitment were reviewed to ensure that their care plans reflect this risk for elopement and civil commitment. Current interventions were reviewed and updated as needed.</p> <p>Education was provided to the IDT team regarding care planning of risk for elopement and civil commitment and to ensure proper interventions were placed on resident's care plan.</p>	11/28/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER The Estates at Fridley LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD , FRIDLEY, Minnesota, 55432	
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F0656 SS = D	<p>Continued from page 1</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure the comprehensive care plan was updated to ensure elopement risk and civil commitment were identified, and appropriate interventions were developed for 1 of 3 residents (R1) reviewed.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 9/23/25 indicated moderate cognitive impairment and diagnoses that included Wernicke's encephalopathy (an acute neurological disorder with symptoms that include difficulty moving and confusion), alcoholic cirrhosis (liver damage) of the liver, and alcoholism not in remission.</p>	F0656	<p>Continued from page 1</p> <p>Recurrence will be prevented by:</p> <p>Director of nursing and/or designee will complete audits of 3 resident's who are at risk for elopement and/or are on civil commitment weekly x 4 weeks to ensure elopement risk, civil commitment, and interventions are placed on the resident's care plan. The results will be shared with QAPI input on the need to increase, decrease or discontinue the audits.</p> <p>Correction date: 11/28/2025</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025
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F0656 SS = D	<p>Continued from page 2</p> <p>R1's Elopement Risk Assessment dated 9/17/25, indicated a score of 4. The assessment indicated an elopement risk based on the nurse's assessment. The assessment further indicated with a risk score of 4 or greater, the facility should develop a care plan related to elopement risk.</p> <p>R1's progress note dated 9/19/25 at 9:03 a.m., indicated R1 was on a civil commitment.</p> <p>R1's care plan reviewed on 10/3/25 lacked information or staff direction related to R1's elopement risk and civil commitment.</p> <p>During an interview on 10/1/25 at 10:52 a.m., social services designee (SSD)-A acknowledged R1 was on a civil commitment and indicated she uploaded court documents on 9/25/25 when she received them by e-fax. The SSD-A stated R1's commitment was through May 21, 2026, and the recommendations in the commitment were for R1 to continue psychiatric treatment because R1 was a significant danger to himself, was chemically dependent, and not safe to live at home alone. The SSD-A acknowledged R1 did not have a care plan related to the commitment but should have.</p> <p>During an interview on 10/1/25 at 11:42 a.m., registered nurse (RN)-A stated R1 did not have care plan interventions related to elopement or civil commitment, but should have, and further stated it was not her job to develop the care plan.</p> <p>During an interview on 10/1/25 at 2:30 p.m., the director of nursing (DON) acknowledged R1's care plan lacked focus areas for elopement and civil commitment, but both should have been included in R1's care plan. The DON stated the care plan was used to direct staff on how to care for the resident, and staff would not have known their responsibilities for either focus area.</p> <p>The Elopement Policy dated 6/23, indicated upon admission, each resident was assessed to establish elopement risk. Documentation should include a care plan that addressed potential to wander or exit the facility and measures taken to prevent elopement.</p>	F0656		

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F0656 SS = D	Continued from page 3	F0656		
F0842 SS = D	<p>A policy for civil commitment was requested and not provided.</p> <p>Resident Records - Identifiable Information</p> <p>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information.</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records.</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,</p>	F0842	<p>Immediate corrective action taken:</p> <p>R1 discharged from the facility on 9/26/25. R3 discharged from the facility on 10/30/25.</p> <p>Corrective Action as it applies to others:</p> <p>All other residents' elopement assessments were reviewed for accuracy to ensure that all risk factors were documented appropriately. Elopement assessments were updated as needed and care plans updated to reflect risk if appropriate.</p> <p>Education initiated to all nurses regarding the completion of the elopement assessment and documenting risks accurately.</p> <p>Recurrence will be prevented by:</p> <p>Director of nursing and/or designee will complete weekly audits of 5 elopement assessments to ensure risk factors are documented appropriately x 4 weeks. Facility will ensure all new admission elopement assessments are completed accurately. The results will be shared with QAPI input on the need to increase, decrease or discontinue the audits.</p> <p>Correction date: 11/28/2025</p>	11/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Fridley LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD , FRIDLEY, Minnesota, 55432	
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F0842 SS = D	<p>Continued from page 4 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to accurately document risk factors on an elopement assessment for 2 of 3 residents (R1, R3).</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 9/23/25, indicated moderate cognitive impairment and diagnoses that included Wernicke's encephalopathy (an acute</p>	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025
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F0842 SS = D	<p>Continued from page 5 neurological disorder with symptoms that include difficulty moving and confusion), alcoholic cirrhosis (liver damage) of the liver, and alcoholism not in remission.</p> <p>R1's orders dated 9/17/25, indicated quetiapine fumarate (antipsychotic medication used to treat mental health conditions) oral tablet and 25 milligrams (mg) at bedtime.</p> <p>R1's Elopement Risk Assessment dated 9/17/25, indicated two risk areas: 1. Ambulatory or ability to self-propel a wheelchair and 2. Resident was asking to go home. Based on Assessment scale, that would have indicated a score of two, but was documented as a score of four. The assessment also included point for risk factors for prescribed antipsychotic medications and cognitive deficits, which were not indicated but should have been. Those indications would have increased the score to four, accurately assessing R1 to be at risk for elopement.</p> <p>R1's care plan reviewed on 10/3/25 lacked information or staff direction related to R1's elopement risk.</p> <p>R1's progress note dated 9/27/25 at 2:05 p.m., written by registered nurse (RN)-A indicated R1 was on LOA, and further indicated vital signs from a previous day, resident was alert and oriented, was free of signs and symptoms of SOB [shortness of breath], no swallowing difficulties, mood indicators, or behaviors observed.</p> <p>R1's progress note dated 9/27/25 at 11:13 p.m., indicated R1 was still on LOA.</p> <p>During an interview on 10/1/25 at 11:42 a.m., RN-A acknowledge she completed R1's Elopement Risk Assessment on 9/17/25. RN-A reviewed the assessment and stated if the assessment indicated a score of 4, the resident was at risk for elopement, and she had not accurately completed the assessment.</p> <p>R3's admission MDS dated 9/22/25, indicated R3 admitted on 9/16/25, with intact cognition and diagnoses that included hepatic (liver) encephalopathy, cachexia (great muscle and weight loss), alcoholic cirrhosis of liver with ascites (abdominal swelling caused by</p>	F0842		

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F0842 SS = D	<p>Continued from page 6 accumulation of fluid), chronic hepatic failure, adult failure to thrive, depression, and alcohol abuse in remission.</p> <p>R3's orders dated 9/16/25, indicated quetiapine fumarate oral tablet, 25 milligrams (mg) at bedtime.</p> <p>R3's Elopement Risk Assessment dated 9/16/25, indicated a score of one because the resident was ambulatory. The Elopement Risk assessment failed to indicated the resident had confusion due to hepatic encephalopathy and was taking a psychotropic medication (drugs that affect the mind, emotions, and behavior). This would have indicated a score of three, instead of one, on the assessment for R3. No care plan intervention needed.</p> <p>During a subsequent interview on 10/2/25 at 10:21 a.m., RN-A acknowledged she completed R3's Elopement Risk Assessment on 9/16/25, RN-A further acknowledge R3 did have confusion due to hepatic encephalopathy and was prescribed an antipsychotic medication and should have checked those risk factors on the assessment. RN-A stated she does not usually look at the diagnosis list and medication list when completing the Elopement Risk Assessment but should. RN-A further acknowledged she did not complete R3's Elopement Risk Assessment accurately.</p> <p>During an interview on 10/1/25 at 2:30 p.m., the director of nursing acknowledged both R1 and R3's Elopement Risk Assessments were completed inaccurately and should have included elopement risk points for cognitive deficits and antipsychotics medications. The DON stated it was the expectation the nurses would review diagnoses and medication list when completing the assessment. Additionally, the DON stated R1 should not have documented progress notes when R1 was on LOA, and the assessment completed by RN-A was not accurate.</p> <p>The Elopement Policy dated 6/23 indicated upon admission, each resident is assessed to establish elopement risk, and is reassessed quarterly, annually, and as needed due to significant changes. For residents at risk of elopement documentation should include a care plan that addresses potential to wander or exit the facility and the measures taken to prevent wandering/elopement.</p>	F0842		

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F0842 SS = D	Continued from page 7 A policy for skilled charting was requested and not provided.	F0842		

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>From 9/30/25 to 10/2/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order were issued.</p> <p>The following complaint was reviewed: H52015282C (2630032) with licensing orders issued at 0565 and 0695.</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
20565	<p>Comprehensive Plan of Care; Use</p> <p>CFR(s): MN Rule 4658.0405 Subp. 3</p> <p>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure the comprehensive care plan was updated to ensure elopement risk and civil commitment were identified, and appropriate interventions were developed for 1 of 3 residents (R1) reviewed.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 9/23/25 indicated moderate cognitive impairment and diagnoses that included Wernicke's encephalopathy (an acute neurological disorder with symptoms that include difficulty moving and confusion), alcoholic cirrhosis (liver damage) of the liver, and alcoholism not in remission.</p> <p>R1's Elopement Risk Assessment dated 9/17/25, indicated a score of 4. The assessment indicated an elopement risk based on the nurse's assessment. The assessment further indicated with a risk score of 4 or greater, the facility should develop a care plan related to elopement risk.</p> <p>R1's progress note dated 9/19/25 at 9:03 a.m., indicated R1 was on a civil commitment.</p> <p>R1's care plan reviewed on 10/3/25 lacked information or staff direction related to R1's elopement risk and civil commitment.</p> <p>During an interview on 10/1/25 at 10:52 a.m., social services designee (SSD)-A acknowledged R1 was on a civil commitment and indicated she uploaded court documents on 9/25/25 when she received them by e-fax. The SSD-A stated R1's commitment was through May 21, 2026, and the recommendations in the commitment were</p>	20565		11/28/2025

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20565	<p>Continued from page 2 for R1 to continue psychiatric treatment because R1 was a significant danger to himself, was chemically dependent, and not safe to live at home alone. The SSD-A acknowledged R1 did not have a care plan related to the commitment but should have.</p> <p>During an interview on 10/1/25 at 11:42 a.m., registered nurse (RN)-A stated R1 did not have care plan interventions related to elopement or civil commitment, but should have, and further stated it was not her job to develop the care plan.</p> <p>During an interview on 10/1/25 at 2:30 p.m., the director of nursing (DON) acknowledged R1's care plan lacked focus areas for elopement and civil commitment, but both should have been included in R1's care plan. The DON stated the care plan was used to direct staff on how to care for the resident, and staff would not have known their responsibilities for either focus area.</p> <p>The Elopement Policy dated 6/23, indicated upon admission, each resident was assessed to establish elopement risk. Documentation should include a care plan that addressed potential to wander or exit the facility and measures taken to prevent elopement.</p> <p>A policy for civil commitment was requested and not provided.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care appropriate care plan focus areas are initiated and followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days.</p>	20565		
20625	<p>Clinical Record Contents; In General</p> <p>CFR(s): MN Rule 4658.0450 Subp. 1 A-P</p> <p>Subpart 1. In general. Each resident's clinical record,</p>	20625		11/28/2025

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20625	Continued from page 3 including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite;	20625		

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20625	<p>Continued from page 4</p> <p>O. pertinent factors regarding changes in the resident's general conditions; and</p> <p>P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to accurately document risk factors on an elopement assessment for 2 of 3 residents (R1, R3).</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 9/23/25, indicated moderate cognitive impairment and diagnoses that included Wernicke's encephalopathy (an acute neurological disorder with symptoms that include difficulty moving and confusion), alcoholic cirrhosis (liver damage) of the liver, and alcoholism not in remission.</p> <p>R1's orders dated 9/17/25, indicated quetiapine fumarate (antipsychotic medication used to treat mental health conditions) oral tablet and 25 milligrams (mg) at bedtime.</p> <p>R1's Elopement Risk Assessment dated 9/17/25, indicated two risk areas: 1. Ambulatory or ability to self-propel a wheelchair and 2. Resident was asking to go home. Based on Assessment scale, that would have indicated a score of two, but was documented as a score of four. The assessment also included point for risk factors for prescribed antipsychotic medications and cognitive deficits, which were not indicated but should have been. Those indications would have increased the score to four, accurately assessing R1 to be at risk for elopement.</p> <p>R1's care plan reviewed on 10/3/25 lacked information or staff direction related to R1's elopement risk.</p> <p>R1's progress note dated 9/27/25 at 2:05 p.m., written by registered nurse (RN)-A indicated R1 was on LOA, and further indicated vital signs from a previous day,</p>	20625		

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20625	<p>Continued from page 5 resident was alert and oriented, was free of signs and symptoms of SOB [shortness of breath], no swallowing difficulties, mood indicators, or behaviors observed.</p> <p>R1's progress note dated 9/27/25 at 11:13 p.m., indicated R1 was still on LOA.</p> <p>During an interview on 10/1/25 at 11:42 a.m., RN-A acknowledge she completed R1's Elopement Risk Assessment on 9/17/25. RN-A reviewed the assessment and stated if the assessment indicated a score of 4, the resident was at risk for elopement, and she had not accurately completed the assessment.</p> <p>R3's admission MDS dated 9/22/25, indicated R3 admitted on 9/16/25, with intact cognition and diagnoses that included hepatic (liver) encephalopathy, cachexia (great muscle and weight loss), alcoholic cirrhosis of liver with ascites (abdominal swelling caused by accumulation of fluid), chronic hepatic failure, adult failure to thrive, depression, and alcohol abuse in remission.</p> <p>R3's orders dated 9/16/25, indicated quetiapine fumarate oral tablet, 25 milligrams (mg) at bedtime.</p> <p>R3's Elopement Risk Assessment dated 9/16/25, indicated a score of one because the resident was ambulatory. The Elopement Risk assessment failed to indicated the resident had confusion due to hepatic encephalopathy and was taking a psychotropic medication (drugs that affect the mind, emotions, and behavior). This would have indicated a score of three, instead of one, on the assessment for R3. No care plan intervention needed.</p> <p>During a subsequent interview on 10/2/25 at 10:21 a.m., RN-A acknowledged she completed R3's Elopement Risk Assessment on 9/16/25, RN-A further acknowledge R3 did have confusion due to hepatic encephalopathy and was prescribed an antipsychotic medication and should have checked those risk factors on the assessment. RN-A stated she does not usually look at the diagnosis list and medication list when completing the Elopement Risk Assessment but should. RN-A further acknowledged she did not complete R3's Elopement Risk Assessment accurately.</p>	20625		

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20625	<p>Continued from page 6</p> <p>During an interview on 10/1/25 at 2:30 p.m., the director of nursing acknowledged both R1 and R3's Elopement Risk Assessments were completed inaccurately and should have included elopement risk points for cognitive deficits and antipsychotics medications. The DON stated it was the expectation the nurses would review diagnoses and medication list when completing the assessment. Additionally, the DON stated R1 should not have documented progress notes when R1 was on LOA, and the assessment completed by RN-A was not accurate.</p> <p>The Elopement Policy dated 6/23 indicated upon admission, each resident is assessed to establish elopement risk, and is reassessed quarterly, annually, and as needed due to significant changes. For residents at risk of elopement documentation should include a care plan that addresses potential to wander or exit the facility and the measures taken to prevent wandering/elopement.</p> <p>A policy for skilled charting was requested and not provided.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The Director of Nursing or designee person could review policies and procedures and provide education for accurately documenting resident information on resident assessments, and about accuracy of documentation requirements. The DON or designee could revise as necessary, educate staff on revisions, and monitor to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: twenty-one (21) days.</p>	20625		