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	11/26/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the comprehensive care plan was updated to ensure elopement risk and civil commitment were identified, and appropriate interventions were developed for 1 of 3 residents (R1) reviewed. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated moderate cognitive impairment and diagnoses that included Wernicke's encephalopathy (an acute neurological disorder with symptoms that include difficulty moving and confusion), alcoholic cirrhosis (liver damage) of the liver, and alcoholism not in remission. R1's Elopement Risk assessment dated [DATE], indicated a score of 4. The assessment indicated an elopement risk based on the nurse's assessment. The assessment further indicated with a risk score of 4 or greater, the facility should develop a care plan related to elopement risk. R1's progress note dated 9/19/25 at 9:03 a.m., indicated R1 was on a civil commitment. R1's care plan reviewed on 10/3/25 lacked information or staff direction related to R1's elopement risk and civil commitment. During an interview on 10/1/25 at 10:52 a.m., social services designee (SSD)-A acknowledged R1 was on a civil commitment and indicated she uploaded court documents on 9/25/25 when she received them by e-fax. The SSD-A stated R1's commitment was through May 21, 2026, and the recommendations in the commitment were for R1 to continue psychiatric treatment because R1 was a significant danger to himself, was chemically dependent, and not safe to live at home alone. The SSD-A acknowledged R1 did not have a care plan related to the commitment but should have. During an interview on 10/1/25 at 11:42 a.m., registered nurse (RN)-A stated R1 did not have care plan interventions related to elopement or civil commitment, but should have, and further stated it was not her job to develop the care plan. During an interview on 10/1/25 at 2:30 p.m., the director of nursing (DON) acknowledged R1's care plan lacked focus areas for elopement and civil commitment, but both should have been included in R1's care plan. The DON stated the care plan was used to direct staff on how to care for the resident, and staff would not have known their responsibilities for either focus area. The Elopement Policy dated 6/23, indicated upon admission, each resident was assessed to establish elopement risk. Documentation should include a care plan that addressed potential to wander or exit the facility and measures taken to prevent elopement. A policy for civil commitment was requested and not provided.

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	11/26/2025

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately document risk factors on an elopement assessment for 2 of 3 residents (R1, R3). Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment and diagnoses that included Wernicke's encephalopathy (an acute neurological disorder with symptoms that include difficulty moving and confusion), alcoholic cirrhosis (liver damage) of the liver, and alcoholism not in remission. R1's orders dated 9/17/25, indicated quetiapine fumarate (antipsychotic medication used to treat mental health conditions) oral tablet and 25 milligrams (mg) at bedtime. R1's Elopement Risk assessment dated [DATE], indicated two risk areas: 1. Ambulatory or ability to self-propel a wheelchair and 2. Resident was asking to go home. Based on Assessment scale, that would have indicated a score of two, but was documented as a score of four. The assessment also included point for risk factors for prescribed antipsychotic medications and cognitive deficits, which were not indicated but should have been. Those indications would have increased the score to four, accurately assessing R1 to be at risk for elopement. R1's care plan reviewed on 10/3/25 lacked information or staff direction related to R1's elopement risk. R1's progress note dated 9/27/25 at 2:05 p.m., written by registered nurse (RN)-A indicated R1 was on LOA, and further indicated vital signs from a previous day, resident was alert and oriented, was free of signs and symptoms of SOB [shortness of breath], no swallowing difficulties, mood indicators, or behaviors observed. R1's progress note dated 9/27/25 at 11:13 p.m., indicated R1 was still on LOA. During an interview on 10/1/25 at 11:42 a.m., RN-A acknowledge she completed R1's Elopement Risk Assessment on 9/17/25. RN-A reviewed the assessment and stated if the assessment indicated a score of 4, the resident was at risk for elopement, and she had not accurately completed the assessment. R3's admission MDS dated [DATE], indicated R3 admitted on [DATE], with intact cognition and diagnoses that included hepatic (liver) encephalopathy, cachexia (great muscle and weight loss), alcoholic cirrhosis of liver with ascites (abdominal swelling caused by accumulation of fluid), chronic hepatic failure, adult failure to thrive, depression, and alcohol abuse in remission. R3's orders dated 9/16/25, indicated quetiapine fumarate oral tablet, 25 milligrams (mg) at bedtime. R3's Elopement Risk assessment dated [DATE], indicated a score of one because the resident was ambulatory. The Elopement Risk assessment failed to indicated the resident had confusion due to hepatic encephalopathy and was taking a psychotropic medication (drugs that affect the mind, emotions, and behavior). This would have indicated a score of three, instead of one, on the assessment for R3. No care plan intervention needed. During a subsequent interview on 10/2/25 at 10:21 a.m., RN-A acknowledged she completed R3's Elopement Risk Assessment on 9/16/25, RN-A further acknowledge R3 did have confusion due to hepatic encephalopathy and was prescribed an antipsychotic medication and should have checked those risk factors on the assessment. RN-A stated she does not usually look at the diagnosis list and medication list when completing the Elopement Risk Assessment but should. RN-A further acknowledged she did not complete R3's Elopement Risk Assessment accurately. During an interview on 10/1/25 at 2:30 p.m., the director of nursing acknowledged both R1 and R3's Elopement Risk Assessments were completed inaccurately and should have included elopement risk points for cognitive deficits and antipsychotics medications. The DON stated it was the expectation the nurses would review diagnoses and medication list when completing the assessment. Additionally, the DON stated R1 should not have documented progress notes when R1 was on LOA, and the assessment completed by RN-A was not accurate. The Elopement Policy dated 6/23 indicated upon admission, each resident is assessed to establish elopement risk, and is reassessed quarterly, annually, and as needed due to significant changes. For residents at risk of elopement documentation should include a care plan that addresses potential to wander or exit the facility and the measures taken to prevent wandering/elopement. A policy for skilled charting was requested and not provided.