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	10/27/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. Findings include: 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. 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. R2's significant change Minimum Data Set (MDS) dated [DATE] 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 caused by trauma), muscle wasting and symbolic dysfunction (a social impairment disorder that refers to language deficits). R1's quarterly MDS dated [DATE] 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). 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 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. R1's progress note dated 10/13/25 indicated at 1:38 p.m. indicated R1 was on an LOA. There were no further progress notes until 10/15/25. 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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to 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. (continued on next page)

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 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. 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. R1's admission MDS dated [DATE] 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 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). 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. R1's care plan dated 6/6/25 - 10/25/25 did not indicate intentions for redirection or one-to-one visits for R1. 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. 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. R1's progress note dated 10/13/25 indicated at 1:38 p.m. indicated R1 was on an LOA. There were no further progress notes until 10/15/25 at 1:29 p.m. 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