



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 6, 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 October 27, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 21, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates at Fridley LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 21, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
 Health Regulation Division
 Minnesota Department of Health
 625 Robert Street N
 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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by **April 27, 2026**, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201

202-795-7490

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,

A handwritten signature in black ink that reads "H. Zahler". The signature is written in a cursive, flowing style.

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

An equal opportunity employer.



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November 6, 2025

Administrator

The Estates at Fridley, LLC
5700 East River Road
Fridley, MN 55432

Re: Event ID: 1D9D56-H1

Dear Administrator:

The above facility survey was completed on October 27, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black 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

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 10/27/2025
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>On 10/23/25 – 10/27/25 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 complaints were reviewed. H52016306C / MN2649682 with deficiencies issued at F600 and F742</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		
F0600 SS = G	<p>Free from Abuse and Neglect</p> <p>CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p>	F0600	<p>Immediate Corrective Action:</p> <p>R1 remains a current resident. R1 was moved to a private room and placed on 1:1s. R1 on monitoring per shift for signs and symptoms of substance use. R1 was offered ACP. R1 provider was notified of current mental health and substance abuse changes. R1's substance abuse policy reviewed, smoking assessment, risk vs benefit for substance abuse, LOA policy, trauma questionnaire, and care plans reassessed and updated.</p> <p>R2 remains a current resident. R2 was moved to a different wing next to the nurse's station. R2's provider was notified. R2 was offered to relocate to another facility. R2 was offered ACP. R2's care plan was updated.</p> <p>Corrective Action as it applies to others:</p> <p>Substance use policy and abuse/vulnerable adult policy</p>	11/20/2025

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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F0600 SS = G	<p>Continued from page 1 This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was free from abuse for 1 of 3 residents (R2) reviewed when the facility did not evaluate the effectiveness of R1's interventions for mental health needs. R1 entered R2's room and physically pushed him over backwards in his wheelchair, then attempted to throw the wheelchair at R2 before staff intervened. R1 displayed an outward change in condition on 10/13/25, went to the hospital on 10/15/25, and R1 called the police on 10/21/25 prior to the incident with R2. R1 had exhibited drug induced psychosis from recreational methamphetamine use in days leading up to the abuse. R2 was fearful of living with R1 in the facility.</p> <p>Findings include:</p> <p>R1's care plan dated 3/24/25 indicated R1 had a history and diagnosis of substance abuse: alcohol use. R1's interventions on 3/24/25 were education on the substance abuse policy and staff was to monitor and check vitals of resident if he was found under the influence. On 10/16/25 the following interventions were added: Monitor resident for intoxication or impairment. Provider notified of substance use while at the facility. When R1 was noted to have been smoking illegal substances like Marijuana, using cocaine or methamphetamine, etc. or was intoxicated (unsteady gait, slurred speech, pinpoint pupils etc. do not administer any medications - update the provider for more directions.</p> <p>R2's care plan dated 7/25/25 indicated R2 had altercations in mood and behavior due to new placement in a skilled facility. R2 had a diagnosis of traumatic subdural hemorrhage with loss of consciousness (bleeding in the brain). R2's interventions were to monitor and document mood state/behaviors upon occurrence. Redirect R2 as needed. Provide emotional support, validation and comfort measures as needed.</p> <p>R2's significant change Minimum Data Set (MDS) dated 8/27/25 indicated R2 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R2 was cognitively impaired. R2 required supervision with toileting, dressing, and personal hygiene. R2's pertinent diagnoses were encephalopathy (disruption in the function of the brain), hemothorax (blood accumulation between the lung and chest wall that is most likely</p>	F0600	<p>Continued from page 1 were reviewed and remains current.</p> <p>All residents who have substance use disorders and mental health disorders were reassessed and reeducated on substance use policy and reviewed like residents offered substance use and mental health resources, and care plans updated.</p> <p>Staff were educated on substance use policy, abuse and vulnerable adult policy, mental health disorders specific to identifying signs and symptoms, 1:1s and 15-minute checks.</p> <p>Recurrence will be prevented by:</p> <p>Audits of five residents who have substance use and mental health disorder will be completed weekly 4x then monthly x2 months to ensure that those who have a substance use and mental health disorder are being provided with the resources and interventions and evaluated appropriately for its effectiveness. The results will be shared with QAPI input on the need to increase, decrease or discontinue the audits.</p>	

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F0600 SS = G	<p>Continued from page 2 caused by trauma), muscle wasting and symbolic dysfunction (a social impairment disorder that refers to language deficits).</p> <p>R1's quarterly MDS dated 9/15/25 indicated R1 had a (BIMS) score of 15 indicating he was cognitively intact. R1 required moderate assistance with toileting and showering. He required set-up assistance with personal hygiene. R1's pertinent diagnoses were displaced fracture of the neck and hand, alcohol abuse and adjustment disorder with mixed anxiety and depressed mood (a mental health condition characterized by a combination of symptoms typically associated with anxiety and depression, arising in response to a significant stressor or life change).</p> <p>R1's progress note dated 10/13/25 at 10:39 a.m. during morning meeting, the DON and intradisciplinary team (IDT) were notified by a housekeeping staff that R1 was out in the facility parking lot letting air out of the DON's vehicle tires. The DON went out and found resident at the far end of the parking lot near a grey truck, in the act of letting air out of the tires. When she asked R1 why he was doing this he mumbled something and went around to the other side of the truck and started letting air out of the front tire. The DON asked him to stop and when he was asked why she informed him she was calling 911. While she was on the phone with 911, R1 went to her vehicle and started letting air out of writer's rear passenger tire, she told R1 to stop touching her vehicle and R1 turned and went towards the front of the parking lot to a black truck owned by another resident and began letting the air out of the rear driver's side vehicle, at that time the police arrived and started speaking with R1. Housekeeping staff called the DON over and pointed out a scratch on the passenger side of her vehicle. The scratch was approximately 12" in length and looked to be superficial. The officer asked R1 why he was doing that, and he said something about the TV and his mental health, it was unclear what he was saying (English is not his first language). The officer asked the DON if she wanted to press charges for the scratch and was told she did not, as it was superficial. The police officer suggested that R1 go back into the facility. R1's information was provided, and the DON's contact information was provided. The IDT would review R1's chart for any medication changes, behavioral notes, and review his substance use disorder (SUD) checklist to ensure resident's care plan was appropriate and up to date. When the DON returned to office, there was a voicemail from the police stating they had observed R1</p>	F0600		

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F0600 SS = G	<p>Continued from page 3 rolling down the frontage road as they were leaving. R1 signed the leave of absence (LOA) binder but did not supply information as to where he was going or when he would return.</p> <p>R1's progress note dated 10/13/25 indicated at 1:38 p.m. indicated R1 was on an LOA.</p> <p>There were no further progress notes until 10/15/25.</p> <p>R1's progress note date 10/15/25 at 1:29 p.m. indicated at around 12:35 p.m. during this shift registered nurse (RN)-A noted R1 moving around with his wheelchair in the hallway speaking in Spanish. A few minutes later R1 came to the nursing station and reported his roommate's TV was loud. RN-A went to the room and found the TV was off and the roommate was asleep. RN-A encouraged R1 to go and sleep with no effect. R1 continued speaking in Spanish and exhibited an anger outburst, using vulgar language to staff. R1 came to the nursing station and stated, "call 911 I am having pain on my lower abdomen". R1 refused to allow RN-A to take his vital signs, 911 call was initiated. R1 continued speaking in Spanish and became aggressive toward RN-A. R1 knocked the nursing station computer with his cane twice and the computer fell to the floor. He also tried to hit RN-A with his cane while on the phone with the 911 dispatcher for the second time. He then started taking photos of RN-A with his iPad and took a wireless phone and threw it toward RN-A. Soon the paramedics and police arrived and took R1 to the emergency department, the DON was notified.</p> <p>R1's emergency department note dated 10/15/25 at 5:11 p.m. indicated R1's clinical impressions were psychiatric illness and methamphetamine-induced mood disorder and altered mental status. R1's assessment indicated due to chronic suicide ideation, severe chronic chemical dependency/alcohol, chronic intoxication, history of multiple violence episodes, he had a chronic risk of suicide, accidental overdose/death, chronic risks for violence towards self and others, unable to care for self, had chronic risks of being a danger to self/society. R1 denied current suicidal or homicidal contracts for safety. R1 was willing to go to chemical dependency treatment and remain sober. He made many future oriented comments. R1 did not meet the criterial for a 72-hour psychological hold therefore he would be discharged back to the facility. R1 admitted to using methamphetamines 5 days</p>	F0600		

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F0600 SS = G	<p>Continued from page 4 ago and then again 3 days ago. R1 had auditory hallucinations to throw things, but denied auditory hallucinations to kill self, hurt self, or others.</p> <p>R1's progress note dated 10/21/25 at 9:31 a.m. indicated R1 called 911 on himself. The assistant director of nursing (ADON) spoke with the police afterwards and they stated R1 had reported that "he knows the facility was tapping into his devices and posting videos of him and broadcasting it to the world and people are looking at him and laughing." In addition, R1 stated to the officers that "staff were putting things in his eyes to make him see what they want him to see." R1 was provided with his case worker and the police department's business cards. The officers stated they would give the case worker the information so they could follow up with the R1. R1 also requested the name and badge numbers of the police officers that responded.</p> <p>R1's nursing progress note dated 10/21/25 at 8:21 p.m. indicated licensed practical nurse (LPN)-A heard someone calling for help in R2's room. LPN-A rushed to the room and witnessed R2 on the floor with his wheelchair tipped over. R1 was standing over the other client threatening to cause more harm. It was reported that R1 had approached R2 throwing him on the floor. R1 was sent to the hospital for evaluation and a 72-hour hold. R1 was agitated and appeared not himself, R1 was threatening to cause harm to staff and taking staff's video stating that he was to call someone to come harm staff. He agreed to go to hospital.</p> <p>R2's nursing progress note dated 10/21/25 at 8:21 p.m. indicated LPN-A heard someone call for call for resident to "stop", on arrival LPN-A witnessed R2 seated on the floor with his wheelchair tipped over next to him. R1 was standing over R2 and continued to make threats toward R2 that he was going to finish this. LPN-A separated both residents. R2 stated R1 was "a very disturbed young man."</p> <p>R1's Emergency Hold Order Application dated 10/21/25 at 8:43 p.m. ordered by R1's Primary Care Physician indicated R1 had a psychiatric history and current methamphetamine usage. R1 was behaving in a violent and erratic way putting the facility staff and other residents at risk. Not transporting him to an elevated level of care is a risk for morbidity and mortality to self and others.</p>	F0600		

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F0600 SS = G	<p>Continued from page 5</p> <p>R2's nursing progress note dated 10/21/25 at 10:20 p.m. indicated R2 was sent to the emergency department for evaluation.</p> <p>R2's hospital after visit summary dated 10/21/25 indicated R2's reason for the visit was due to a fall. R2's instructions were to return to the emergency department if he developed any pain such as severe headache, trouble breathing, vomiting. It did not appear R2 had any injuries related to his fall.</p> <p>R2's care plan on 10/21/25 indicated R2 was the victim in a resident-to-resident altercation. R2's interventions were 15-minute checks initially for safety. Monitoring R2 for signs and symptoms of emotional distress.</p> <p>R1's incident report dated 10/22/25 at 10:31 a.m. indicated on 10/21/25 at 8:20 p.m. there was a resident-to-resident altercation. The incident was reviewed with the resident, direct care staff, the medical provider, and the IDT. The incident analysis indicated R1 was exhibiting paranoid behaviors earlier in the day. R1 was in the hallway and had flipped R1 out of his wheelchair. He stated "I got you'll pictures, watch, see what happens" holding a camera and making threats toward staff, R1 appeared upset that staff called law enforcement to intervene. The contributing factors were R1's diagnoses of double below the knee amputation, muscle weakness, other signs involving cognitive function and awareness were fatigue, major depression disorder and adjustment disorder. R1's prescriptions were cyclobenzaprine (muscle relaxant) which R1 had not taken recently, duloxetine (anti-depressant), melatonin (natural sleep agent), metoprolol (blood pressure medication), gabapentin (for seizure and nerve pain), and Seroquel (anti-psychotic). R1 had been having refusing his medications and having erratic behaviors in the past week. R1 had a history of substance abuse. R1's interventions indicated to see his care plan. Other interventions included R1 was taken by paramedics/police department. If he returned to the facility, he would be on 15-minute checks for safety. R1 was already on substance use monitoring.</p> <p>R2's incident report dated 10/22/25 at 11:09 a.m. indicated on 10/21/25 at 8:20 p.m. there was a</p>	F0600		

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F0600 SS = G	<p>Continued from page 6</p> <p>resident-to-resident altercation. The incident was reviewed with the responsible party, the resident, direct care staff, the medical provider and IDT. The incident analysis indicated a nurse heard someone call for R2 to "stop" on arrival the nurse witnessed R2 seated on the floor with his wheelchair tipped over next to him. R1 was standing over R2 and continued to make threats toward R2 that "he was going to finish this". The nurse separated the residents. The contributing factors was documented as not applicable (NA). The follow-up interventions indicated to see the care plan. Other interventions included the resident was placed on 15-minute checks for safety and monitoring for emotional distress after returning from the emergency department. The facility was unable to provide documentation of the 15-minute checks completed on R2. Additional notes indicated IDT reviewed the resident-to-resident altercation R2 was the victim. The IDT team would continue to monitor.</p> <p>R1's medical record lacked a reassessment or if care planned interventions for support treatment or services for mental health concerns were provided to R1 as it related to his mood or behavior to attain the highest practicable mental and psychosocial wellbeing of R1. Interventions and position responsible included:</p> <ul style="list-style-type: none"> • MDS section D/PHQ 9 will be conducted per regulation and PRN. Date Initiated: 3/24/2025 Social Service Designee (SSD) • Monitor and document mood state/behaviors upon occurrence. Date Initiated: 03/24/2025 Nursing (NSG) • Redirect prn. Date Initiated: 03/24/2025 NSG • Social Services to assist resident and family prn. Date Initiated: 04/18/2025 SSD • Encourage utilization of social supports. Date Initiated: 04/18/2025 SSD • Staff to visit with resident one on one during cares and prn. Date Initiated: 04/18/2025 <p>All</p> <ul style="list-style-type: none"> • Provide emotional support, validation, and comfort measures prn. Date Initiated: 3/24/2025 All • Introduce resident to other residents with similar interests. Date Initiated: 04/18/2025 	F0600		

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F0600 SS = G	<p>Continued from page 7</p> <p>All</p> <ul style="list-style-type: none"> • Monitor Target Behaviors per protocol. Date Initiated: 04/18/2025 NSG <p>R2's social service progress note dated 10/22/25 indicated R2 had a trauma questionnaire completed due to the resident-to-resident altercation. R2 stated he had no trauma, but stated he was very confused. That was his baseline.</p> <p>R2's trauma assessment dated 10/22/25 at 1:33 p.m. indicated R2 was asked; have you ever had any traumatic experiences in the past that you feel we should be aware of that may affect your preferences or care needs. R2 answered no. Additional notes indicated R2 stated he had no trauma at that time; however, he was very confused.</p> <p>R2's nursing progress note dated 10/23/25 at 1:11 p.m. indicated R2 expressed he was scared because of the incident that happened with R1. It was explained to him that the facility would do everything in their power to keep him safe if R1 were to return. R2 was offered social services to assist him to move to a sister facility if he no longer felt safe at this facility. R2 stated that prospect was also scary because he would have to get to know new staff and his way around a new facility. He was asked if he would like to speak with a therapist to discuss his feelings. R2 stated that talking would not do anything he just needed to cool down and think. He was again offered social services if he needed to talk.</p> <p>R2's social service progress note dated 10/23/25 at 1:51 p.m. indicated social services met with R2 again and offered therapy, which he declined. The facility would request the therapist introduce themselves to R2 when they were onsite. R2 was also offered alternate placement; to which R2 stated the facility was his home and his grandmother even lived there at one point. Other facility options were discussed and R2 stated that two things could be true at the same time, he could feel uncomfortable at the facility yet have the feelings it was his home.</p> <p>Upon observation and interview on 10/23/25 R2 was seated in his room in his wheelchair looking at his phone trying to call a non-emergency police line to get</p>	F0600		

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F0600 SS = G	<p>Continued from page 8 a restraining order on R1. R2 stated a young tough "crazy" man became aggressive and pushed him, tipping him backwards in his wheelchair, then he lifted the wheelchair and was going to throw it on top of him. R2 stated he was scared and still was. R1 had a street personality and assaulted R2. R2 felt he was an easy target because he was a smaller man in a wheelchair and did not have the appearance of a fighter. During the interview R2 wheeled himself to the door four times to look out the door to see if R2 had returned from the hospital. R2 stated he had been told if he was fearful there was a sister facility R2 could be moved to when R1 returned. R2 stated the facility was his home, he had friends and why would "an aggressive 20-something year old criminal be to stay?"</p> <p>Upon observation on 10/23/25 at 12:58 p.m. R2 was in the hallway of the facility speaking to the director of nursing (DON). The DON was telling R2 the facility would do their best to keep him safe if R1 were to return and if they could not and he was still scared he could be a moved to a sister facility. R2 was upset stating why should he move? Why should he feel unsafe in his own home? What gave the criminal the right to live there?</p> <p>Upon interview on 10/23/25 at 2:35 p.m. RN-A stated he was the nurse who worked 10/15/25 when R1 was complaining about hearing his roommate's television when it was off. R1 was pacing the hallways speaking in Spanish trying to tie rubber therapy bands around residents' doors. He states speaking loudly and wanted 911 called for abdominal pain. R1 called 911 himself and following his call RN-A spoke with the dispatches who told RN-A to call the police. R1 then got upset, threw his phone, and started hitting the computers and attempted to attack RN-A. R1 was taken to the emergency department. RN-A stated he did not feel safe with R1 around and he was scared for the residents. RN-A stated R2 was really scared, especially if R1 would be returning to the facility. R2 told RN-A he could not stop thinking of when R2 assaulted him. R2 remembered the situation well, even though he was forgetful.</p> <p>Upon interview on 10/23/25 at 2:55 p.m. licensed practical nurse, LPN-B stated on the evening of 10/21/25 she heard yelling and part of the yelling was LPN-A yelling for help. She went to R2's room and saw him on the floor and R1 yelling and trying to hit LPN-A. LPN-A told LPN-B to call the police so she called the police. R1 was still trying to fight staff</p>	F0600		

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F0600 SS = G	<p>Continued from page 9 when the police arrived. The police calmed R1 down and the paramedics arrived the paramedics did not want to take R2. The facility had called the DON, and the DON was in the process of having the Medical Director place a 72-hour on R1 for the safety of the residents and staff. R1 had assaulted staff a few days prior, and the hospital returned R1 the same day. LPN-B denied any interventions for R1 following his physical altercations with staff on 10/15/25. LPN-B stated when R2 returned from the hospital following the assault he told her that was the worst situation he had ever been in and how painful it was. LPN-A stated she was personally fearful because R1 would try to fight any staff, he would fight anyone.</p> <p>Upon interview on 10/23/25 at 3:45 p.m. Nurse Practitioner, NP stated it sounded to her like the hospital was trying to send R1 back to the facility. She stated he needed inpatient care for safety. She was not certain how R1 ended up at the facility in the first place. She stated she was concerned for R1 going out and using drugs and there was a not skilled need for him to be at the facility anymore. She stated R2 suffered mental abuse as he did tell her he was upset about the incident, but did not give her specific details. R2 had cognitive issues at his baseline.</p> <p>Upon interview on 10/27/25 at 8:21 a.m. R3 stated he was aware that R1 had used methamphetamines and assaulted R2. He stated he was fearful at the facility and concerned R1 could have a weapon.</p> <p>Upon interview on 10/27/25 at 9:40 a.m. LPN-C stated she heard about R1's assaulting of staff and R2. She stated she was scared and R2 was going to kill people.</p> <p>Upon interview via a Spanish interpreter on 10/27/25 at 10:20 a.m. R1 stated he recalled scratching the employee cars in the parking lot on 10/13/25, getting upset and attempting to hit staff with is his cane on 10/15/25 and then on 10/21/25 pushing R2 over in his wheelchair. He stated he was hearing voices. He stated he had received psychiatric care back in his country (Ecuador) for alcohol and mental health. He nodded his head yes to methamphetamine use in the past few weeks. He stated the lights and noises at the facility made him "not be himself". He felt like the staff were all liars and joking about him. This was not the first time he had used illegal drugs. He did not answer the question of if he heard voices in the past.</p>	F0600		

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F0600 SS = G	<p>Continued from page 10</p> <p>Upon interview on 10/27/25 at 1:01 p.m. the director of social services (SW)-A stated R1 started having behaviors after an unplanned leave of absence from 10/10/25 – 10/11/25. On 10/13/25 R1 was letting air out of the tires of staff cars in the parking lot. On 10/15/25 R1 physically assaulted registered nurse (RN)-A. On 10/15/25 R1 was discharged from the emergency department with a lab result showing R1 tested positive for methamphetamines. On 10/21/25 R1 pushed over R2 unprovoked in his room and was assaultive to staff. The paramedics took R2 to the hospital and he was there until 10/24/25.</p> <p>Upon interview on 10/27/25 at 1:26 p.m. the ADON stated R1's behaviors started on 10/13/25 when a housekeeper noticed R1 in the employee parking lot scratching cars and letting the air out of times. The ADON stated R1 was off his baseline. R1 told the police officers the television voices were telling him to scratch the cars. The officers told the ADON if he started behavior like that again to reach out to them. R1 left the facility for a couple of hours and the ADON had gone home before R1 returned. 10/14/25 a staff member reported to the ADON R1 was out in the parking lot again. The ADON went out to speak with R1. R1 admitted to hearing voices, but did not have a diagnosis for hearing voices. R1 stated he had heard voices before. The ADON told R1 if the voices felt real to let the staff know. R1's next situation was a few days later when he started going after RN-A with his cane. The ADON did not speak with R1 following R1's actions of trying to hit staff.</p> <p>The ADON stated she reported R1 hearing voices to the DON and she thought SW-A had reached out to the in-house psychiatrist to complete a diagnostic assessment. The ADON the believed the facility added interventions for R1 following the car scratching of 10/13/25 and the attempt to hit staff with his cane on 10/15/25 were to "just be more alert to his behaviors."</p> <p>Upon interview on 10/27/25 at 2:14 p.m. the DON stated 10/13/25 was the date she felt R1 started a psychotic episode and at that point the staff was not aware R1 had used methamphetamine. R1 was scratching the cars and letting air out of the times in the staff parking lot. R1 told the DON as he scratched her car that the television told him to do it. She stated staff was to monitor him more often. On 10/15/25 R1 assaulted a staff member with his cane behind the nurse's station. R1 was taken to the emergency department and sent back</p>	F0600		

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F0600 SS = G	<p>Continued from page 11 hours later. On 10/21/25 the DON received a call from the facility stating R1 had pushed R2 over in his wheelchair. The police and paramedics had been called. The DON had the paramedics wait as she was obtaining a 72-hour hold on R1 since two days prior he had gone to the hospital with methamphetamine psychosis and was sent right back. R1 required acute psychiatric care due to the vandalism, assaulting of staff and the resident assault. The staff and residents were not safe.</p> <p>Upon interview on 10/27/25 at 3:10 p.m. LPN-A stated he had a week off prior to his shift on 10/21/25. He was unaware there were any concerns with R1. R1 was going in and out of the building from his room to the smoking area on 10/21/25, which was common for him. He was laughing and smiling, which was not out of the ordinary either, however he was speaking to himself in Spanish. LPN-A did not think anything of him speaking to himself. The facility was not completing 15-minute checks on him. A little after 8:00 p.m. on 10/21/he heard R2's roommates wife yelling for help. He ran to the room, R2 was on the floor, R1 was screaming at him ready to throw his wheelchair on him. LPN-A stood between them, and R1 was pushing him. LPN-A yelled for help and LPN-B responded and called the police. LPN-A got R1 out of R2's room and LPN-B tended to R2 along with a nursing assistant. R1 got angry and went outside. LPN-A called the DON, and she wanted to send both R1 and R2 to the emergency department and get a 72-hour psychiatric hold on R1. They were both taken to the emergency department. R2 was released later that evening with no concerns and R1 was hospitalized until 10/24/24. LPN-A had not worked with R1 since 10/21/25 and was told R1 had an aide monitoring one-to-one 24 hours a day. LPN-A stated the night of the 10/21/25 the officers did not want to take R1, but LPN-A told them he did not feel safe. LPN-A stated he wondered if R1 would be under the influence again at the facility. LPN-A stated R1 "still goes out and God knows what he does" which was why he got violent when he returned.</p> <p>Upon interview on 10/27/25 at 3:38 p.m. the Administrator stated on 10/13/25 R1 was found scratching cars and deflating tires. R1 was not redirectable when staff attempted. He was unaware the nurse practitioner had not been notified and stated she should have been. He was not certain whether the staff had started monitoring R1 for signs and symptoms of substance abuse or not. He believed the staff implemented 15-minute safety checks on R1 after he assaulted RN-A and was found to have methamphetamines in his system. The administrator stated there was an</p>	F0600		

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F0742 SS = D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-	F0742	Immediate Corrective Action: R1 remains a current resident. R1 was moved to a private room and placed on 1:1s. R1 on monitoring per shift for signs and symptoms of substance use. R1 was offered ACP. R1 provider was notified of current mental	11/20/2025

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F0742 SS = D	<p>Continued from page 13</p> <p>§483.40(b)(1)</p> <p>A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure appropriate treatment and/or services were provided to 1 of 3 residents (R1) reviewed for mental health needs. R1 was assessed with a history of alcohol abuse, extreme trauma, and mental health disorders with limited interventions. R1's mental health declined resulting in abuse towards staff and a resident (R2), calls to the police, and hospitalizations.</p> <p>Findings include:</p> <p>R1's nursing progress note by social services dated 3/24/24 at 3:28 p.m. indicated R1 was cognitively intact with minimal depression. R1's goal was to be strong and go home. R1 was offered the facilities inhouse psychiatry services and declined. The note did not indicate if client was offered opportunities for autonomy, arrangements to keep R1 in touch with his prior community and alcoholic anonymous group, cultural heritage, and religious practices.</p> <p>R1's care plan dated 3/24/25 indicated R1 had a history and diagnosis of substance abuse: alcohol use. R1's interventions on 3/24/25 were to educate R1 on the substance abuse policy and staff was to monitor and check vitals of resident if he was found under the influence. R1's care plan failed to thoroughly describe R1's distress from a person-centered perspective, it did not describe programs and/or activities to assist R1 in reaching and maintaining his highest level of mental and psychosocial functioning. In addition, the care plan did not have measurable language that allowed assessment of its effectiveness.</p> <p>R1's admission MDS dated 3/27/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating he was cognitively intact. R1 required moderate assistance with toileting and showering. He</p>	F0742	<p>Continued from page 13</p> <p>health and substance abuse changes. R1's substance abuse policy reviewed, smoking assessment, risk vs benefit for substance abuse, LOA policy, trauma questionnaire, and care plans reassessed and updated.</p> <p>R2 remains a current resident. R2 was moved to a different wing next to the nurse's station. R2's provider was notified. R2 was offered to relocate to another facility. R2 was offered ACP. R2's care plan was updated.</p> <p>Corrective Action as it applies to others:</p> <p>Substance use policy and abuse/vulnerable adult policy were reviewed and remains current.</p> <p>All residents who have substance use disorders and mental health disorders were reassessed and reeducated on substance use policy and reviewed like residents offered substance use and mental health resources, and care plans updated.</p> <p>Staff were educated on substance use policy, abuse and vulnerable adult policy, mental health disorders specific to identifying signs and symptoms, 1:1s and 15-minute checks.</p> <p>Recurrence will be prevented by:</p> <p>Audits of five residents who have substance use and mental health disorder will be completed weekly 4x then monthly x2 months to ensure that those who have a substance use and mental health disorder are being provided with the resources and interventions and evaluated appropriately for its effectiveness. The results will be shared with QAPI input on the need to increase, decrease or discontinue the audits. (need to do audits)</p>	

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F0742 SS = D	<p>Continued from page 14 required set-up assistance with personal hygiene. R1's pertinent diagnoses were displaced fracture of the neck and hand, alcohol abuse and adjustment disorder with mixed anxiety and depressed mood (a mental health condition characterized by a combination of symptoms typically associated with anxiety and depression, arising in response to a significant stressor or life change).</p> <p>R1's facility Target Behavior Form dated 6/6/25 indicated R1 was ordered duloxetine HCl (antidepressant used to treat a variety of conditions including mood disorders and chronic pain) and Melatonin (sleep aid). Charted behaviors were documented as non-applicable (NA). Non-pharmacological interventions were redirection and one-to-one visits. The behavior assessment did not indicate the purpose of R1's redirection or one-to-one visits.</p> <p>R1's care plan dated 6/6/25 – 10/25/25 did not indicate intentions for redirection or one-to-one visits for R1.</p> <p>R1's progress note dated 10/13/10:39 a.m. during morning meeting, the DON and intradisciplinary team (IDT) were notified by a housekeeping staff that R1 was out in the parking lot letting air out of the DON's vehicle tires. The DON went out and found resident at the far end of the parking lot near a grey truck, in the act of letting air out of the tires. When she asked R1 why he was doing this he mumbled something and went around to the other side of the truck and started letting air out of the front tire. The DON asked him to stop and when he was asked why she informed him she was calling 911. While she was on the phone with 911, R1 went to her vehicle and started letting air out of writer's rear passenger tire, she told R1 to stop touching her vehicle and R1 turned and went towards the front of the parking lot, to a black truck owned by another resident and began letting the air out of the rear driver's side vehicle, at that time the police arrived and started speaking with R1. Housekeeping staff called the DON over and pointed out a scratch on the passenger side of her vehicle. The scratch was approximately 12" in length and looked to be superficial. The officer asked R1 why he was doing that, and he said something about the TV and his mental health, it was unclear what he was saying (English is not his first language). The officer asked the DON if she wanted to press charges for the scratch and was told she did not, as it was superficial. The police officer suggested that R1 go back into the facility.</p>	F0742		

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F0742 SS = D	<p>Continued from page 15</p> <p>R1's information was provided, and the DON's contact information was provided. The IDT would review R1's chart for any medication changes, behavioral notes, and review his substance use disorder (SUD) checklist to ensure resident's care plan was appropriate and up to date. When the DON returned to office, there was a voicemail from the police stating they had observed the R1 rolling down the frontage road as they were leaving. R1 signed the leave of absence (LOA) binder but did not supply information as to where he was going or when he would return.</p> <p>R1's progress note dated 10/13/25 indicated at 1:38 p.m. indicated R1 was on an LOA.</p> <p>There were no further progress notes until 10/15/25 at 1:29 p.m.</p> <p>R1's progress note dated 10/15/25 at 1:29 p.m. indicated at around 12:35 p.m. during this shift registered nurse (RN)-A noted R1 moving around with his wheelchair in the hallway speaking in Spanish. A few minutes later R1 came to the nursing station and reported his roommate's TV was loud. RN-A went to the room and found the TV was off and the roommate was asleep. RN-A encouraged R1 to go and sleep with no effect. R1 continued speaking in Spanish and exhibited anger outburst, using vulgar language to staff. R1 came to the nursing station and stated, "call 911 I am having pain on my lower abdomen". R1 refused to allow RN-A to take his vital signs. 911 call was initiated. R1 continued speaking in Spanish and became aggressive toward RN-A. R1 knocked the nursing station computer with his cane twice and the computer fell to the floor. He also tried to hit RN-A with his cane while on the phone with the 911 dispatcher for the second time. He then started taking photos of RN-A with his iPad and took a wireless phone and threw it toward RN-A. Soon the paramedics and police arrived and took R1 to the emergency department. The DON was notified.</p> <p>R1's emergency department note dated 10/15/25 at 5:11 p.m. indicated R1's clinical impressions were psychiatric illness and methamphetamine-induced mood disorder and altered mental status. R1's assessment indicated due to chronic suicide ideation, severe chronic chemical dependency/alcohol, chronic intoxication, history of multiple violence, R1 had a chronic risk of suicide, accidental overdose/death, chronic risks for violence towards self and others,</p>	F0742		

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F0742 SS = D	<p>Continued from page 16 unable to care for self, has chronic risks of being a danger to self/society. R1 has a history of extreme trauma. R1 denied current suicidal or homicidal contracts for safety. R1 was willing to go to chemical dependency treatment and remain sober. He made many future oriented comments. R1 did not meet the criterial for a 72-hour psychological hold therefore he would be discharged back to the facility. R1 admitted to using methamphetamines 5 days ago and then again 3 days ago. R1 had auditory hallucinations to throw things, but denied auditory hallucinations to kill self, hurt self, or others. R1's risk assessment identified: risk of violence: chronic. Suicide assessment risk factors included – being male, unmarried, diagnosis of Major Depression, Bipolar, Schizophrenia, or Schizoaffective Disorder, diagnosis of chronic medical illness and/or chronic pain, problematic alcohol or drug use (current or historical), history of sexual or physical abuse, prior suicide attempt or aborted suicide attempt, recent history of loss (particularly interpersonal), and provider or treatment changes.</p> <p>R1's progress note dated 10/21/25 at 9:31 indicated R1 called 911 on himself. The assistant director of nursing (ADON) spoke with the police afterwards and they stated R1 had reported that "he knows the facility was tapping into his devices and posting videos of him and broadcasting it to the world and people are looking at him and laughing." In addition, R1 stated to the officers that "staff were putting things in his eyes to make him see what they want him to see." R1 was provided with his case worker and the police department's business cards. The officers stated they would give the case worker the information so they could follow up with the R1. R1 also requested the name and badge numbers of the police officers that responded.</p> <p>R1's nursing progress note dated 10/21/25 at 8:21 p.m. indicated licensed practical nurse (LPN)-A heard someone calling for help in R2's room. LPN-A rushed to the room and witnessed R2 on the floor with his wheelchair tipped over. R1 was standing over the other client threatening to cause more harm. It was reported that R1 had approached R2 throwing him on the floor. R1 was sent to the hospital for evaluation and a 72-hour hold. R1 was agitated and appeared not himself, R1 was threatening to cause harm to staff and taking staff's video stating that he was to call someone to come harm staff. client agreed to go to hospital.</p>	F0742		

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F0742 SS = D	<p>Continued from page 17</p> <p>R1's incident report dated 10/22/25 at 10:31 a.m. indicated on 10/21/25 at 8:20 p.m. there was a resident-to-resident altercation. The incident was reviewed with the resident, direct care staff, the medical provider, and the IDT. The incident analysis indicated R1 was exhibiting paranoid behaviors earlier in the day. R1 was in the hallway and had flipped R1 out of his wheelchair. He stated "I got you'll pictures, watch, see what happens" holding a camera and making threats toward staff, R1 appeared upset that staff called law enforcement to intervene. The contributing factors were R1's diagnoses of double below the knee amputation, muscle weakness, other signs involving cognitive function and awareness were fatigue, major depression disorder and adjustment disorder. R1's prescriptions were cyclobenzaprine (muscle relaxant) which R1 had not taken recently, duloxetine (anti-depressant), melatonin (natural sleep agent), metoprolol (blood pressure medication), gabapentin (for seizure and nerve pain), and Seroquel (anti-psychotic). R1 had been having refusing his medications and having erratic behaviors in the past week. R1 had a history of substance abuse. R1's interventions indicated to see his care plan. Other interventions included R1 was taken by paramedics/police department. If he returned to the facility, he would be on 15-minute checks for safety. R1 was already on substance use monitoring.</p> <p>R1's medical record lacked a reassessment or if care planned interventions for support treatment or services for mental health concerns were provided to R1 as it related to his mood or behavior to attain the highest practicable mental and psychosocial wellbeing of R1. Interventions and position responsible included:</p> <ul style="list-style-type: none"> • MDS section D/PHQ 9 will be conducted per regulation and PRN. Date Initiated: 3/24/2025 Social Service Designee (SSD) • Monitor and document mood state/behaviors upon occurrence. Date Initiated: 03/24/2025 Nursing (NSG) • Redirect prn. Date Initiated: 03/24/2025 NSG • Social Services to assist resident and family prn. Date Initiated: 04/18/2025 SSD • Encourage utilization of social supports. Date Initiated: 04/18/2025 SSD • Staff to visit with resident one on one during cares and prn. Date Initiated: 04/18/2025 	F0742		

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<p>F0742 SS = D</p>	<p>Continued from page 18</p> <p>All</p> <ul style="list-style-type: none"> • Provide emotional support, validation, and comfort measures prn. Date Initiated: 3/24/2025 All • Introduce resident to other residents with similar interests. Date Initiated: 04/18/2025 <p>All</p> <ul style="list-style-type: none"> • Monitor Target Behaviors per protocol. Date Initiated: 04/18/2025 NSG <p>Upon interview on 10/23/25 at 3:45 R1's Nurse Practitioner (NP) stated she saw R1 on 10/16/25 because he was in the emergency department on 10/15/25. She stated R1 appeared paranoid, and she believed it was fear after he admitted he used methamphetamines. She was not certain of any changes the facility made with R1 following the assault on a staff member, damaging facility property, and a positive methamphetamine test. She was not aware of any psychosocial therapies the facility was working on with R1.</p> <p>Upon interview via a Spanish interpreter on 10/27/25 at 10:20 a.m. R1 stated he recalled scratching the employee cars in the parking lot of 10/13/25, getting upset and attempting to hit staff with is his cane on 10/15/25 and then on 10/21/25 pushing R2 over in his wheelchair. He stated he was hearing voices. He stated he had received psychiatric care back in his country (Ecuador) for alcohol and mental health. R1 did not recall refusing in-house therapy services he was offered upon his admission. He denied being offered treatment for his alcoholism while at the facility. He was going to alcoholics anonymous (AA) meetings when he was staying at the shelter before he ended up in the hospital. He would like to go to those meetings, but did not know how to get there. He stated the reason he drank and used drugs was because he lost his legs and realizes that he had probably rehabilitated himself to where he will be the rest of his life. He stated he drinks alcohol almost daily and refused to answer how often he used illegal drugs.</p> <p>Upon interview on 10/27/25 at 1:01 p.m. the director of social services (SW)-A stated R1 started having behaviors after an unplanned leave of absence on 10/10/25 – 10/11/25. On 10/13/25 R1 was letting air out of the tires of staff cars in the parking lot. On</p>	<p>F0742</p>		

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F0742 SS = D	<p>Continued from page 19</p> <p>10/15/25 R1 physically assaulted registered nurse (RN)-A. On 10/15/25 R1 was discharged from the emergency department with a lab result showing R1 tested positive for methamphetamines. On 10/21/25 R1 pushed over R2 unprovoked in his room and was assaultive to staff. The paramedics took R2 to the hospital and he was there until 10/24/25. SW-A stated every resident gets offered in-house therapy visits. She denied offering R1 chemical dependency inpatient or outpatient or any therapeutic interventions while he at the facility due to his age, English as a second language, trauma from being found frost bitten unconscious and bilateral below the knee amputations. She was not aware of any treatment offered to R1 after his behavior changed and he was found to have used methamphetamines while being at the facility. SW-A was not aware if the facility staff had knowledge of how to support R1 when he was distressed.</p> <p>Upon interview on 10/27/25 at 2:14 p.m. the DON stated she was aware that residents were offered in-house psychiatry upon admission and it was their right to refuse it. She stated she thought SW-A had reached out to the in-house provider to complete a diagnostic assessment on R1 following the incident on 10/15/25 when R1 assaulted staff and was found to have methamphetamines in his system. The DON denied knowledge of R1 being offered chemical dependent or other treatment outside the facility during his stay.</p> <p>A policy for treatment and/or services for mental and psychosocial concerns was requested however none was provided.</p>	F0742		

Minnesota State Department of Health

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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>On 10/23/25 – 10/27/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during the survey. H52016306C / MN2649682</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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Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		



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