

Office of Health Facility Complaints Investigative Report PUBLIC

| Facility Name: The Estates at Fridle | y LLC | | Report Number: H5201054 | Date of Visit: October 31, 2017 | | |
|---|-------------------|---------------------|--|------------------------------------|--|--|
| Facility Address: 5700 East River Road | | | Time of Visit: 9:00 a.m. to 3:30 p.m. | Date Concluded: January 22, 2018 | | |
| Facility City: Fridley | | | Investigator's Name and Michele Strahan, RN, Spe | l Title: | | |
| State: Minnesota | ZIP: 55432 | County: Hennepin | | | | |

Nursing Home

Allegation(s):

It is alleged that the resident was neglected when staff failed to provide adequate supervision for the resident during an off-site appointment. The transportation company did not return the resident to the facility. The facility failed to ensure the resident returned to the facility and failed to initiate th facilities missing person policy after the resident never came back.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- X State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

Conclusion:

Based on a preponderance of evidence neglect occurred when the facility sent the resident to a canceled clinic appointment without supervision. A person in the community found the resident several hours later and ten miles away from the clinic.

The resident's diagnoses included dementia, Parkinson's disease, and sepsis. The resident was confused, weak, unable to ambulate short distances, and used a wheelchair for mobility. The resident required extensive assistance of one staff person to transfer, toilet, and grooming.

The resident's admitting papers from his/her previous facility, listed a clinic appointment approximately one month after admission to the facility. Office staff person spoke with the resident's family member and it was decided that the family would go with the resident to the appointment. A week prior to the

Facility Name: The Estates at Fridley LLC

appointment facility office staff spoke with family regarding the appointment. The day before the appointment office staff called the family, left a voice-mail with an appointment reminder, and asked if the family were to meet the resident at the appointment or pick the resident up from the facility. The family did not return the call and the office staff assumed the family was going to meet the resident at the clinic. Facility office staff arranged transportation with a medical transportation company.

The day shift nurse assigned to the resident was unaware that the resident had a clinic appointment at 3:30 p.m. Between 2:00 p.m. and 2:30 p.m., the day nurse gave report to the evening nurse and did not report that the resident had a clinic appointment at 3:30 p.m. The transportation company arrived at the facility at approximately 2:30 p.m., spoke with the office staff, and picked up the resident to bring him/her to the clinic appointment. The clinic called the facility at approximately 3:00 p.m. and reported to the office staff that the appointment had been rescheduled. The clinic called the transportation company to request a return ride. At 4:30, the transportation company was not at the clinic and the clinic closed. The clinic staff called the office staff at the facility to say that the ride was on the way to bring the resident back to the facility. The clinic staff took the resident to the clinic lobby and left him/her there with a security guard. The transportation company arrived at the clinic lobby at 5:00 p.m., did not see the resident, and left. The transportation company did not call the facility to report that they did not give the resident a ride back to the facility.

A nursing assistant reported to the evening shift nurse, first that the resident was not in his room at the start of the shift and then the resident was not at dinner. The evening nurse responded that s/he would look into the matter. At approximately 6:00 p.m., a therapist checked the appointment book and reported to the nursing assistant that the Resident was at a clinic appointment.

At approximately 8:00 p.m., the resident's family called the facility and spoke with the evening nurse. The evening nurse told the family that the resident was in his room at the facility. The family told the evening nurse that a person in the community found the resident at a bus stop in downtown St. Paul. The family called the Police and went to the facility to collect the resident's medication. The family took the resident home. The next day the family took the resident back to the facility for a meeting. Facility staff assessed the resident. The resident was calm, content, pain free, and with stable vital signs.

The facilities internal investigation indicated that the clinic initially called the resident's previous health care facility to change the appointment date. A person in the community found the resident at a bus stop in St. Paul ten miles from the clinic appointment, on the ground with his/her wheelchair nearby.

During an interview, the resident stated s/he did not recall going to a clinic appointment or getting lost.

During an interview, a family member stated that a person in the community called to report s/he found the resident wandering around in downtown St. Paul. S/he stated that the family and the facility had an understanding that if the family could not take the resident to appointments a facility staff would go with the resident to appointments. The facility staff called the family a week prior to the appointment and not on the day of the appointment. The family member did not recall receiving a voice-mail the day before the appointment. The family member stated that she called the facility and staff were unaware that the

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| resident was not at t | he facility. | |
|---|---|--|
| Minnesota Vulnerabl | e Adults Act (Minnesota Statu | ites, section 626.557) |
| Under the Minnesota | Vulnerable Adults Act (Minn | esota Statutes, section 626.557): |
| ☐ Abuse | Neglect Neglect | ☐ Financial Exploitation |
| Substantiated Sub | ☐ Not Substantiated | ☐ Inconclusive based on the following information: |
| | | tion 626.557, subdivision 9c (c) were considered and it was |
| | ☐ Individual(s) and/or ☐ Fac | , , |
| Although the facility | had policies and procedures in | loitation. This determination was based on the following: n place in case a resident did not return to the facility place to make staff aware of the missing residents. |
| substantiated against possible inclusion of | an identified employee, this re the finding on the abuse regist | to appeal the maltreatment finding. If the maltreatment is eport will be submitted to the nurse aide registry for try and/or to the Minnesota Department of Human Services provisions of the background study requirements under |
| Compliance: | | |
| The facility was foun | • | ates, section 626.557) – Compliance Met ate Statutes for Vulnerable Adults Act (MN Statutes, sued. |
| | - | 42 CFR, Part 483, subpart B) - Compliance Not Met or Long Term Care Facilities (42 CFR, Part 483, subpart B), |
| Deficiencies are issue | ed on form 2567: 🗵 Yes | □ No |
| (The 2567 will be ava | ailable on the MDH website.) | |
| _ | | s Chapter 4658) - Compliance Not Met Nursing Homes (MN Rules Chapter 4658) were not met. |
| State licensing order | s were issued: 🕱 Yes | □ No |
| (State licensing orde | rs will be available on the MDI | H website.) |
| | ers 144 & 144A – Compliance nder State Statues for Chapter | Not Met - Compliance Not Met s 144 &144A were not met. |
| State licensing order | s were issued: 🗵 Yes | □ No |
| (State licensing orde | rs will be available on the MDI | H website.) |

| Facility Name: The Estates at Fridley LLC | Report Number: H5201054 |
|--|-----------------------------|
| Compliance Notes: | |
| Definitions: | |
| Minnesota Statutes, section 626.5572, subdivision 17 - Neglect "Neglect" means: | |
| (a) The failure or omission by a caregiver to supply a vulnerable adult but not limited to, food, clothing, shelter, health care, or supervision which is | _ |
| (1) reasonable and necessary to obtain or maintain the vulnerable ad or safety, considering the physical and mental capacity or dysfunction of the | • • |
| (2) which is not the result of an accident or therapeutic conduct. | |
| | |
| Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated "Substantiated" means a preponderance of the evidence shows that an act t maltreatment occurred. | hat meets the definition of |
| The Investigation included the following: <u>Document Review</u> : The following records were reviewed during the inve | estigation: |
| ▼ Medical Records | |
| ▼ Care Guide | |
| Medication Administration Records | |
| ▼ Weight Records | |
| ▼ Nurses Notes | |

| Faci | lity Name: The Estates at Fridley LLC | Report Number: H5201054 |
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| 17.71 | A consequence with | |
| X | Assessments Physician Orders | |
| X | Treatment Sheets | |
| X | Physician Progress Notes | |
| X | Care Plan Records | |
| X | Social Service Notes | |
| X | Skin Assessments | |
| X | Facility Incident Reports | |
| X | Activities Reports | |
| X | Laboratory and X-ray Reports | |
| X | Therapy and/or Ancillary Services Records | |
| X | ADL (Activities of Daily Living) Flow Sheets | |
| التنا | ···\··· | |
| Oth | er pertinent medical records: | |
| X | Police Report | |
| Ada | litional facility records: | |
| X | Staff Time Sheets, Schedules, etc. | |
| X | Facility Internal Investigation Reports | |
| X | Facility In-service Records | |
| X | Facility Policies and Procedures | |
| Nur | mber of additional resident(s) reviewed: Four | |
| We | re residents selected based on the allegation(s)? Yes No N/A | |
| Spe | ecify: | |
| We | re resident(s) identified in the allegation(s) present in the facility at the time of t | he investigation? |
| • ' | Yes O No N/A | |
| Spe | ecify: | |
| ACCESSES. | erviews: The following interviews were conducted during the investigation: | |
| ACRES (\$1000) | erview with reporter(s) • Yes O No N/A | |
| | ecify: | |
| - | nable to contact reporter, attempts were made on: | |
| Dat | | Time: |
| | | |

Interview with family:

Yes ○ N/A Specify: O No Did you interview the resident(s) identified in allegation: ○ N/A Specify: Yes \bigcirc No Did you interview additional residents? () Yes \bigcirc No Total number of resident interviews:Twelve Interview with staff:

Yes ○ No Tennessen Warnings \bigcirc No Tennessen Warning given as required: • Yes Total number of staff interviews: Sixteen Physician Interviewed: \(\cap \) Yes No Nurse Practitioner Interviewed: Yes No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s): Yes \bigcirc No N/A Specify: Attempts to contact: Date: Time: Date: Time: Date: Time: O No If unable to contact was subpoena issued: () Yes, date subpoena was issued Were contacts made with any of the following: ☐ Emergency Personnel 🗵 Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: Nursing Services | Infection Control ▼ Dignity/Privacy Issues ▼ Safety Issues Was any involved equipment inspected: () Yes ○ No N/A O No Was equipment being operated in safe manner: Yes \bigcirc N/A Were photographs taken: (Yes \bigcirc No Specify:

Report Number: H5201054

cc:

Health Regulation Division - Licensing & Certification

Facility Name: The Estates at Fridley LLC

Minnesota Board of Examiners for Nursing Home Administrators

Facility Name: The Estates at Fridley LLC

Report Number: H5201054

The Office of Ombudsman for Long-Term Care
Fridley Police Department
Hennepin County Attorney
Fridley City Attorney



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 6, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: Project Number H5201054

Dear Ms. Hagenow:

On February 13, 2018, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 6, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 13, 2018, 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 March 6, 2018.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on December 6, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our February 13, 2018 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 13, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2017, as of December 10, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of February 13, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

The Estates At Fridley LLC March 6, 2018 Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 6, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 6, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 6, 2018, is to be rescinded.

In our letter of February 13, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 10, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program
Minnesota Department of Health

Kamala Fish Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/28/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---------------|--|---|---|-----|---|-------------------------------|--------------------|
| | | 245201 | | | | | -C |
| NAME OF F | PROVIDER OR SUPPLIER | 240201 | | | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 021 | 13/2018 |
| INAIVIE OF F | -KOVIDER OR SUFFLIER | | | | 700 EAST RIVER ROAD | | |
| THE EST | ATES AT FRIDLEY LI | -C | | | RIDLEY, MN 55432 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | ٧ | (X5) |
| PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | COMPLETION DATE |
| {F 000} | INITIAL COMMEN | rs | {F 0 | 00} | | | |
| | 02/13/18, to follow relate to complaint Fridley LLC is in course 483, subpart B, requirements. The facility is enroll signature is not requage of the CMS-2 correction is require | revisit was conducted on up on deficiencies issued #H5201054. The Estates at ampliance with 42 CFR Part uirements for Long Term Care ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents. | | | | | |
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| | | | | | | | |
| LABORATOR'S | A DIDECTORIO OD DECLAS | DER/SUPPLIER REPRESENTATIVE'S SIGN | JATUDE | | TITLE | | (X6) DATE |
| LABURAIUR | L DIKEGTOK & OK PROVIL | ルーウン・ロート アード・ストー・ストー・ストー・ストー・ストー・ストー・ストー・ストー・ストー・ストー | MIUNE | | | | V 10/ 0/ 11 L |

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 6, 2018

Ms. Michaela Hagenow, Administrator The Estates At Fridley LLC 5700 East River Road Fridley, MN 55432

Re: Enclosed Reinspection Results - Complaint Number H5201054

Dear Ms. Hagenow:

On February 13, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 6, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/28/2018 FORM APPROVED

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: __ R-C 02/13/2018 00935 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {2 000} Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5201054. The Estates at Fridley LLC was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

6899

PRINTED: 02/28/2018 FORM APPROVED

| Minneso | Minnesota Department of Health | | | | | | | | |
|--|--|---|---------------------|--|-------|--------------------------|--|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | | |
| | | 00935 | B. WING | B. WING | | C 3/2018 | | | |
| | DOWNER OF CURRIER | | DDESS CITY S | STATE, ZIP CODE | | | | | |
| | PROVIDER OR SUPPLIER | 5700 FAS | T RIVER RO | | | | | | |
| THE EST | ATES AT FRIDLEY LL | C | MN 55432 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE | | | |
| {2 000} | Continued From pa | ge 1 | {2 000} | | | | | | |
| | signature is not req page of the CMS-2 correction is require | uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents. | | | | | | | |
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Minnesota Department of Health STATE FORM

PRINTED: 01/05/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|---------|---|-------------------------------|----------------------------|
| | | 245201 | | B. WING | | | |
| NAME OF F | PROVIDER OR SUPPLIER | 2-10201 | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 12/0 | 06/2017 |
| | ATES AT FRIDLEY LL | .c | | 5 | 7700 EAST RIVER ROAD FRIDLEY, MN 55432 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | rs | FC | 000 | | | |
| F 226 SS=D | to investigate case following deficiencia. The facility is enroll signature is not req page of the CMS-29 submission of the F verification of comp DEVELOP/IMPLME POLICIES CFR(s): 483.12(b) (483.12 (b) The facility muswritten policies and (1) Prohibit and preexploitation of resident property, (2) Establish policie investigate any suc (3) Include training §483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to teducates staff on- (c)(1) Activities that | ENT ABUSE/NEGLECT, ETC 1)-(3), 483.95(c)(1)-(3) t develop and implement procedures that: vent abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum c constitute abuse, neglect, isappropriation of resident | F2 | 226 | | | |
| ABODATON | A DIBECTORIS OF BROWN | DER/SUPPLIER REPRESENTATIVE'S SIGN | IATURE | | TITI E | | (X6) DATE |

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

| | IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE COMF | SURVEY | | | |
|--------------------------|---|--|-------------------|--------|---|--------------|----------------------------|
| | | 245201 | B. WING | | 12/0 |) 06/2017 | |
| | PROVIDER OR SUPPLIER | | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD FRIDLEY, MN 55432 | 12/0 | 10,2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | neglect, exploitation resident property (c) (3) Dementia maprevention. This REQUIREMED by: Based on docume the facility failed to Policy to protect the residents, (R1), what approximately 2: the facility. Staff win the facility until Fithree hours after R found approximate miles away from the Findings include: A policy titled Abus Plan, undated, indicated and the planned return times the staff is to contact the planned return time. R1's medical recording to the planned return time. R1's medical recording to the planned return time. R1's medical recording to the planned return time. R1's minimum data | or reporting incidents of abuse, in, or the misappropriation of an agement and resident abuse. NT is not met as evidenced. It is not met as evidenced intation review, and interview, follow their Abuse Prevention is safety of one of four en R1 went to an appointment 30 p.m. and did not return to ere not aware that R1 was not it is family contacted the facility 1's expected return. R1 was ly three hours later and ten e clinic. The Prevention/Vulnerable Adult cated that in case a resident in a planned leave of absence the family within 2 hours of their | F | 226 | DEFICIENCY) | | |
| | mental status score indicated R1 had m | e of 8 out of 15. Which noderately impaired cognition. | | | | | |
| | | ent summary dated 08/11/17, ad cognitive loss, dementia, | | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
|--|--|---|-------------------|--|---|------|------------------------------|--|--|
| | | 245201 | B. WING | | | 1 |) 06/2017 | | |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432 | 1 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | | |
| F 226 | required extensive for transfer, wheeld toileting, dressing, indwelling urinary of the control of the clinic appointment of the clinic called the rest of the change the appointment of the clinic approximation of the clinic staff called the rest of the clinic approximation of the clinic staff called the rest of the clinic approximation of the clinic staff called the rest of the clinic approximation of the clinic staff called the rest of the clinic staff called the clinic s | cation issues. ed 08/17/17, indicated that R1 assistance of one staff person chair mobility, bed mobility, and grooming. R1 had an eatheter. ed 09/06/17, indicated R1's cility at 8:30 p.m. to report a und R1 ten miles away from ent. R1's family was upset and ack to the facility. R1's family dication from the facility ad ed 09/06/17, indicated police by to assist FM-1 with a civil y at 9:51 p.m. R1 was found at away from the clinic. ed 09/07/17, indicated R1 and to the facility for a meeting. In the facility for a meeting. In the facility for a meeting and the facility for a meeting. In the facility for a meeting and the facility for a meeting. In the facility for a meeting are stable as a significant of pain, and was considered the sident's prior health care facility for the appointment of the Travelon transportation and facility. The clinic called the sately 3:10 p.m. and told MR-Five an appointment that day, ed Travelon for a return ride, | | 226 | | | | | |
| | Travelon told the c | ed Travelon for a return ride, linic the computers were down, led to call the clinic later. The | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|------------------------|--|-------------------------------|----------------------------|--|
| | | 245201 | B. WING | | 12 | C / 06/2017 | |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CO 5700 EAST RIVER ROAD FRIDLEY, MN 55432 | | /00/2017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION DATE | |
| F 226 | the ride was on the called the facility and arrived and the clinic staff took R1 the security guard if they did not arrived if they did not arrived if they did not arrived director of nursing clinic appointment miscommunication was meeting R1 and aware the clinic aware the clinic to the facility staff with the records stransportation for 09/06/17. MR-F stransportation for 09/06/17. MR-F stransportation for 09/06/17 aride or meet appointment. MR-would go with R1 before R1's appointment. MR-would meet R1 at she was at the nutransportation cor saw R1 leave the clinic called the fa appointment and have an appointment. | rom Travelon at 4:28 p.m. that e way to pick up R1. The clinic at 4:30 p.m. to say the ride had e clinic was now closed. The to the clinic lobby, left him with told the guard to call Travelon ive in 15 minutes. Travelon ived at the lobby at 5:00p.m., | | | | | |

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | | | |
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| | | 245201 | B. WING | i | | |) 06/ 2017 | | |
| | PROVIDER OR SUPPLIER | LC | | STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432 | | | 1 12/05/2011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY) | D BE | (X5) COMPLETION DATE | | |
| F 226 | Licensed Social W Services, (SW)-G the facility without to n 09/06/17, with rother supervision During an interview Registered Nurse 09/06/17, on the exhis assignment and clinic appointment get report that R1 did not know R1 w nursing assistant approximately 6:00 appointment. Her family member at a family came to the approximately 9:00 facility, requested requested medication to R1's his family. During an interview family member (FI facility had an und could not take the facility staff would facility staff would facility staff called appointment. FM-voice-mail the day the evening of the called the family member and the called the family member the called the family member the called the family member and the called | _ | | 226 | | | | | |

PRINTED: 01/05/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | | |
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| | | 245201 | B. WING | i | | 12/0 | 6/2017 |
| | PROVIDER OR SUPPLIER | | | 5 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD FRIDLEY, MN 55432 | 1 12/0 | 0/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 SS=D | eight miles away fr good samaritan loo phone number to of that she called the that the resident will buring an interview director of nursing R1 on the day shift she was not aware appointment and his gave report to 2:30 p.m. FREE OF ACCIDE HAZARDS/SUPEF CFR(s): 483.25(d) (d) Accidents. The facility must e (1) The resident end from accident haze (2) Each resident and assistance de (n) - Bed Rails. The propriate alternated that is a bed rail. If a bed of must ensure correspondent of the following election (1) Assess the restrom bed rails prior (2) Review the risident rails prior (3) Review the risident rails r | om the clinic. FM stated the oked into R1's wallet to obtain a contact. FM-I member stated facility and staff were unaware as not at the facility. If you on 11/16/17, at 3:04 p.m. the (DON)-D stated she cared for a on 09/06/17. DON-H stated that R1 had an afternoon are was still in the facility when LPN-H between 2:00 p.m. and ENT RVISION/DEVICES (1)(2)(n)(1)-(3) Insure that - Invironment remains as free ards as is possible; and receives adequate supervision vices to prevent accidents. The facility must attempt to use actives prior to installing a side or or side rail is used, the facility ext installation, use, and end rails, including but not limited ements. | F | 323 | | | |

| IDENTIFICATION AND INCOME. | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245201 | B. WING | i | 12 | /06/2017 | |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | STREET ADDRESS, CITY, STATE 5700 EAST RIVER ROAD FRIDLEY, MN 55432 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | ARAGA PEREBELIARD | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 323 | informed consent (3) Ensure that the appropriate for the This REQUIREME by: Based on docume the facility failed to the safety of one owent to an appoint p.m. and did not renot aware that R1 family contacted the expected return. Three hours later a clinic. Findings include: R1's medical recordiagnoses included disease, urinary resepsis. R1's minimum da 08/10/17, indicated mental status scoindicated R1 had R1's care assess | prior to installation. be bed's dimensions are eresident's size and weight. ENT is not met as evidenced entation review, and interview, or ensure supervision to protect of four residents, (R1), when R1 tement at approximately 2:30 eturn to the facility. Staff were was not in the facility until R1's he facility three hours after R1's R1 was found approximately and ten miles away from the entated was reviewed. R1's etention, heart failure, and that a brief interview for or or 8 out of 15. Which moderately impaired cognition. The ment summary dated 08/11/17, had cognitive loss, dementia, | F | 323 | | | |
| | required extensiv | ted 08/17/17, indicated that R1 e assistance of one staff person elchair mobility, bed mobility, and grooming. R1 had an eatheter. | | | | | |

| IDENTIFICATION AND ADDED | | ' ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245201 | B. WING | | 12 | /06/2017 | |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | | STREET ADDRESS, CITY, STATE, ZIP C 5700 EAST RIVER ROAD FRIDLEY, MN 55432 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| F 323 | A nurse's note da family called the good samaritan f the clinic appoint did not bring R1 picked up R1's m took R1 home. A police report da arrived at the factorized and content An internal investigation of the clinic called the facility at approximated and the clinic staff of the clinic staff heard the ride was on called the facility not arrived and clinic staff took the security gual if they did not a sufficient and the clinic staff took the security gual if they did not a sufficient and the clinic staff took the security gual if they did not a sufficient and they did not a | ated 09/06/17, indicated R1's facility at 8:30 p.m. to report a facility at 8:30 p.m. to report a found R1 ten miles away from ment. R1's family was upset and back to the facility. R1's family nedication from the facility ad faced 09/06/17, indicated police fility to assist FM-1 with a civil fility at 9:51 p.m. R1 was found at the saway from the clinic. Sated 09/07/17, indicated R1 and finto the facility for a meeting. And blood sugar were stable. R1 werbal signs of pain, and was | | 23 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245201 | B. WING | | | | 6/2017 |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | | 57 | REET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD RIDLEY, MN 55432 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | did not see R1 and During an interview director of nursing clinic appointment miscommunication was meeting R1 at not aware the clinic The facility staff we return to the facility family took R1 hor to the facility the n During an interview medical records stansportation for log/06/17. MR-F s family member a would go with R1 to before R1's appointed a message as R1 a ride or meet appointment. MR-would meet R1 at she was at the nutransportation consaw R1 leave the clinic called the fa appointment and have an appointment and have an appointment and return him to During an interview Licensed Social V Services, (SW)-G the facility without | I left the clinic. I on 10/31/17, at 1:37 p.m. the (DON)-D stated R1 went to a on 09/06/17. There was a the facility thought the family the clinic, and the facility was crescheduled the appointment. B1's me that night, and brought him ext day for an assessment. I on 10/31/17, at 1:54 p.m. taff (MR)-F stated she arranged R1 to go to an appointment on tated she spoke with R1's week before and was told family to the appointment. The day nument MR-F called FM-1 and king if FM-1 was going to give him at the medical F stated FM-1 told her family the appointment. MR-F stated rse's desk when the Travelon appointment. MR-F stated rse's desk when the Travelon appointment told MR-F R1 did not the clinic told MR-F R1 did not the clinic told MR-F R1 did not the facility. W on 10/31/17, at 2:26 p.m. Worker, Director of Social stated that R1 could not leave a supervision. She stated R1 left medical transport staff and no | | 323 | | | |

PRINTED: 01/05/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | | |
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| | | 245201 | B. WING | | | 1 | 6/2017 |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | | 570 | REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RIVER ROAD RIDLEY, MN 55432 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 323 | Registered Nurse 09/06/17, on the evening of the called the family nember (Flacility staff called appointment. FM-voice-mail the day food samaritan logisterics and same to the approximately 9:00 facility, requested requested medication to R1's his family. | v on 10/31/17, at 2:37 p.m. (RN)-H, stated he worked on vening shift. RN-H had R1 on d he did not know R1 was at a RN-H stated that he did not was at a clinic appointment and as not in the facility until staff informed him at 0 p.m. that R1 was at an received a phone call from R1's approximately 8:00 p.m. R1's facility that evening at 0 p.m. did not bring R1 into the to speak with a manager, and tion. RN-H gave R1's family and R1 went home with a family and R1 went home with erstanding that if the family resident to appointments the accompany resident. The the family a week prior to the not on the day of the lidd not recall receiving a performent, a good samaritar nember and told him/her he his wheelchair approximately from the clinic. FM stated the tooked into R1's wallet to obtain a | | 323 | | | |
| | that she called the that the resident v | contact. FM-I member stated a facility and staff were unaware was not at the facility. Iw on 11/16/17, at 3:04 p.m. the part (DON)-D stated she cared for | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245201 | | B. WING | | |) 6/2017 |
| NAME OF PROVIDER OR SUPPLIER THE ESTATES AT FRIDLEY LLC | | | | 570 | REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST RIVER ROAD IDLEY, MN 55432 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 323 | she was not awar appointment and she gave report to 2:30 p.m. A policy titled Abu Plan, undated, indoes not return fr | ift on 09/06/17. DON-H stated re that R1 had an afternoon he was still in the facility when to LPN-H between 2:00 p.m. and use Prevention/Vulnerable Adult dicated that in case a resident rom a planned leave of absence the family within 2 hours of their | F | 323 | | | |

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 12/06/2017 00935 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** A complaint investigation was conducted to investigate complaint #H5201054. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at Minnesota Department of Health

STATE FORM 6899 VJPF11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 12/06/2017 00935 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. 2 830 2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on documentation review, and interview,

Minnesota Department of Health

the facility failed to ensure supervision to protect the safety of one of four residents, (R1), when R1 went to an appointment at approximately 2:30 p.m. and did not return to the facility. Staff were not aware that R1 was not in the facility until R1's

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 00935 12/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 2830 2 830 Continued From page 2 family contacted the facility three hours after R1's expected return. R1 was found approximately three hours later and ten miles away from the Findings include: R1's medical record was reviewed. R1's diagnoses included dementia. Alzheimer's disease, urinary retention, heart failure, and sepsis. R1's minimum data set (MDS) assessment dated 08/10/17, indicated R1 had a brief interview for mental status score of 8 out of 15. Which indicated R1 had moderately impaired cognition. R1's care assessment summary dated 08/11/17, indicated that R1 had cognitive loss, dementia, falls, and communication issues. R1's care plan dated 08/17/17, indicated that R1 required extensive assistance of one staff person for transfer, wheelchair mobility, bed mobility, toileting, dressing, and grooming. R1 had an indwelling urinary catheter. A nurse's note dated 09/06/17, indicated R1's family called the facility at 8:30 p.m. to report a good samaritan found R1 ten miles away from the clinic appointment. R1's family was upset and did not bring R1 back to the facility. R1's family picked up R1's medication from the facility ad took R1 home. A police report dated 09/06/17, indicated police arrived at the facility to assist FM-1 with a civil

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matter at the facility at 9:51 p.m. R1 was found at

bus stop ten miles away from the clinic.

6899

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 12/06/2017 00935 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2830 2 830 Continued From page 3 A nurse's note dated 09/07/17, indicated R1 and his family came into the facility for a meeting. R1's vital signs and blood sugar were stable. R1 showed no non-verbal signs of pain, and was calm and content. An internal investigation undated indicated the clinic called the resident's prior health care facility to change the appointment date from 09/06/17, to 08/31/17. The facility sent R1 to the appointment on 09/06/17, and the Travelon transportation company picked R1 up at between 2:20 p.m. and 2:40 p.m. from the facility. The clinic called the facility at approximately 3:10 p.m. and told MR-F that R1 did not have an appointment that day. The clinic staff called Travelon for a return ride. Travelon told the clinic the computers were down, and Travelon needed to call the clinic later. The clinic staff heard from Travelon at 4:28 p.m. that the ride was on the way to pick up R1. The clinic called the facility at 4:30 p.m. to say the ride had not arrived and the clinic was now closed. The clinic staff took R1 to the clinic lobby, left him with the security guard, told the guard to call Travelon if they did not arrive in 15 minutes. Travelon Company staff arrived at the lobby at 5:00p.m., did not see R1 and left the clinic. During an interview on 10/31/17, at 1:37 p.m. the director of nursing (DON)-D stated R1 went to a clinic appointment on 09/06/17. There was a miscommunication, the facility thought the family was meeting R1 at the clinic, and the facility was not aware the clinic rescheduled the appointment. The facility staff were unaware that R1 did not return to the facility after the appointment. R1's family took R1 home that night, and brought him to the facility the next day for an assessment.

During an interview on 10/31/17, at 1:54 p.m.

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES

| AND DUAN OF CODDECTION DENTIFICATION NUMBER. | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 00935 | B. WING | | 12/0 | 6/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | TATE, ZIP CODE | | |
| THE ES | TATES AT FRIDLEY LI | C | T RIVER RO. MN 55432 | AU | | |
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| 2 830 | medical records statransportation for F 09/06/17. MR-F st family member a w would go with R1 to before R1's appointed a message ask R1 a ride or meet happointment. MR-F would meet R1 at the she was at the nurtransportation comes aw R1 leave the folinic called the fact appointment and the have an appointment and the record and return him to the called the transportation comes and return him to the called the transportation comes and return him to the called the transportation on 09/06/17, with record supervision. During an interview Registered Nurse 09/06/17, on the ending and interview Registered Nurse 09/06/17, on the ending appointment and clinic appointment and clinic appointment and clinic appointment. He family member at family came to the approximately 9:00 appointment. He family member at family came to the approximately 9:00 appointment. | aff (MR)-F stated she arranged R1 to go to an appointment on ated she spoke with R1's reek before and was told family to the appointment. The day atment MR-F called FM-1 and sing if FM-1 was going to give nim at the medical stated FM-1 told her family the appointment. MR-F stated se's desk when the Travelon pany picked up R1 and she acility. MR-F stated that the billity shortly after R1 left for his ne clinic told MR-F R1 did not ent. MR-F stated that the clinic tation company to pick up R1 | | JENOLINE I | | |

Minnesota Department of Health

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: С B. WING 00935 12/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2830 2 830 Continued From page 5 requested medication. RN-H gave R1's medication to R1's family and R1 went home with his family. During an interview on 11/13/17, at 1:12 p.m. family member (FM)-I stated R1's family and the facility had an understanding that if the family could not take the resident to appointments the facility staff would accompany resident. The facility staff called the family a week prior to the appointment and not on the day of the appointment. FM-I did not recall receiving a voice-mail the day before the appointment. On the evening of the appointment, a good samaritan called the family member and told him/her he found R1 alone in his wheelchair approximately eight miles away from the clinic. FM stated the good samaritan looked into R1's wallet to obtain a phone number to contact. FM-I member stated that she called the facility and staff were unaware that the resident was not at the facility. During an interview on 11/16/17, at 3:04 p.m. the director of nursing (DON)-D stated she cared for R1 on the day shift on 09/06/17. DON-H stated she was not aware that R1 had an afternoon appointment and he was still in the facility when she gave report to LPN-H between 2:00 p.m. and 2:30 p.m. A policy titled Abuse Prevention/Vulnerable Adult Plan, undated, indicated that in case a resident does not return from a planned leave of absence staff is to contact the family within 2 hours of their planned return time. SUGGESTED METHOD OF CORRECTION:

Minnesota Department of Health

The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary,

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | |
|---|---|---|---|--|-------|--------------------------|
| | | 00935 | B. WING | | 12/0 | ; 6/2017 |
| | PROVIDER OR SUPPLIER | C 5700 EAS | DRESS, CITY, S T RIVER ROA MN 55432 | TATE, ZIP CODE AD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 830 | • | evisions, and monitor to . R CORRECTION: | 2 830 | | | |
| 21850 | Residents of HC Farsidents shall be defined in the Vulne "Maltreatment" measection 626.5572, sintentional and non physical pain or injuconduct intended to distress. Every resident in fully docuauthorized in writing resident's physiciar period of time, and protect the resident others. This MN Requirem by: Based on document the facility failed to (R1), reviewed was R1 went to an approximately 2:30 facility. Staff were the facility until R1' three hours after R | om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the therapeutic infliction of ary, or any persistent course of o produce mental or emotional sident shall also be free from emical and physical restraints, amented emergencies, or as g after examination by a n for a specified and limited only when necessary to t from self-injury or injury to ent is not met as evidenced intation review, and interview, ensure one of four residents, as free from maltreatment when ointment unsupervised at in p.m. and did not return to the not aware that R1 was not in s family contacted the facility and by three hours later and ten | 21850 | | | |

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---------------------|--|------------|--------------------------|
| | | 2 | A. BUILDING: | | C | |
| | | 00935 | B. WING | | 12/06/2017 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| THE EST | TATES AT FRIDLEY LI | l C | T RIVER ROAMN 55432 | AD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21850 | Plan, undated, indi ensure residents a maltreatment by ar to, facility staff, star individual. R1's medical recordiagnoses included disease, urinary resepsis. R1's minimum data 08/10/17, indicated mental status scorindicated R1 had not status scorindicated that R1 had falls, and commun. R1's care assessmindicated that R1 had falls, and commun. R1's care plan data required extensive for transfer, wheeled to ileting, dressing, indwelling urinary of the clinic appointment of the c | e Prevention/Vulnerable Adult cated the policy exists to re not subjected to neglect or nyone, including, but not limited ff or other agencies serving the d was reviewed. R1's d dementia, Alzheimer's tention, heart failure, and a set (MDS) assessment dated R1 had a brief interview for e of 8 out of 15. Which noderately impaired cognition. The nent summary dated 08/11/17, had cognitive loss, dementia, ication issues. ed 08/17/17, indicated that R1 assistance of one staff person chair mobility, bed mobility, and grooming. R1 had an | 21850 | DETICIENCY | | |
| | arrived at the facili | ed 09/06/17, indicated police ity to assist FM-1 with a civil ty at 9:51 p.m. R1 was found at | t | | | |

Minnesota Department of Health

Minnesota Department of Health

| AND DLAN OF CORDECTION DENTIFICATION NUMBER. | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|------------------------|--|-------|--------------------------|
| | | A. BOILDING. | | C | | |
| 00935 | | | B. WING | | i | 6/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE EST | TATES AT FRIDLEY LI | (- | T RIVER RO MN 55432 | AD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21850 | Continued From pa | ige 8 | 21850 | | | |
| | bus stop ten miles | away from the clinic. | | | | |
| | his family came into | ed 09/07/17, indicated R1 and to the facility for a meeting. I blood sugar were stable. R1 bal signs of pain, and was | | | | |
| | clinic called the rest to change the apponous on 09/06/17, and the company picked Right 2:40 p.m. from the facility at approximation that R1 did not have the clinic staff called the ride was on the called the facility at not arrived and the clinic staff took R1 the security guard, if they did not arrived Company staff arrived in the security guard, if they did not arrived company staff arrived in the security guard, if they did not arrived in they did not arrived in they did not arrived in they did not see R1 and the clinic appointment miscommunication was meeting R1 at not aware the clinic The facility staff we return to the facility family took R1 home | ation undated indicated the ident's prior health care facility pintment date from 09/06/17, to lity sent R1 to the appointment he Travelon transportation 1 up at between 2:20 p.m. and facility. The clinic called the ately 3:10 p.m. and told MR-F e an appointment that day. The computers were down, and the computers were down, and the computers were down, and to call the clinic later. The form Travelon at 4:28 p.m. that is way to pick up R1. The clinic at 4:30 p.m. to say the ride had clinic was now closed. The to the clinic lobby, left him with told the guard to call Travelon in 15 minutes. Travelon at 15 minutes. Travelon at 15 minutes. Travelon at 15 minutes. Travelon at 16 minutes. Travelon at 17 minutes. Travelon at 18 minutes. The clinic. The con 10/31/17, at 1:37 p.m. the (DON)-D stated R1 went to a con 09/06/17. There was a the facility thought the family the clinic, and the facility was a rescheduled the appointment. At after the appointment. R1's the that night, and brought him ext day for an assessment. | | | | |

Minnesota Department of Health

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|---|-----------------------------------|--------------------------|
| | | 00935 B. WING | | C 12/06/2017 | | |
| | ROVIDER OR SUPPLIER | LC 5700 EAS | DRESS, CITY, S T RIVER ROA MN 55432 | TATE, ZIP CODE AD | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | ΓΙΟΝ SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| | medical records statransportation for F 09/06/17. MR-F st family member a w would go with R1 to before R1's appoin left a message ask R1 a ride or meet happointment. MR-F would meet R1 at the she was at the nurst transportation comes aw R1 leave the facilinic called the fact appointment and the have an appointment and the have an appointment and return him to the Licensed Social W. Services, (SW)-G state facility without son 09/06/17, with nother supervision During an interview Registered Nurse (09/06/17, on the exhibit assignment and clinic appointment. get report that R1 without supervision appointment. He report that R1 without supervision appointment. | or on 10/31/17, at 1:54 p.m. aff (MR)-F stated she arranged R1 to go to an appointment on ated she spoke with R1's week before and was told family to the appointment. The day atment MR-F called FM-1 and ting if FM-1 was going to give nim at the medical stated FM-1 told her family the appointment. MR-F stated se's desk when the Travelon pany picked up R1 and she acility. MR-F stated that the cility shortly after R1 left for his ne clinic told MR-F R1 did not ent. MR-F stated that the clinic tation company to pick up R1 | | | | |

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00935 12/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) 21850 Continued From page 10 21850 approximately 9:00 p.m. did not bring R1 into the facility, requested to speak with a manager, and requested medication. RN-H gave R1's medication to R1's family and R1 went home with his family. During an interview on 11/13/17, at 1:12 p.m. family member (FM)-I stated R1's family and the facility had an understanding that if the family could not take the resident to appointments the facility staff would accompany resident. The facility staff called the family a week prior to the appointment and not on the day of the appointment. FM-I did not recall receiving a voice-mail the day before the appointment. On the evening of the appointment, a good samaritan called the family member and told him/her he found R1 alone in his wheelchair approximately eight miles away from the clinic. FM stated the good samaritan looked into R1's wallet to obtain a phone number to contact. FM-I member stated that she called the facility and staff were unaware that the resident was not at the facility. During an interview on 11/16/17, at 3:04 p.m. the director of nursing (DON)-D stated she cared for R1 on the day shift on 09/06/17. DON-H stated she was not aware that R1 had an afternoon appointment and he was still in the facility when she gave report to LPN-H between 2:00 p.m. and 2:30 p.m. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary. educated staff on revisions, and monitor to ensure compliance.

TIME PERIOD FOR CORRECTION:

PRINTED: 01/05/2018 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ____ COMPLETED С 00935 B. WING_ 12/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5700 EAST RIVER ROAD** THE ESTATES AT FRIDLEY LLC FRIDLEY, MN 55432 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21850 Continued From page 11 21850 Twenty-One (21) days.

Minnesota Department of Health