

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER The Estates at Fridley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579</p> <p>Based on observation, interview, and document review, the facility failed to provide ordered podiatry care for 1 of 1 resident (R23) reviewed for foot care.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, and extensive assist required with personal hygiene and bathing. Diagnoses included of heart failure (affects blood circulation), respiratory failure, hypertension, morbid obesity, and candidiasis (fungal infection) of nail. Anticoagulant medication was taken daily.</p> <p>R23's care plan dated 3/29/24, identified self-care deficit related to history of repeated falls, bilateral osteoarthritis, chronic pain, weakness, morbid obesity, difficulty walking, muscle weakness, other fatigue, other abnormalities of gait. Assist of one staff was required with personal grooming and hygiene.</p> <p>R23's nurse practitioner order dated 7/21/23, identified consult podiatry for diagnosis of overgrown toenails.</p> <p>R23's medical record dated 7/21/23 through 5/2/24, lacked documentation a podiatry visit was completed.</p> <p>During an interview and observation on 4/29/24 at 8:38 a.m., R23 stated she needed podiatry because she couldn't reach her feet, staff had not completed nail care during her bed baths and her toenails were long, torn, yellow, and dirty looking. R23's left foot toenails measured about 1/4 inch above the pink, yellow, thickened and beginning to curve off to the side. R23's right foot toenails were slightly shorter but were also yellowed and thickened.</p> <p>During an interview on 4/30/24 at 1:13 p.m., nursing assistant (NA)-A stated nail care was done on bath days except for residents with diabetes or other concerns, then the nurse or podiatry did it. NA-A stated she was not sure when R23's nail care was last done. NA-A stated R23's nails were longer and thicker, and the health unit coordinator (HUC) would set up podiatry.</p> <p>During an interview on 4/30/24 at 1:15 p.m., the HUC stated the podiatrist came to the facility about once a month and she did not think F23 had been seen historically. The HUC reviewed R23's medical record and did not find evidence the podiatry order was initiated.</p> <p>(continued on next page)</p>

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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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/24 at 5:16 p.m., licensed practical nurse (LPN)-A stated R23's asked about her toenails today and upon nurse evaluation of the nails, podiatry was needed due to thick nails. LPN-A stated the nails on R23's right foot were too thick to cut now with regular nail clippers and the HUC should make an appointment for podiatry.</p> <p>During an interview on 4/30/24 at 5:30 p.m., the director of nursing (DON) stated ancillary services including podiatry were addressed at care conferences, then the HUC was updated, and the residents were added to the visit list. The DON stated residents with diabetes, blood thinner medications, or if nails were too thick with fungus would require special tools from podiatry in order to avoid potential injury.</p> <p>During a follow up interview on 5/2/24 at 12:30 p.m., the DON stated at the time the nurse practitioner ordered R23's podiatry, the HUC thought transitional care unit (TCU) residents could not be seen by podiatry, but now they know that is not true, so R23 was now placed on the podiatry visit list.</p> <p>The undated facility policy titled Foot care identified trained staff may provide routine foot care (i.e., toenail clipping within professional standards for residents without complicating disease processes. Residents with foot disorders or medical conditions associated with foot complications would be referred to qualified professionals. Residents would be assisted to make transportation appointments to and from specialists such as a podiatrist as needed.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>42586</p> <p>Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of 8 consecutive hours a day. This had the potential to affect all 35 residents who resided at the facility.</p> <p>Findings include:</p> <p>Review of the facility daily staffing hours and staff schedules from 2/1/24-4/30/24, indicated there was no RN scheduled on the following dates: 2/10/24, 2/17/24, 2/18/24, 2/25/24, 3/2/24, 3/3/24, 3/9/24, 3/10/24, 3/16/24, 3/17/24, 3/23/24, 3/24/24, 3/30/24, 3/32/24, 4/6/24, 4/7/24, 4/13/24, 4/14/24, 4/20/24, 4/21/24, 4/27/24, and 4/28/24.</p> <p>During interview on 5/01/24 at 2:38 p.m., the staffing coordinator verified there was not an RN working 8 consecutive hours on the dates above and stated they do not have any RN's on staff except the assistant director of nursing (ADON), the director of nursing (DON), and the occasional agency/pool nurse. The staffing coordinator further stated the ADON and DON are not included on the schedule during the week so they can be pulled in if needed. They are not scheduled to work on the weekends but take turns being on call if there are questions or a licensed practical nurse (LPN) calls in.</p> <p>During interview on 5/2/24 at 8:38 a.m., LPN-D stated there are never registered nurses (RN) working on the floor, the only RN's we have work days and they are management. There have been times when we've needed someone higher up to explain things to us, so we call the on-call or the provider. They also have a manager on duty on the weekends but not all of the managers are RN's.</p> <p>During interview on 5/2/24 at 8:52 a.m., LPN-A stated there are not RN's working on the floor but the ADON and the DON are RN's. LPN-A further stated if there was a problem during the shift she would notify the on call physician. The facility doesn't notify them when there isn't an RN on shift, they just know from looking at the schedule.</p> <p>During interview on 5/1/24 at 3:30 p.m., the ADON verified she was an RN and stated she generally doesn't work weekends but they have a manager on duty (MOD) that was required to work 4 hours/day on the weekends. The ADON further stated not all the MOD's were RN's and the managers rotate through all the monarch managers.</p> <p>During interview on 5/1/24 at 3:40 p.m., the DON verified she was an RN and was not scheduled to work weekends, however she works an occasional weekend as an MOD which requires all monarch managers to work 4 hours a day on rotating weekends. The DON stated not all MOD's were RN's and she was also on-call every other weekend if the LPN's have questions or if there are call in's.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/2/24 10:20 a.m., the administrator verified there was no RN's working 8 consecutive hours a day on the dates listed above and if staff needed an RN on the weekends, they should call the ADON or the DON. They also have a MOD every weekend and the MOD was required to work 4 hours a day (each day) but not all of them were RN's. The administrator further stated they have been trying to hire RN's but for a long time they weren't getting any applicants and hospitals pay their employee's more. They recently switched to a new hiring platform and have been getting more applicants and they recently hired 2 RN's who are still training but will be ready to start soon. They also have some LPN's that are in school to be RN's.</p> <p>The facility does not have a policy on staffing.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579</p> <p>Based on interview and document review, the facility failed to ensure prescribed medications were available for 1 of 1 resident (R23) who was awaiting a new medication.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, and extensive assist required with personal hygiene and bathing. Diagnoses included heart failure (affects blood circulation), respiratory failure, hypertension, and morbid obesity. There were no ulcers, wounds, skin problems or skin treatments identified in the MDS.</p> <p>R23's activities of daily living (ADL) care area assessment (CAA) dated 6/8/23, identified the CAA triggered since resident needed extensive assist with most ADLs related to her respiratory condition and morbid obesity.</p> <p>R23's care plan dated 8/11/23, identified an alteration in skin integrity due to multiple areas of self-inflicted skin tears. The goal was to have skin breakdown resolved by next review. Skin was to be monitored daily during cares, weekly skin inspection by the nurse, and to provide treatment to open areas as ordered.</p> <p>R23's provider order dated 4/25/24, identified start the medication N-acetyl-cysteine (an amino acid supplement) 1,000 milligrams (mg) three times by mouth daily for the diagnosis of skin picking.</p> <p>R23's medication administration record (MAR) dated 4/26/24 through 5/2/24, identified the medication had not been given since it was ordered (15 potential doses missed).</p> <p>R23's electronic MAR (eMAR) notes dated 4/25/24 through 5/2/24, lacked follow up documentation to obtain the medication.</p> <p>During an interview and observation on 4/29/24 at 8:38 a.m., R23 stated she had not received her medication that was ordered for skin picking. R23 stated I pick at myself; I can't help it. R23 had around 10 pencil eraser sized dried brownish red spots which resembled dried blood on her right and left bedgown arm sleeves.</p> <p>During an interview on 4/30/24 at 1:13 p.m., nursing assistant (NA)-A stated R23 had a behavior where she picked which caused bleeding. NA-A stated R23 had her own lotion to put in it.</p> <p>During an interview on 4/30/24 at 5:16 p.m. licensed practical nurse (LPN)-A stated R23 picked at her skin and saw psychology. LPN-A stated R23 took N-acetyl-cysteine in the past. LPN-A stated most medications came from the pharmacy; however, N-acetyl-cysteine was considered a house stock medication, so the business office manager (BOM) oversaw ordering medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/24 at 11:33 a.m. the pharmacy technician (PHT) from R23's pharmacy stated the N-acetyl-cysteine order was sent from the facility to the pharmacy, however, the pharmacy required a house stock medication form to be filled out by the facility. The PHT stated the facility had not followed up with the form, so no medication was sent out.</p> <p>During an interview on 5/1/24 at 11:37 a.m. the BOM stated she thought she had ordered some house stock medications in April but was not sure. The BOM stated she would review her records to see which medications were ordered.</p> <p>During an interview on 5/1/24 at 2:09 p.m., registered nurse (RN)-A stated R23 had not received the medication in almost a week, and the missing medication should have been addressed sooner. RN-A stated he had not called the pharmacy but had marked the order for someone to follow up and notify the provider.</p> <p>A list titled House Stock Medications dated 5/1/24 at 3:26 p.m., from the administrator, lacked notation N-acetyl-cysteine had been ordered.</p> <p>During an interview on 5/2/24 at 11:45 a.m., the director of nursing (DON) stated she had noticed the scabs on R23's arms from picking, and this was a long-term behavior. Additionally, if the pharmacy was not able to provide a house stock medication, then the facility staff would go out and buy the medication. The DON stated the medications should be obtained that way the same day, and before two days at the most.</p> <p>The Facility assessment dated [DATE], identified services the facility offered included administration of medications that residents needed, and vendors were in place to provide supplies and services.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>42580</p> <p>Based on observation, interview, and document review, the facility failed to ensure the pharmacist recommendations were implemented timely for 1 of 5 residents (R9) reviewed for unnecessary medications.</p> <p>Findings Include:</p> <p>R9's annual Minimum Data Set (MDS) indicated R9's diagnosis included coronary artery disease, hypertension, hyperlipidemia and was on antiplatelet medication.</p> <p>R9's care plan initiated 2/16/23, lacked documentation for coronary artery disease and hyperlipidemia goals or interventions.</p> <p>R9's physician orders dated 2/16/23, indicated rosuvastatin calcium oral tablet, give 10 mg by mouth at bedtime for hyperlipidemia.</p> <p>R9's pharmacy medication regimen review (MRR) were as follows:</p> <p>-3/6/24, pharmacy MRR indicated, note: reissued recommendation from 2/6/24, this resident continues on rosuvastatin 10 milligram every bedtime and Fenofibrate 54 mg every day treating hyperlipidemia, does not have type II diabetes. I was unable to locate a lipid panel. If not recently drawn, please clarify if a lipid panel should be drawn to evaluate the ongoing use of Fenofibrate. A provider signature was noted with agree checked for a lipid panel on 4/3/24.</p> <p>-4/3/24, pharmacy MRR indicated note: reissued recommendation from 2/6/24, and 3/6/24. This resident continues on rosuvastatin 10 mg every bedtime and Fenofibrate 54 mg every day treating hyperlipidemia, does have type II diabetes. I was unable to locate a lipid panel.</p> <p>During interview on 5/2/24 at 2:23 p.m., the director of nursing (DON) stated was unable to find documentation since they had just started at the facility and was unable to locate followup documentation for pharmacy MRR for 2/2024. DON further explained the process was pharmacy MRR's were completed at the beginning of the month and a copy was given to provider and another copy to the facility from the pharmacist. The facility would also fax the MRR's to the provider and the DON would track for provider's response to the MRR's. DON also verified R9's pharmacy MRR order for a lipid panel was missed for 2/2024, and 3/2024, but had ordered for 4/2024's pharmacy MRR but was unable to locate in R9's record but would call the laboratory to provide the results.</p> <p>The pharmacist requested a lipid panel for 2/2024, 3/2024, and 4/2024 and recommendations were addressed until 4/9/24.</p> <p>DON emailed surveyor R9's lipid panel collected on 4/9/24, and the results were noted faxed to the provider on 4/9/24. Results included: tryglyceride was 217 (High) (Normal range < 149).</p> <p>The facility policy on pharmacy MRR's was requested but not received.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579</p> <p>Based on interview and document review, the facility failed to ensure an antipsychotic medication was not started without adequate medical justification; and that a discussion of risks, benefits and potential side effects was understood by the resident, representative, or family for 1 of 1 resident (R30) reviewed who had a newly prescribed antipsychotic. In addition, the facility failed to include individualized approaches for care, including behavior tracking and non-pharmacological interventions for 2 of 4 residents (R30 and R89), and failed to ensure as needed (PRN) antipsychotic medication was not used longer than 14 days without the resident being directly evaluated by the prescriber for 1 of 2 residents (R89) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R30's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. No psychosis, rejection of care, or behaviors occurred in the lookback period. Diagnoses included head injury, communication deficit, muscle weakness. A diagnosis of insomnia was not included. High risk medications received included a hypnotic medication. R30 was dependent on staff assistance with bed mobility, transfers, and toileting.</p> <p>R30's Care Area Assessment (CAA) dated 12/23/23, identified triggers for cognitive loss. R30 was able to direct cares but was at risk for further decline in cognition secondary to multiple comorbidities.</p> <p>R30's Care Plan dated 5/2/24, lacked a focus area, goals or interventions related to insomnia or antipsychotic medications.</p> <p>R30's medical record dated 2/1/24 through 5/1/24, lacked tracking of insomnia behaviors, or non-pharmacological interventions to manage insomnia behaviors.</p> <p>R30's provider order dated 4/19/24, identified to discontinue melatonin (the hypnotic medication classified in the MDS), and start Seroquel (antipsychotic medication) 25 milligrams (mg) by mouth every evening for diagnosis of insomnia. The corresponding provider visit note dated 4/22/24, lacked adequate medical justification or discussion of risk, benefits, or side effects of antipsychotic medications with the resident or representative.</p> <p>R30's Medication Administration Record (MAR) dated 4/1/24 through 5/1/24, identified Melatonin 5 mg by mouth at bedtime for insomnia was discontinued on 4/18/24; and Seroquel 25 mg by mouth at bedtime for insomnia was started. R30 received Seroquel every evening from 4/18/24 through 5/1/24.</p> <p>During an observation on 4/29/24 at 10:50 a.m., R30 was in bed with his eyes closed. No behaviors were observed.</p> <p>During an observation on 4/30/24 at 12:45 p.m., R30 was in bed and awake. R30 stated he was doing well when asked, and stated he slept fine.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/30/24 at 6:00 p.m., R30 was up in his wheelchair, alert, no behaviors.</p> <p>During an observation on 5/1/24 at 9:14 a.m., R30 was up in his wheelchair in hallway, alert, no behaviors.</p> <p>During an interview on 5/1/24 at 10:00 a.m., R30 stated he was not aware what medications he took or what the side effects were.</p> <p>During an interview on 5/1/24 at 10:22 a.m., R30's family member (FM)-A stated R30 had an irregular sleep pattern due to his diagnoses and he was not sure what the facility implemented for interventions. FM-A stated he was not involved in a discussion about starting an antipsychotic. FM-A stated R30's provider discussed R30's mentation with FM-A and began the process for FM-A to help direct R30's healthcare decisions. FM-A stated he was not aware what the risk, benefits or side effects related to antipsychotics used for insomnia were.</p> <p>During an interview on 5/1/24 at 11:44 a.m., nursing assistant (NA)-B stated she worked with R30 routinely. NA-B was not aware of any insomnia behaviors or non-pharmacological interventions for insomnia.</p> <p>During an interview on 5/1/24 at 2:25 p.m., registered nurse (RN)-A stated he worked from an outside agency; but had worked in this facility before. RN-A stated he would look for non-pharmacological interventions and behavior tracking in the care plan and resident orders. RN-A reviewed R30's medical record and stated it lacked that monitoring of non-pharmacological interventions or behavior tracking related to antipsychotic medications.</p> <p>During an interview on 5/1/24 at 2:40 p.m., licensed practical nurse (LPN)-C stated he worked with R30 routinely. LPN-C stated R30 was confused, was easygoing and rarely hallucinated. LPN-C stated the managers would coordinate antipsychotic medications and he was unaware of regulations related to antipsychotic administration.</p> <p>Resident #89</p> <p>R89's admission MDS dated [DATE], identified moderately impaired cognition. No psychosis, delusions, behaviors, or rejection of care occurred during the lookback period. Diagnoses include paranoid personality disorder and non-Alzheimer's dementia and depression. High risk medications received included antipsychotic, antidepressant, and a hypnotic. R89 was dependent on staff assistance with bed mobility, transfers, and toileting.</p> <p>R89's CAA for behavior was not triggered. Psychotropic medications triggered due to receiving antidepressant, hypnotic and antipsychotic medication, had a history of falls and at risk for adverse reactions to these medications. The pharmacist reviewed medications monthly and made necessary recommendations to the physician and nursing staff. R89 had fall since admission and proceed to care plan with goal to have no drug related side effects.</p> <p>R89's care plan dated 5/2/24, lacked behavior tracking and non-pharmacological interventions related to antipsychotic medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R89's physician order dated 4/17/24, identified give quetiapine (Seroquel) 25 mg by mouth PRN agitation related to paranoid personality disorder.</p> <p>R89's MAR dated 4/1/24 through 5/1/24, identified the Seroquel 25 mg was given PRN on 4/23/24 at 11:33 p. m., 4/29/24 at 5:13 p.m., and 4/30/23 at 11:30 p.m. R89's medical record lacked documentation of behaviors occurring before medication administration and lacked documentation of non-pharmacological interventions attempted prior to administration of a PRN antipsychotic.</p> <p>During an observation on 4/29/24 at 11:01 a.m. R89 was awake in bed and stated he was cold. NA-C entered the room, covered R89 with a blanket and repositioned him in bed. R89 had no behaviors or agitation.</p> <p>During an interview on 4/29/24 at 12:01 p.m., R89's FM-B stated he had some confusion and falls, which was his new baseline after a stroke.</p> <p>During an observation and interview on 4/30/24 at 1:55 p.m., R89 was in his wheelchair at the nurse's station with the DON. R89's conversation was non-sensical. The DON stated R89 fell out of his wheelchair, so staff were watching him closely.</p> <p>During an observation on 5/1/24 at 2:30 p.m., R89 was up in his wheelchair engaged in an activity. R89 was calm, interacting and no behaviors.</p> <p>During on observation on 5/2/24 at 9:43 p.m., R89 was in bed with his eyes closed. No behaviors were observed.</p> <p>During an interview on 5/1/24 at 11:44 a.m., NA-B stated she had worked with R89 since his admission. NA-B stated R89 was confused, and sometimes he tried to get out of bed. NA-B stated she wasn't sure what other behaviors R89 had, but if they occurred, would be documented in the medical record. NA-B stated the nursing assistant charting prompts would let her know what specific behaviors and interventions were in place.</p> <p>During an interview on 5/1/24 at 2:25 p.m., RN-A stated the MAR would identify behaviors and non-pharmacological interventions to be attempted prior to administration of PRN psychotropic medications. RN-A was not aware of any regulations related to how long a PRN antipsychotic could be in place.</p> <p>During an interview on 5/1/24 at 2:40 p.m., LPN-C stated when PRN medications were given a prompt occurred on the MAR to document a note and then the effectiveness. LPN-C was not aware of any regulations related to how long a PRN antipsychotic could be in place. LPN-C reviewed R89's medical record and agreed behavior tracking and non-pharmacological interventions were not in place and should have been. LPN-C stated R89 was confused and sometimes restless but was not sure what other behaviors occurred.</p> <p>During an interview on 5/2/24 at 10:46 a.m., the director of social services (DSS) stated psychotropic medications were reviewed monthly with the pharmacist and interdisciplinary team (IDT). The DSS stated behavior tracking was required to determine if a resident was declining or improving and nursing would establish target behaviors for tracking purposes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER The Estates at Fridley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview together with the director of nursing (DON) and regional nurse consultant (RNC) on 5/2/24 at 11:10 a.m., the DON stated the pharmacy would review psychotropic medications monthly and let nursing know their recommendations. The DON stated psychotropic medications required an appropriate justification for starting, which included non-pharmacological interventions attempted and documented along with behavior tracking. The DON also stated a consent should be obtained from the resident or representative which included a discussion of risk, benefits, and potential side effects. The DON stated PRN antipsychotics were limited to 14 days, then the provider needed to review. The DON stated the nurse practitioner was in the facility at least two days per week, so there were opportunities to review antipsychotic medications. The DON and RNC agreed it was important to monitor antipsychotic medications closely to ensure they were used appropriately not for staff convenience, and because there was a higher risk of side effects in the elderly.</p> <p>During an interview on 5/2/24 at 1:30 p.m., the consultant pharmacist (CP) stated Seroquel required a correct diagnosis and the risks of antipsychotics included metabolic side effects, orthostasis, tardive dyskinesia (a drug induced involuntary movement disorder), sedation and an increased risk of falls. The CP stated behavior tracking and non-pharmacological interventions were important to track to see what was effective and what was not. The CP stated she had reviewed R30 and R89's medical records this day, and agreed the medical records were lacking appropriate justification for use, non-pharmacological interventions, behavior tracking and evaluation by the provider after 14 days of using a PRN antipsychotic. The CP stated Seroquel was not approved to treat insomnia.</p> <p>The facility's undated policy titled Psychotropic Medication Use, identified residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. The IDT would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms and risks to the resident and others. Pertinent non-pharmacological interventions must have been attempted, unless contraindicated, and documented. Informed consent, including effects and potential side effects would be obtained from resident and/or responsible party for each psychotropic medication. Lastly, the policy identified PRN orders for psychotropic medications would not be renewed beyond 14 days unless the healthcare practitioner evaluated the resident for appropriateness of that medication.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42580</p> <p>Based on interview and document review, the facility failed to ensure 1 of 5 residents (R9) was offered or received the pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations.</p> <p>Findings include:</p> <p>The CDC Pneumococcal Vaccine Timing for Adults dated 3/15/23, indicated adults aged [AGE] years and older who have had no prior pneumococcal vaccinations could either have option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to [AGE] years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than [AGE] years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old.</p> <p>R9's admission Minimum Data Set (MDS) diagnosis included non-Alzheimer's dementia, asthma, chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), chronic lung disease and pneumococcal vaccinations were up to date.</p> <p>R9's signed vaccine consent form was dated 2/2023.</p> <p>R9's Profile form indicated R9 was [AGE] years old.</p> <p>R9's immunization form in the electronic health record (EHR) indicated R9 received Prevnar 23 on 1/29/2010, and received Prevnar 13 on 5/3/15. The documentation also indicated to refer to CDC guidelines.</p> <p>R9's record was reviewed and lacked evidence a shared clinical decision making-discussion occurred.</p> <p>During interview on 5/2/24 at 2:36 p.m., assistant director of nursing (ADON) stated they had reviewed immunizations with ongoing audits and thought R9 was up- to- date. ADON clarified they had assumed based on R9's current pneumococcal vaccinations documentation, she did not need additional pneumococcal vaccinations and therefore did not offer R9 additional pneumococcal vaccinations. ADON then checked the vaccine tracker and noted R9 was not up-to-date and clarified facility and provider had not had a clinical decision making discussion with R9, but would begin the process to ensure additional pneumococcal was offered to R9.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy on titled Pneumococcal Vaccine updated 2/2024, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated.</p>		