STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Fridley LLC	5700 East River Road Fridley, MN 55432

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview and document review, the facility failed to ensure an allegation of potential abuse for 1 of 1 resident (R1) who complained of rough care by staff, was reported immediately but no later than 2 hours to the State Agency (SA). Findings include: On 4/21/25, a review of a facility Grievance Form dated 4/6/25, indicated [NAME] police contacted the facility and spoke to the Social Services Director (SSD) and informed the SSD a Minnesota Abuse Reporting Center (MAARC) report was filed indicating a nursing assistant (NA) was rough when getting R1 into his wheelchair on 4/6/25 around 4:30 p.m., and R1's leg and abdomen were subsequently hurting. On 4/21/25, the SSD was not available for interview. On 4/21/25 at 11:51 a.m., during an interview registered nurse (RN)-A stated when she learned of any type of abuse, she was expected to report it to the director of nursing (DON) right away, and the facility had 24 hours to report it to the SA. On 4/21/25 at 12:35 p.m., during an interview NA-A stated if he saw abuse, he was expected to report it to a nurse, the assistant DON, or the DON immediately, and the facility would report to the SA within two hours. On 4/21/25 at 2:35 p.m., during an interview NA-B stated she had abuse training three weeks prior and learned she was required to report abuse to a nurse immediately when she saw or heard about it, and the facility was required to report abuse to the SA within 24 hours. On 4/21/25 at 1:40 p.m., during an interview, the DON stated the facility was aware of the SA report by another entity. The DON stated she consulted with the SSD about the incident, and inquired if the facility should file a MAARC report. The DON stated she was advised by the SSD the incident was now after the fact, someone else filed the report, so the facility was not required to file an additional report. The DON confirmed the allegation had not been reported to the SA. The DON stated she thought the facility was required to file MAARC reports within 24 hours of learning of an abuse allegation. The DON reviewed the facility Abuse Prohibition/ Vulnerable Adult policy and acknowledged the facility did not file a report, and should have filed a separate report. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. Building B. Wing	04/21/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 2:15 p.m., during an interview, the social services designee (SS)-A stated he was familiar with R1's incident, and knew maltreatment allegations were expected be reported to the SA, But it would depend upon the severity of the injury to the resident. SS-A stated he thought maltreatment should have been reported within 24 or 72 hours. SS-A stated the facility should have reported the incident to the SA and was unsure why the facility did not. Review of the Abuse Prohibition/Vulnerable Adult policy, updated 2/2025, indicated suspected abuse would be reported to the OHFC [Office of Health Facility Complaints] reporting process not later than 2 hours after forming the suspicion of abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 44654 Based on interview and document review, the facility failed to ensure annual performance reviews were completed for 1 of 1 nursing assistants (NA-A) whose personnel files were reviewed. This deficient practice had potential to affect all residents who currently resided in the nursing home and who could receive care from this staff. Findings include: NA-A was hired on 10/27/23. NA-A's personnel record lacked evidence an annual performance review was ever completed. On 4/21/25 at 12:14 p.m., during an interview NA-A stated he was hired in October 2023, and had not had a performance evaluation. On 4/21/25 at 4:22 p.m., during an interview the director of nursing stated performance reviews were expected to be completed every 12 months, and acknowledged NA-A's performance review was due in October 2024, and had not been completed. A policy on performance reviews was requested; the facility did not have a policy about performance reviews.