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	08/07/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review the facility failed to assess residents for the ability to self-administer medications, or obtain orders for leaving medications at bedside and/or self-administration for 1 of 1 (R21) residents reviewed for self-administration of medications.Findings include: R21's face sheet dated 8/7/25, indicated R21 was re-admitted to facility on 7/30/25 and had the following diagnoses: end stage renal failure, fluid overload, conversion disorder with seizures, hypertension, cerebral infarction, pulmonary edema and need for assistance with personal care.During observation on 8/04/25 at 6:18 p.m., an albuterol inhaler with resident's name on the label, and a bottle of Ocean nasal spray with resident's name on the label was noted on the bedside table.During observations on 08/06/2025 at 9:49 a.m., an albuterol inhaler with resident's name on the label was observed on the bedside table.During observations on 08/06/2025 at 11:22 a.m. and 1:38 p.m., a bottle of Ocean nasal spray with resident's name on the label was noted on the bedside table.Review of R21's medical record lacked a self-administration of medications assessment, an order to self-administer medications and/or leave medications at bedside and lacked an order for Ocean saline nasal spray.During interview on 08/06/25 at 1:51 p.m., registered nurse (RN)-A stated she was familiar with R21 and worked with him often. RN-A stated if a resident had an order to self-administer medications (SAM) or leave at the bedside the order would be in the electronic medical record (EMR). RN-A confirmed there was a bottle of Ocean nasal spray on R21's bedside table and there was no order for SAM. RN-A stated R21 required a medication SAM assessment before he could have medications at the bedside or self-administer medications.During interview 08/06/25 at 4:12 p.m., director of nursing (DON) stated any resident who wished to self-administer medications needed to be competent and assessed. If found to be safe to self-administer, a SAM order would be obtained from the provider. DON confirmed R21 did not have a SAM order, lacked an order to leave medications at bedside and was unable to locate an order for Ocean Nasal spray. DON went on to say she expected staff to verify if a resident had a SAM order before allowing residents to self-administer or keep medications as the bedside. DON stated it was important to assess and obtain a SAM order to ensure resident safety and cause no harm.A medication self-administration policy was requested but 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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview the facility failed to ensure a written notification of transfer was sent to the office of the Ombudsman for long term care for 2 of 5 (R12, R21) upon transfer to the hospital. Findings include: R12 face sheet dated 8/7/2025, indicated R12 was admitted on [DATE] and had the following diagnoses: wound of the lower back and pelvis, major depressive disorder, paraplegia, pulmonary embolism (blood clot in lung), gunshot wound, neurogenic bladder, incontinence, septicemia (blood infection), and neurogenic bowel. R12's hospital transfer form dated 6/2/25, indicated R12 was hospitalized on [DATE]. R12's progress notes indicated R12 was hospitalized from [DATE]-[DATE]. R12's medical record lacked evidence a written notification of transfer was sent to the office of the Ombudsman for long term care. R21's face sheet dated 8/7/25, indicated R21 was re-admitted to facility on 7/30/25 and had the following diagnoses: end stage renal failure, fluid overload, conversion disorder with seizures, hypertension, cerebral infarction, pulmonary edema and need for assistance with personal care. Review of R21's medical record indicated R21 hospitalized from [DATE] thru 7/20/25. The record lacked any documentation of notification to the Ombudsman for long term care office. Documentation of Ombudsman notification was requested for June and July 2025, however none provided On 8/7/25 at 10:37 a.m., the social services worker (SS)-A stated they were responsible for completing the ombudsman notifications by the 7th of every month, however they had only been working at the facility for two weeks, and the date in question they were not employed there. However, it would have been the responsibility of the social worker at the time and was missed. SS-A stated the importance of sending the notice to the ombudsman to limit the number of transfers and prevent re-hospitalizations if possible. On 8/6/25 at 08:24 a.m., the administrator confirmed the previous social worker had not completed the Ombudsman notifications in June or July of 2025. The facility's transfer, or discharge notice for discharged policy last reviewed 2/1/23, indicated a copy of the notice of transfer or discharge is sent to the office of the state long term care Ombudsman at the same time the notice of transfer of discharge is provided to the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to complete proper checks for 1 of 1 residents (R58) reviewed for medication administration documentation.R58's significant change MDS dated [DATE], included diagnosis of psychotic disorder and depression. R58's Moments Hospice order dated 6/7/25, included an order for lorazepam 0.5 mg by mouth every 4 hours as needed for terminal agitation (restlessness that occurs close to death). R58's Order Summary Report dated 8/6/25, included an order for lorazepam oral tablet 0.5 milligrams (mg) by mouth every 4 hours as needed for terminal agitation. Facility narcotic book included an entry for R58 for lorazepam liquid give 0.5 milliliters (mL) every 4 hours. Administrations were documented for 7/8 and 7/9. Medication record for R58 included administration for lorazepam oral tab 0.5 mg was administered on 7/8/25 and 7/9/25. During interview on 8/7/25 at 11:53 a.m., registered nurse (RN)-A stated she would review the original order if she had a question during medication administration. RN-A confirmed the medication record said oral tabs, However, the narcotic book said liquid medication for the same time and documentation. During interview on 8/7/25 at 11:59 a.m., director of nursing (DON) stated she would expect staff to complete the five rights of medication administration (right resident, right drug, right dose, right route, right time) prior to administering a medication. The DON expected staff to clarify with the pharmacy and update the medication record if there were changes. The DON confirmed a change from tablets to liquid form would require a new order. During interview on 8/7/25 at 12:21 p.m., consultant pharmacist (CP) confirmed a new order was necessary if changing from tablet to liquid form of a medication. Facility policy for medication administration dated April 2018, included a triple check of the five rights is recommended during administration. The five rights include: right resident, right drug, right dose, right route, and right time. The facility included the physician was to be contacted for a new order prior to changing from pill solid tablet to liquid dosage.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure coordination of care and communication between the facility and the dialysis center for 1 of 1 residents (R21) who received hemodialysis. Findings include:R21's admission minimum data set (MDS) dated [DATE], indicated R21 had diagnoses of anemia, hypertension, renal insufficiency, renal failure, or end stage renal disease (ESRD) and was receiving hemodialysis. Additionally, the MDS indicated R21's brief interview of mental status (BIMS) score was 15 indicating R21 was cognitively intact.During interview on 8/4/25, at 5:40 p.m., R21 stated he attended dialysis three days per week on Tuesday, Thursday and Saturday.R21's clinical physician orders report printed 8/7/25, indicated the following orders: hemodialysis scheduled every Tuesday, Thursday and Saturday at Davita Dialysis Center of [NAME], monitor dialysis site for bleeding, monitor fistula for bruit and thrill, complete post dialysis vital signs, complete dialysis communication form and send with resident to dialysis, and review post dialysis treatment report for updates; if none found call dialysis.Review of R21's care plan indicated R21 was at risk for complications due to dialysis and listed goals of attending dialysis per schedule and resident will have no uncontrolled bleeding from fistula. Care plan interventions included calling 911 for bleeding, attending dialysis per schedule, treatment and dressing protocol to dialysis site per physician order, and send communication folder/form to each dialysis appointment.During interview on 8/5/25 at 3:10 p.m., registered nurse (RN)A stated she printed out a med list on R21's dialysis days and would send it with to the appointments. She went on to say staff completed a dialysis communication form and fill out any pertinent information. RN-A then pointed to a white binder located on the desk of the nurse's station. RN-A stated she did not routinely send a dialysis communication form unless there was a change since the previous dialysis appointment and had not sent the form with R21 for that day's appointment. RN-A also stated if the resident did not bring back a form from dialysis, she would not call for an update.Review of the dialysis binder lacked any completed communication forms for R21 for the months of June, July and August 2025.Review of R21's electronic medical record (EMR) indicated staff had completed and sent the form with R21 to dialysis on the following dates: 7/1/25, 7/3/25, 7/5/25, 7/8/25, 7/10/25, 7/12/25, 7/15/25, 7/17/25, 7/19/25, 7/22/25, 7/24/25, 7/31/25, 8/2/25 and 8/5/25. The EMR also indicated staff had reviewed the post dialysis treatment report for the following dates: 7/1/25, 7/3/25, 7/5/25, 7/8/25, 7/10/25, 7/12/25, 7/15/25, 7/17/25, 7/19/25, 7/22/25, 7/24/25, 7/31/25, and 8/2/25.During interview on 8/5/25 at 3:28 p.m., the Director of Nursing (DON) stated residents on dialysis had a dialysis communication form completed by nursing staff prior to each dialysis appointment and sent with resident to dialysis. Upon the residents' return, the nursing staff reviewed the communication form for any new information or orders. DON went on to say nurses were to document in the EMR completion of and review of the communication form before/after each dialysis appointment. DON then confirmed although the EMR contained documentation of the completed/reviewed communication form, R21 had not had any dialysis communication forms completed since May 2025. DON stated her expectation was nursing staff completed the form. DON went on to state it was important to have ongoing communication with the dialysis center for resident safety, and to be sure there was no additional orders from the dialysis center.Facility policy titled Hemodialysis dated 11/22/19, indicated facility staff and the dialysis center will have ongoing communication and collaboration regarding dialysis care and services; if the dialysis run information is not received with the resident upon return, facility staff will call the dialysis unit to obtain the information; Documentation requirements will be met to assure that treatments are provided as ordered by the nephrologist, attending practitioner, and dialysis team; Documentation should include, but is not limited to, pre and post dialysis assessment/observation, daily check of access site, evaluation for signs and symptoms of infection, and fluid intake amounts for each shift with a 24 hour total, if a fluid restriction was in place.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly dispose of controlled medication for 2 of 2 residents (R57, R58) reviewed for disposal of medications after discharge.R57's death in facility minimum data set (MDS) dated [DATE], included R57 was discharged /deceased on [DATE].R57's Order Summary Report printed [DATE], included an order for lorazepam oral concentrate 2 mg/ml (a medication give for anxiety) give 0.25 milliliters (mL) by mouth every 2 hours as needed for restlessness and anxiety AND give 0.25 mL by mouth every 4 hours for restlessness and anxiety.During tour of medication room on [DATE] at 1:50 p.m., assistant director of nursing (ADON) opened lock box used to store controlled substances requiring refrigeration. Lock box contained a box containing a bottle with a label that identified it as lorazepam 2mg/ml for R57. ADON was unable to locate tracking page for R57's lorazepam in narcotic book currently being used in the facility. ADON was able to locate the tracking for R57's lorazepam in an unused book in the medication room in a cupboard. The last time count of narcotics in book containing R57's lorazepam was documented as completed was on [DATE]During interview on [DATE] at 1:50 p.m., ADON confirmed R57 was no longer a resident at the facility. ADON confirmed the medication was not in any of the current narcotic tracking books in the facility and was written down for tracking in an unused book that was stored in the cupboard. ADON confirmed tracking of the controlled substance was not being completed since [DATE] when the book was retired from use.R58's significant change MDS dated [DATE], included diagnosis of psychotic disorder and depression.R58's progress note dated [DATE] at 12:45 p.m., included R58 passed away in the presence of a hospice nurse while in the facility.R58's Moments Hospice order dated [DATE], included an order for lorazepam 0.5 mg by mouth every 4 hours as needed for terminal agitation (restlessness that occurs close to death).During tour of medication room on [DATE] at 1:50 p.m., ADON opened lock box used to store controlled substances requiring refrigeration. Lock box contained a box containing a bottle with a label that identified it as lorazepam 2mg/ml for R58.During interview on [DATE] at 1:50 p.m., ADON confirmed R58 was no longer a resident at the facility and floor staff should have disposed of the medication. Destruction of controlled medications was witnessed by two licensed staff members. During interview on [DATE] at 8:13 a.m., director of nursing (DON) stated all medications were counted at shift change or any time the medication cart/narcotic keys change hands during the shift. DON stated previously all refrigerated controlled medications were tracked in a narcotic book that was kept in the medication room, however, that would be changed because it was noted the counts were not being completed every shift as required. The DON stated it was important to complete narcotic counts to prevent medication diversion and to know what medication was on hand. During interview on [DATE] at 8:56 a.m., consultant pharmacist (CP) stated medications should be disposed of or destroyed when a resident discharges or passes away. CP stated there was not a specific time frame for destruction, however believed within a week would be reasonable. CP confirmed a resident who passed away in July should have had medications destroyed. Facility policy for disposal of controlled substances dated [DATE], included all medications should have been disposed of by two licensed nurses and documented in a record book after a resident had been discharged .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and document review, the facility failed to properly store controlled substances in 1 of 1 medication rooms reviewed for medication storage.During tour of medication room on 8/6/25 at 1:50 p.m., assistant director of nursing (ADON) showed the unlocked medication refrigerator with small unaffixed lockbox. ADON removed the lockbox from the refrigerator and unlocked it to show 6 controlled medications in the lock box. During interview on 8/6/25 at 1:50 p.m., ADON confirmed the lockbox was not permanently affixed to the refrigerator. ADON stated the facility had explored options to attach the lock box but had not yet found a solution. ADON described the box as similar to the size of an iPad and about 4 inches thick. ADON confirmed the whole box could be removed from the medication room. During interview on 8/7/25 at 8:13 a.m., director of nursing (DON) stated controlled refrigerated medications were stored in the refrigerator in the locked medication room in a lock box. The DON confirmed the lock box was not permanently affixed to the refrigerator because they have not figured out how the facility would like to secure it. The DON confirmed the controlled medication are double locked, but not in a permanently affixed compartment. The DON stated this was important to prevent diversion of medications.During interview on 8/7/25 at 8:56 a.m., consultant pharmacist (CP) stated controlled substances should have been stored in a permanently affixed double lock compartment to prevent diversion. The CP stated the pharmacy does complete routine audits of the medication storage and had noted this to be an issue during a recent audit and had reported the findings to the facility.Facility provided policy for medication storage dated August 2019, included controlled substances that require refrigeration are stored within a locked box in the refrigerator that must be attached to the inside of the refrigerator.