DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2022

CMS Certification Number (CCN): 245222

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 12, 2022 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
August 17, 2022

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

RE: CCN: 245222
Cycle Start Date: August 5, 2022

Dear Administrator:

On August 5, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an E tag), i.e., the plan of correction should be directed to:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 5, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 5, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/1/22 through 8/5/22, a survey for compliance with Appendix Z - Emergency Preparedness Requirements at §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/1/22 through 8/5/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to not be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5222152C (MN820141) H5222153C (MN82039) H5222154C (MN82038) H5222155C (MN80738) H5222156C (MN79202) H5222157C (MN82044) H5222158C (MN82076) H5222159C (MN79040) H52223707C (MN84821) H52223629C (MN84840), however, incidental non-compliance was cited at F610. The facility's plan of correction (POC) will serve	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment	F 553		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 2 and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R39) was provided follow-up and informed of options for care to facilitate person-centered care planning regarding the use of a positioning cushion in their wheelchair. Findings include: R39's significant change Minimum Data Set (MDS), dated 6/29/22, identified R39 had intact cognition. On 8/1/22, at 4:14 p.m. R39 was interviewed and expressed she had "cysts" on her buttocks which caused her discomfort if seated in her wheelchair for extended periods. As a result, she communicated with a physician and then visited with an occupational therapist (OT)-A several weeks ago about possibly adding a cushion to her wheelchair, however, there had been no follow-up since then. R39 stated she was unaware what, if any, interventions or actions were being taken to address the potential for adding a cushion to her chair and reiterated she wished staff would follow up and include her in such discussions. R39's progress note, dated 7/6/22, identified R39 was seen by a wound physician and new orders	F 553	F553 Right to Participate in Planning Care Corrective action for residents found to have been affected by the deficient practice: Therapy staff have assessed resident R39 for a wheelchair appropriate cushion and placement. Therapy staff provided communication to the resident. R39 has an appropriate wheelchair cushion at this time while awaiting the specialized cushion. Identify other residents having the potential to be affected by the same deficient practice: Full house audit to ensure all residents who utilize a wheelchair for mobility are provided with an appropriate wheelchair cushion. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Upon admission and prn all residents who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 3 were written. The corresponding Communication Form, dated 7/6/22, identified several hand-written orders for R39 including, "PT/OT [physical therapy/occupational therapy]- to assess for ROHO cushion [cushions which are constructed of individual cells or bubbles that move independently]." When interviewed on 8/3/22, at 2:10 p.m. nursing assistant (NA)-C stated she routinely worked with R39; however, voiced she was unaware of any discussion or involvement by therapy to help place a new cushion in R39's electric wheelchair. On 8/4/22, at 9:00 a.m. OT-A was interviewed and expressed she was aware R39 had a history of cysts on her buttocks which she was "not sure" if were healed or not, and she verified she was aware of the physician order to screen R39 (dated 7/6/22) for a cushion in her wheelchair. OT-A explained R39's wheelchair was called a "Captain's Chair" and placing a cushion in the seat was not a safe option and could impede her balance. As a result, they would have to "look at some alternatives" for R39's seating in her wheelchair. OT-A stated she could reach out to the chair' manufacturer to see if the seat could be adjusted, or have an outside equipment representative come review the chair and provide potential options, however, none of these options had been implemented yet. OT-A stated she recalled discussing such a plan with licensed practical nurse (LPN)-B several weeks ago, however, did not follow up or explain the options to R39 as she solely "followed up with nursing." OT-A stated she was unaware if licensed practical nurse (LPN)-B had discussed the options or situation with R39.	F 553	require a wheelchair will be evaluated for a cushion and made aware of plan of care. Nursing and therapy staff to be educated on resident wheelchair cushion procedure including their responsibility for new admits, location of wheelchair cushions, and communication to resident. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit 10 residents with wheelchairs weekly x4 weeks, then monthly x2 months to ensure resident has appropriate wheelchair cushion. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 4 R39's medical record was reviewed and lacked evidence R39 had been consulted or updated on OT-A's actions to address the placement of cushion when it was determined an additional cushion may be unsafe. There was no evidence R39 had the options explained to her to afford her the opportunity to be involved in her care and subsequent decisions about cushion use or the alternatives. When interviewed on 8/4/22, at 9:13 a.m. R39 stated nobody had told her placing another cushion in her wheelchair was unsafe and, as a result, not an option. Further, R39 stated nobody had discussed any other options with her (i.e., outside equipment representative) and reiterated she wanted to be included in these discussions and not getting updated was upsetting adding staff "do things without talking with me" and, "It pisses me off!" On 8/4/22, at 9:38 a.m. LPN-B was interviewed and recalled having a discussion with OT-A several weeks prior about R39's positioning and wheelchair cushion use. LPN-B stated she was told another cushion would not be appropriate, however, did not ever follow up with R39 about it as she "figured they [therapy] were going to follow up with her." LPN-B stated she felt having her discuss the cushion, and potential alternatives, with R39 was not appropriate as recommendations would be made by therapy and not nursing. When interviewed on 8/4/22, at 12:37 p.m. licensed practical nurse manager (LPN)-C stated therapy staff should have updated R39 on the situation with her wheelchair cushion and any alternatives which were an option. LPN-C added,	F 553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 5 "I would expect therapy to go and address that." Further, LPN-C stated R39 should have been updated on the wheelchair cushion, including any alternative options if a cushion wasn't safe as, "You want them [the resident] to be involved in their care." A facility' policy on participation in care planning was requested, however, was not received.	F 553		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate resident needs by ensuring the call light was appropriate and accessible for 1 of 1 resident (R44) incapable of using the provided call light according R44's physical limitations. Findings include: R44 diagnosis included spastic quadriplegic cerebral palsy (lack of the ability to move or feel both arms, both legs, and other parts of the body) leaving him unable to control and use his legs, arms, and body. R44's annual Minimum Data Set (MDS) dated 7/6/22, identified R44 required total dependence of one to two staff assistance with all activities of daily living, speech was usually understood with clear comprehension in ability to	F 558	F558 (D) Reasonable Accommodations needs/preference Corrective action for residents found to have been affected by the deficient practice: 0n 8/3/22 resident R44 was provided with a breath activated call light. Resident was educated on how to use call light and demonstrated proper use. Identify other residents having the potential to be affected by the same deficient practice: Full house audit on all residents to ensure that they are provided with a call light that	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 6 understand others, and impaired functional limitations in range of motion to both upper and lower extremities. R44's care plan dated 9/19/2018 and 12/23/201, indicated staff were to keep call light within reach at all times. On 8/13/20, an additional care plan indicated staff were to, "make sure resident has the right resources that can help him call for help without screaming and hollering at staff for help." During observation on 8/1/22 at 1:01 p.m., R44 was in bed with a soft call light under pillow on left side of head. When asked if he could press the call light, R44 responded by shaking his head from left to right. Both hands contracted with forearms and fingers facing R44 torso. He was unable to move fingers when asked. When interviewed on 8/1/22 at 6:21 p.m., nursing assistant (NA)-B stated R44 never used his call light and relied on his roommate to ask for help when R44 would "grunt or fuss." NA-B stated R44 was able to bite on his soft call light if he needed assistance. During observation on 8/2/22 at 8:23 a.m., R44's call light was observed not on his bed and it was clipped to fabric room divider curtain not in reach of R44. When interviewed on 8/2/22 at 9:02 a.m., NA-A and licensed practical nurse (LPN)-A stated the call light should be accessible to R44 and confirmed that it was not. When interviewed on 8/3/22 at 9:21 a.m., registered nurse (RN)-A stated R44 was unable to use a soft cell call light and to ask for	F 558	they can appropriately use and that call light is within reach unless care plan indicates otherwise. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Upon admission and PRN thereafter resident will be assessed for appropriate call light. If special call light is determined by facility staff, this will be reflected in the resident plan of care. All nursing staff will be educated on call light process including what to do if the resident is unable to demonstrate use. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit weekly x4 weeks, then monthly x2 months of 10 residents to ensure appropriate call light is available to them. If special call light is determined, this is indicated in resident plan of care. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 7 assistance. RN-A placed a call light on a pillowcase touching R44's face and asked R44 to use the call light with his mouth. R44 attempted several times but was unable to bite down or activate the call light. RN-A asked R44 if he could turn on the call light and R44 shook his head left to right. RN-A stated therapy was responsible for evaluating R44 for appropriate call light use. During observation on 8/3/22 at 12:31 p.m., R44 was observed with a flat metal call light on his bed placed on a pillow. It was located next to side rail and right shoulder. When asked if he could use the call light R44 shook head from left to right. During interview on 8/3/22 at 3:19 p.m., the director of nursing, (DON) stated she trialed the flat metal call light with R44. DON indicated R44 "squeals" to get attention and staff anticipate his needs. DON stated R44 can only move his head and is unable to press a call light and to use his fingers. DON stated a call light "has to be in reach" and usable by the resident. DON also stated the expectation was that nursing was responsible for call light evaluations and confirmed it was not done for R44. A call light policy and procedure for assessing for call light use was requested and not received.	F 558		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another	F 563		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 8 resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure the right to withdraw consent and deny visitors at any time for 1 of 3 residents (R54) reviewed for visitation. In addition, the facility failed to ensure after hour visitation occurred in a manner that did not impose on the rights of 1 of 3 residents (R58) reviewed for visitation. Findings include: R54's admission Minimum Data Set (MDS) dated 7/19/22, indicated R54 had intact cognition with	F 563	F563 (D) Right to receive/ deny visitors Corrective action for residents found to have been affected by the deficient practice: Resident R54 was immediately interviewed to discuss visitor preference. At this time, R54 stated they did not want FM-A to be visiting him. FM-A was removed from resident's face sheet and trespass notice was completed. All staff educated that R54 does not want FM-A to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 9 little interest or pleasure in doing things, feelings of depression, or hopelessness, trouble falling asleep or sleeping too much, feeling tired and bad about self, and trouble concentrating, 2-6 days during the assessment period. R54 required supervision with dressing, toileting, bed mobility, personal hygiene, and eating and was independent with transfers. R54 had diagnoses including spinal stenosis, acute stress reaction, post-traumatic stress disorder (PTSD), major depressive disorder, and high blood pressure. R54's admission CAA dated 7/19/22, indicated R54 triggered for psychosocial well-being. R54's care plan dated 7/13/22, indicated R54 was a vulnerable adult at risk for abuse and decreased cognitive and physical abilities due to spinal stenosis and PTSD. R54 was also at risk for alteration in psychosocial wellbeing related to PTSD and major depressive disorder. Interventions included monitoring for signs of emotional distress and mood. R54 attended therapeutic recreational (TR) activities as interested saying "I just need someone to listen to me." Interventions included providing time for R54 to talk at TR activities because being listened to "helps me." R54's electronic medical record (EMR) profile dated 8/2/22, indicated FM-A as R54's Emergency Contact # 1. R54's progress note dated 7/17/22, at 10:15 p.m. indicated he requested not to have visitors, especially FM-A. After 30 minutes FM-A entered the unit yelling and wanting to see R54. Staff advised FM-A to leave because R54 did not want to see her. FM-A stayed for approximately 15	F 563	be visiting him and that if they see her, they are to escort her out of the building and call the police. Identify other residents having the potential to be affected by the same deficient practice: All residents interviewed to ensure that they are receiving visitors per their preference and are educated to notify staff if they do not want someone to visit them. All residents contacts reviewed with resident to ensure accuracy. Visitor sign in log in place at front door. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: All staff to be educated on resident visitor policy. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit 10 residents weekly x4 weeks, then monthly x2 months to ensure residents are okay with those who are visiting them. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 10 minutes then left the facility. R54 came out of his room and stated he was concerned about the security of the facility and how anyone can come in. During an interview on 8/2/22, at 11:08 a.m. R54 stated since his admission on 7/12/22, an ex-girlfriend (FM)-A had been coming into the building and his room although he had told staff he does not want to see her. R54 stated if he ignored FM-A's calls to his cell phone, FM-A would call the nurse's station. R54 has told staff to tell FM-A that he does not want to talk to her, which prompts FM-A to come to the facility. R54 stated he was concerned because FM-A had been able to walk into the building and up to his room on the fourth floor without staff knowing. R54 stated during the night, although the front door was supposed to be locked, residents would prop it open while they smoke, allowing people off the street to enter. R54 further stated the lights were turned out in the hallways and staff were sleeping at night and therefore, R54 did not feel safe. R54 stated FM-A was a "real stalker" and was "crazy, rude, and obnoxious." R54 stated he did not want FM-A in the facility because she was "the type that could hurt you." During an interview on 8/2/22, at 2:19 p.m. registered nurse (RN)-C stated she had seen FM-A on the unit before but since R54 did not want to see FM-A, the staff would send her away. RN-C stated FM-A was in the facility twice on 7/31/22, once after breakfast and again after lunch. RN-C told FM-A that R54 did not want any visitors and FM-A left. RN-C stated FM-A did not always leave "easily" and would use foul language toward R54. RN-C further stated the facility doors were locked at night but residents	F 563	Monitored by: Social services director or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 11 who smoked would prop open the door to get back in. RN-C stated the director of nursing (DON) and the assistant director of nursing (ADON) were aware of the situation with FM-A; however, RN-C did not know of any interventions in place to keep FM-A from entering the facility or getting onto R54's unit. RN-C was also unaware that FM-A was still listed as R54's emergency contact allowing FM-A to obtain information about R54. During an interview on 8/3/22, at 9:51 a.m. nursing assistant (NA)-F stated FM-A would call the facility but when she was told R54 did not want to speak to her, FM-A would "get angry" and come into the facility being "aggressive and disruptive" towards R54 and the staff. NA-F stated he last saw FM-A on the morning of 8/1/22. During an interview on 8/3/22, at 12:15 p.m. RN-D stated on 7/17/22, R54 told her if FM-A called or came into the facility, he did not want to speak to or see her. Later that day, RN-D saw FM-A get off the elevator and attempt to enter R54's room. RN-D told FM-A, R54 did not want any visitors and FM-A was not allowed to go into his room. RN-D stated she "was so scared" because FM-A yelled, cursed, and pointed her finger at RN-D saying, "I will see you," before getting into the elevator; however, FM-A came back to the unit two more times before leaving the facility. On 7/31/22, RN-D again saw FM-A attempt to enter R54's room but was able to redirect FM-A out of the building without confrontation. During an interview on 8/2/22, at 3:37 p.m. the director of social services (DSS) stated she was aware that staff had told FM-A to leave the facility	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 12 because R54 did not want to see FM-A. DSS stated she had not spoken to R54 about the incident and was unaware of interventions other than staff telling FM-A to leave the facility. DSS further stated it was concerning that a visitor could enter the facility and "wander into resident room." DSS stated there was no staff assigned to screen visitors entering the facility or a visitor sign-in book to keep track of visitors. During an interview on 8/3/22, at 9:53 a.m. the ADON stated he saw FM-A once on the morning of 7/29/22, when the ADON told her to leave and escorted FM-A out of the facility. During an interview on 8/3/22, at 10:06 a.m. the DON stated she was unaware of the situation between R54 and FM-A or that the ADON had escorted FM-A out of the facility on 7/29/22. The DON stated she should have been notified immediately. It was also a concern that FM-A continued to be listed as an emergency contact for R54 even though R54 did not want to see FM-A. During an interview on 8/3/22, at 10:40 a.m. the administrator stated management was aware of the situation between R54 and FM-A on 7/18/22, when they read the progress note from the previous evening. The administrator stated the staff were aware that FM-A was not supposed to be in the facility and should be escorted out. No other interventions were discussed or in place. The administrator further stated she did not know why FM-A remained listed as R54's emergency contact. R58's quarterly MDS dated 7/12/22, indicated R58 had intact cognition and required supervision	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 13	F 563		

with toileting and personal hygiene. R58 was independent with all other activities of daily living (ADLs). R54 had trouble falling, or staying asleep, or slept too much for an unspecified time, and felt tired or had little energy for 2-6 days during the assessment period. R54's MDS also indicated it was very important for R54 to choose his preferences for customary routines and activities including what time he went to bed. R58's diagnoses included major depressive disorder, displaced fracture of the left wrist, diabetes, alcoholic cirrhosis of the liver, and esophageal varices (abnormally dilated veins in the esophagus).

R58's significant change CAA dated 1/22/22, indicated R54 triggered for psychosocial well-being.

R58's care plan dated 11/19/21, indicated R58 had potential for alteration in mood related to major depressive disorder. Interventions included staff being alert to mood and behavioral changes. R58 care plan additionally indicated he was at risk for moderate pain related to a recent fracture to his left forearm. Interventions included non-medical pain relief such as rest.

R58's progress note dated 7/12/22, indicated R54 stated he had been feeling tired and had had trouble sleeping for a few days.

R24's quarterly MDS dated 6/21/22, indicated R24 had intact cognition and had verbal behaviors directed towards others and other behaviors not directed towards others 1-3 days during the assessment period.

During an interview on 8/1/22, at 12:36 p.m. R58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 14 stated on two occasions, his roommate (R24) had visitors that stayed overnight in their shared room. R58 stated approximately two weeks ago, a woman and two young girls around five and six years old, spent the night in their shared room. R58 stated the girls were crying and had the TV turned up loud, keeping R58 "up all night." R58 stated, on a second unknown date, the same two young girls were in the shared room during the night and kept R58 "up all night". During an interview on 8/1/22, at 3:00 p.m. R24 stated he was watching his grandkids in his room one night and their mother picked them up around 3:00 a.m.. During an interview on 8/2/22, at 2:38 p.m. RN-C stated approximately two weeks ago, she was coming into the facility around 6:00 a.m. and saw a woman and child leaving R24 and R58's shared room. R58 told RN-C they had been in their room and kept him awake all night. RN-C stated she told the assistant director of nursing (ADON) but was unaware of any follow up regarding the situation. During an interview on 8/4/22, at 2:05 p.m. the ADON stated he did not recall a nurse telling him about visitors staying overnight in R24 and R58's shared room. The ADON stated visitors were allowed to visit after hours, however, they were not supposed to spend the night. The ADON further stated he was unaware of the policy regarding late night visitation for residents with a roommate. During an interview on 8/4/22, at 2:18 p.m. the administrator stated quiet hours for the facility began at 11:00 p.m. and therefore, the	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 15 expectation was that R24 would visit with his family outside his shared room, so they did not disturb R58. Facility Resident Visitation Rights policy dated 11/2016, indicated the facility encouraged resident self-determination regarding the visitation rights of residents. Residents had the right to receive visitors of his or her choosing subject to the resident's right to deny visitation, and in a manner that does not impose on the rights of another resident. The facility must provide immediate access to a resident by visitors with the consent of the resident, subject to the resident's right to deny or withdraw consent at any time.	F 563		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 16 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Medicare A beneficiaries received the skilled nursing facility advanced beneficiary notice (SNFABN) form, for 2 of 2 residents (R7, R64) remaining in the facility and 1 of 1 residents (R65) who did not receive	F 582	F582 (D) Medicaid/ Medicare Coverage/ Liability Notice Corrective action for residents found to have been affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 17 the Notice of Medicare Non-coverage-Form (NOMNC) when discharged from the facility. Findings include: R7's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed by the facility identified R7's Medicare Part A Skilled services Episode Start date was 5/17/2022, and last covered day of part A service was 5/27/2022. R7's form lacked documentation the SNFABN form was provided. R64's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed by the facility identified R64's Medicare Part A Skilled services Episode Start date was 5/21/2022, and last covered day of part A service was 5/30/2022. R64's form lacked documentation the SNFABN form was provided. R65's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed by the facility identified R65's Medicare Part A Skilled services Episode Start date was 3/19/2022, and last covered day of part A service was 5/13/2022. R65's form identified R65 was not provided a SNFABN form CMS-10055 form since R65 was discharged from the facility and had received non-covered services. During an interview on 8/4/2022, at 9:01 a.m., facility administrator stated she could not locate the forms in the electronic chart where they were expected to be found. The administrator stated she spoke with the business office manager and the forms were not provided as required. A policy from the facility on beneficiary notices	F 582	Resident R7 received SNFABN form. R65 and R64 have been discharged from the facility. Identify other residents having the potential to be affected by the same deficient practice: All residents will receive SNFABN and NOMNC per regulation. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Business office manager was re-educated on beneficiary notice initiative. Tracking of SNFABN and NOMNC was added to facility's daily IDT meeting. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit all skilled residents weekly x4 weeks, then monthly x2 months to ensure NOMNCs are issued per regulation. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 18 was requested however not provided.	F 582		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 585		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 19 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 20 regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced grievance concerning missing clothing was addressed and resolved to satisfaction for 1 of 1 resident (R55) who reported missing clothes. Findings include: R55's admission Minimum Data Set (MDS), dated 7/19/22, identified R55 admitted to the nursing home on 7/12/22, and had moderate cognitive impairment but demonstrated no delusional behaviors (i.e., a belief or altered reality that is persistently held despite evidence to the contrary). On 8/1/22, at 2:12 p.m. R55 was interviewed and expressed frustration as she recently had a couple pairs of pants and shirts go missing. R55 stated these items had been missing "about a	F 585	F585 (D) Grievances Corrective action for residents found to have been affected by the deficient practice: Missing item report was completed for resident R55 and missing clothing was located. Identify other residents having the potential to be affected by the same deficient practice: Residents will be interviewed specifically to any missing clothes or items. The facility will follow missing items policy if missing items are identified. Measures put into place, or systemic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 21 week and a half" now, and she reported them missing to nursing assistant (NA)-C, however, there had been no follow-up or discussion about them since. R55 added, "They don't care." When interviewed on 8/3/22, at 11:37 a.m. NA-C recalled R55 had reported some missing clothing to her "over a week ago," and explained the items reported as missing included some pairs of pants and a purple shirt. R55 had mentioned these items being missing "multiple times" since she moved rooms (on 7/28/22), and as a result, NA-C stated she went to the laundry and searched for the items in the lost and found. The items were not there. NA-C explained when items were reported as missing, the nurse should be notified and there was a "missing items" form to complete which gets routed to management so the items can be addressed. However, NA-C stated she did not complete this form as "I don't have one up here [on the unit]." Further, NA-C verified she had not reported R55's voiced complaint of missing items since she moved rooms to the social services department but added, "I thought I did my part." A provided Grievance/Lost Missing Items listing, dated 7/6/22 to 7/22/22, identified all grievances reported to and tracked by the nursing home. R55's name was recorded on 7/18/22 as having reported missing money with a section labeled, "Notes," adding, " ... was in her wallet." The provided form lacked any evidence R55's reported missing clothes had been acted upon, addressed or resolved despite direct care staff having knowledge she had reported missing items since moving rooms on 7/28/22. On 8/3/22, at 11:59 a.m. the social services	F 585	changes made, to ensure that the deficient practice will not recur: All staff will be educated on missing items policy and forms made available to staff and residents. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit 10 residents weekly x4 weeks, then monthly x2 months to ask if residents have any missing clothes or items. If items are reported, ensure missing item is completed and facility investigation policy is followed. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 22 director (SSD) was interviewed and explained missing items were asked about and discussed at the routine care conferences. However, if something was reported as missing in-between those conferences, then a "missing item report" could be completed and a search for the item would take place. SSD stated "anybody" was able to complete a missing item form. SSD recalled R55 had voiced a concern about missing clothes in the past and some were located in the laundry and returned to her which was documented on a missing item form. R55's provided Lost and Missing Items form, dated 7/22/22, identified R55 reported missing clothes which were written as, "sweatpants - gray [and] red [illegible writing]." The form was routed to the laundry department. A section labeled, "Options Discussed," identified, "most items were in laundry," with additional writing which outlined, "Pants founds, along with other items and now [illegible]. TR [therapeutic recreation] looking for red [illegible]." The form was then signed by the SSD and the administrator on 7/22/22. SSD stated the items on the form were "the things she told me" were missing and verified the grievance was completed on 7/22/22, when most of the items were located. SSD stated she was unaware R55 reported additional items (i.e., more pants, purple shirt) to NA-C since she had changed rooms on 7/28/22. SSD stated NA-C should have completed a missing items form and alerted social services so follow-up could happen. SSD added, "It's important we keep track of these things." A provided Lost, Missing and Damaged Items policy, dated 5/2017, identified any resident who	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 23 had items missing or damaged could bring the concern to the attention of the nursing home so " ... that it can be investigated and resolved." The policy directed the person receiving the initial complaint was responsible to completed a Lost, Missing and Damaged Items Form which were available in the social services office or nurses' station. Following, the form should then be routed to the administrator's office " ... as soon as is reasonably possible ..." The report would then trigger an investigation into the missing items.	F 585		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of misappropriation of funds for 1 of 1 residents (R49) reviewed for misappropriation of	F 610	F610 (D) Investigate/ prevent/ correct alleged violation Corrective action for residents found to	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 24 funds. Findings include: Nursing Home Incident Report (NHIR) dated 7/5/22, at 11:12 a.m. indicated on 7/4/22, at 11:00 a.m. R49 reported to staff that someone had taken his money while he was sleeping. R49 put his money in a pouch and placed it under a pair of pants and the following morning, the pouch was on the floor and his money was missing. R48's room was searched but no money was located. NHIR 5-day report dated 7/12/22, at 10:56 a.m. indicated on 7/5/22, R49 told the director of social services (DSS) that he was missing $130.00 from the pouch he kept his money and cigarettes in. R49 requested the police be notified, however, due to the holiday on 7/4/22, staff were unable to get through to the police. Staff searched R49's room and followed up with laundry and housekeeping but were unable to locate R48's money. R49's quarterly MDS dated 7/7/22, indicated R49 had intact cognition and diagnoses included end stage chronic kidney disease requiring renal dialysis, below the left knee amputation, insomnia, major depressive disorder, legal blindness, and diabetes. R49's significant change MDS dated 10/15/21, indicated it was somewhat to very important for R49 to decide on his preferences for customary and routine activities including having a safe place to lock up personal items. R49's significant change CAA dated 10/15/22,	F 610	have been affected by the deficient practice: Staff interviews completed for alleged misappropriation of funds for resident R49. Identify other residents having the potential to be affected by the same deficient practice: Audit all reported investigations in the past 3 months to ensure a thorough investigation was completed. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Social Services Director and designee educated on through investigation. All staff to be educated to facility abuse and vulnerable adult policy. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit weekly x4 weeks, then monthly x2 months to ensure all allegations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated by the facility. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 25 indicated R49 triggered for visual function, and communication. During an interview on 8/2/22, at 8:46 a.m. R49 (through interpreter) stated when he woke up on 7/4/22, at 5:00 a.m. to go to dialysis, he realized he was missing $130.00. R49 stated the money was in his pouch under a hat on his chair when he went to bed the previous night. During an interview on 8/3/22, at 1:50 p.m. DSS stated she did not interview any staff regarding R49's missing money other than the staff member who initially reported the incident to the DSS. DSS also stated because R49 was blind, she did not know how he knew how much money he had or was missing. DSS further stated a questionnaire was given to the other residents on R49's unit. Review of the investigation file for R49's missing money indicated a questionnaire was sent to 15 residents on R49's unit on 7/11/22, asking if they had "a way to store any money you have safely". The residents were not asked if they had had any money stolen recently or if they had seen or heard anything regarding R49's missing money. The facility Abuse Prohibition/Vulnerable Adult Plan dated 4/11/22, indicated investigations of abuse, neglect, and misappropriation of resident property may include interviewing staff, residents, or other witnesses to the incident and a summary which identified trends or patterns would be forwarded to the Quality Assurance and Performance Improvement (QAPI) committee.	F 610	Monitored by: Administrator or Designee	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess to ensure adequate interventions were placed to promote healing and reduce the risk of deterioration; ensure physician-ordered treatments were implemented; and ensure adequate, routine monitoring of a developed pressure ulcer was completed and recorded for 1 of 2 residents (R42) reviewed for pressure ulcer care. Findings include: R42's quarterly Minimum Data Set (MDS), dated 6/30/22, identified R42 had severe cognitive impairment and required extensive to total assistance to complete her activities of daily living (ADLs). Further, the MDS identified R42 was at risk of developing pressure ulcers, however, had no current stage one or higher unhealed pressure ulcers.	F 686	F686 (D) Treatment/ services to prevent/ heal pressure ulcer Corrective action for residents found to have been affected by the deficient practice: On 8/3/2022 resident R42 had tissue tolerance completed, was evaluated by wound MD, and new orders received. Wound resolved on 8/10/22. Continues to receive preventative treatment and interventions. Identify other residents having the potential to be affected by the same deficient practice: Residents will have skin inspection reviewed to identify any skin concerns. Any skin concerns identified in the audit will have proper assessment and follow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 R42's care plan, dated 7/15/22, identified R42 was at high risk for impaired skin integrity along with a goal which read, "Resident will remain free from skin breakdown." The care plan listed several interventions to help R42 meet this goal including 'checking and changing' her every one to two hours, monitoring her skin daily with cares, and, "Measure, assess skin breakdown weekly and prn [as needed]." R42's MHM (Monarch Healthcare Management) Weekly Skin Inspection, dated 6/16/22, identified R42's skin was intact and barrier cream was applied to perineal redness. However, a subsequent progress note, dated 6/30/22, identified R42 received a bed bath and skin check. The note recorded, " ... has skin breakdown on their coccyx ... cleaned and covered with a foam dressing ... informed nurse manager and will update evening shift." A subsequent MHM Braden Scale, dated 6/30/22, was completed which scored R42 at "mild risk" for skin breakdown. However, a corresponding MHM Tissue Tolerance Evaluation and Skin Risk Factors, was loaded in the record but only recorded with, "In Progress." The entire assessment and evaluation was left blank and not completed. A Vohra Wound Physician Wound Evaluation & Management Summary, dated 7/6/22, identified R42 was assessed by the wound physician who recorded R42 presented with a wound on her posterior sacrum which was recorded as, "SHEAR WOUND OF THE POSTERIOR SACRUM PARTIAL THICKNESS," and recorded measurements of 2.1 centimeters (cm) long X 0.2 cm wide X 0.1 depth. Further, a section labeled,	F 686	up. All residents will be audited to ensure all had braden and tissue tolerances per regulations and interventions in place where appropriate. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Licensed nurses will be educated on facility skin assessment and wound management policy including what to do when a new skin concern is identified, how to identify if a wound is new vs preexisting, and completing braden and tissue tolerance eval per assessment grid and with identification of a new pressure ulcer. Nursing leadership will be educated regarding the assessment grid to ensure braden and tissue tolerances are completed per regulation. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit 10 residents weekly x4 weeks, then monthly x2 months to ensure all skin breakdown is captured, assessed, and treated. Additionally, dressing change audit to ensure correct dressing is being applied per physician orders. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 "Dressing Treatment Plan," directed a primary dressing be applied, "Transparent film apply twice a week for 30 days." R42's subsequent MHM Weekly Skin Inspection, dated 7/7/22 (the following day), identified R42's skin was " ... clean, dry, and intact. Slight redness noted on coccyx, groin, underneath breast." There was no recorded measurements of the identified redness or any other characteristics of the wound (i.e., drainage, odor) recorded. A subsequent MHM Weekly Skin Inspection, dated 7/14/22, identified R42 had a bed bath completed and " ... skin breakdown on coccyx, management is aware of this and res[ident] is being followed by wound care ..." However, again, there was no recorded measurements of the identified breakdown or any other characteristics of the wound (i.e., drainage, odor) recorded to ensure it was healing appropriately. An additional Vohra Wound Physician Wound Evaluation & Management Summary, dated 7/20/22, identified the service was signing off R42's care without visiting her. It concluded, "Reconsult as needed." A subsequent MHM Weekly Skin Inspection, dated 7/21/22, identified, " ... overall skin was intact ... breakdown on coccyx was cleansed and dressed per [physician] orders." However, again, there was no recorded measurements of the identified breakdown or any other characteristics of the wound (i.e., drainage, odor) recorded to ensure it was healing appropriately. A subsequent MHM Weekly Skin Inspection, dated 7/28/22, identified R42's skin as " ... clean	F 686	Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29 and intact. Minor skin breakdown on bottom ... was cleaned and barrier cream applied ... Nurse manager notified." However, again, there was no recorded measurements of the identified breakdown or any other characteristics of the wound (i.e., drainage, odor) recorded to ensure it was healing appropriately. R42's medical record was reviewed and lacked evidence R42 had been comprehensively reassessed for pressure ulcer risk and potential interventions after 6/30/22, when an open area was identified. There was no indication the facility had assessed how R42 had developed this pressure area, nor was there any evidence it was being comprehensively monitored on a weekly basis for healing including routine measurements and characteristics being recorded to track the wound' progress and ensure it remained free of complications (i.e., infection). On 8/3/22 at 8:58 a.m. morning cares for R42 were observed. Nursing assistant (NA)-D and NA-E entered R42's room and stated they were going to check and change her. NA-D removed R42's single white sheet cover exposing R42 who was positioned directly on her back and buttocks. R42's soiled incontinence product was undone, and she was assisted to turn to her side exposing a tan-colored non-transparent foam dressing on her sacrum just above the gluteal crease. The dressing had visible black writing present, "EW 7/30/22 PM." NA-D and NA-E completed peri-cares and placed a new incontinence product underneath of her buttocks. NA-E stated she was "not sure" why R42 had a dressing on her sacrum and pulled up the lower edge exposing visible sheared, dark red-colored skin underneath. NA-E replaced the dressing edge and stated she must	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 have "a little wound" present. R42 was then positioned on her left side using a pillow and her covers replaced. Immediately following, at 9:11 a.m., NA-D and NA-E were interviewed. NA-D stated R42 needed total care and they repositioned her "every two hours," adding that was "all I really know." NA-D stated she did not recall ever seeing a "major wound" on R42's buttocks but added there wasn't consistently a dressing on it, either, explaining a dressing seemed to be present "once in awhile" only. On 8/3/22 at 1:14 p.m., licensed practical nurse manager (LPN)-C was interviewed. LPN-C explained R42 was supposed to have a clear tegaderm film placed on the shear wound, in accordance with the physician treatment plan on 7/6/22, as "more of a preventative thing" and not a tan-colored foam dressing. LPN-C stated she was under the impression the pressure ulcer "was still healed" due to the skin inspection completed on 7/7/22, however, due to the surveyor investigation did have the wound physician observe the wound that day (on 8/3/22). The wound physician determined it was a stage II pressure ulcer and recommended barrier cream be applied twice a day to promote healing. LPN-C verified the wound should not have had a tan-colored dressing placed on top of it as it was not the physician order and should only be used on wounds with heavy drainage. LPN-C expressed she believed the tan-colored foam dressing was placed "per nursing judgement," and verified if a wound was worsening and needing a dressing order change, the nurses should update the physician; however, there was no evidence that had been completed. LPN-C	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31 stated a developed pressure wound should be monitored and recorded on weekly basis which typically was accomplished through the rounding wound physician (Vohra); however, this was not completed as the wound service signed off on 7/20/22. LPN-C verified the medical record lacked recorded evidence demonstrating the wound was comprehensively monitored and recorded since 7/6/22 (nearly a month prior). Further, LPN-C stated a resident should be comprehensively reassessed after a new pressure ulcer develops using a Braden Scale and a Tissue Tolerance Test; however, again, verified this had not been completed so far. LPN-C stated all these actions were important to do as, "You want to make sure its [the wound] improving and [the treatments] working." On 8/3/22 at 2:55 p.m., LPN-C and the registered nurse consultant (RNC)-A were interviewed. RNC-A verified she had reviewed R42's medical record, and she explained she believed the nurses were charting R42 as having a pressure ulcer solely due to the dressing being in place. They likely had been unaware the dressing was solely intended to help prevent recurrent breakdown. RNC-A stated "as far as we can tell," R42 developed the pressure ulcer on 7/14/22, when the recorded notes specifically identified skin breakdown was present. RNC-A verified R42 and the developed pressure wound should have been reassessed using a Braden scale and Tissue Tolerance Evaluation; and the wound should have been monitored and recorded on a weekly basis after it developed. This was important to do in effort to promote healing of the wound. A provided Skin Assessment & Wound	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 32 Management policy, dated 5/2022, identified the general guidelines for assessing and managing wounds; this included completion of a Braden Scale upon admission, quarterly and " ... upon significant change in condition, as indicated," and, a Tissue Tolerance Evaluation being completed on admission and annually thereafter. A section labeled, "Pressure Wounds," directed actions when a pressure ulcer was identified. This included notification to the physician and initiating Weekly Pressure Wound Evaluation(s).	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide treatment/services to maintain or improve range of motion (ROM) for 1 of 1 resident (R44)	F 688	F688 (D) Increase/ Prevent Decrease in ROM/ Mobility Corrective action for residents found to	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33 assessed for splint use. Findings include: R44 diagnosis included spastic quadriplegic cerebral palsy leaving him unable to control and use his legs, arms, and body. R44's annual Minimum Data Set (MDS) dated 7/6/22, identified R44 required total dependence of one to two staff assistance with all activities of daily living, speech was usually understood with clear comprehension in ability to understand others, and impaired functional limitations in range of motion to both upper and lower extremities. R44's orders dated 5/8/22 instructed staff to complete PROM (passive range of motion) to bilateral shoulders, elbows, wrists, and fingers daily with care every day shift to decrease risk of contractures. R44's care plan dated 10/17/2018 directed staff to perform PROM as ordered by therapy. Also, a revised care plan dated 10/12/21, directed staff to apply resting grip splint on during the day, off at night. Observation on 8/1/22 at 1:01 p.m., R44 laying in bed with arms and hands contracted towards torso with no hand splints on. During observation and interview on 8/1/22 at 6:27 p.m., nursing assistant (NA)-B stated the hand splints were discontinued and were not in R44 room. Observation on 8/2/22 at 8:48 a.m., hand splints not applied to R44.	F 688	have been affected by the deficient practice: R44 hands splints were discontinued due to resident being on hospice and preference to not use the splints. Identify other residents having the potential to be affected by the same deficient practice: Audit to identify residents that have order for ROM and splits. If a resident is identified, ensure proper doctors' orders are in place. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Nursing staff will be educated regarding following orders for ROM and splints including what to do if splints are not available, are unable to be applied, causing resident pain, or resident refuses. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit 5 residents weekly x4 weeks, then monthly x2 months of residents on ROM program and/or splits to ensure facility is following orders. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 34 When interviewed on 8/2/22 at 9:05 a.m., occupational therapist (OT)-B stated responsibility for applying hand splints and range of motion (ROM) exercises were nursing staff. When interviewed on 8/2/22 at 9:09 a.m., licensed practical nurse (LPN)-A and NA-A stated they were not aware of any splints or ROM exercises per care plan and agreed that R44 hands were contracted inwards towards his torso. When interviewed on 8/3/22 at 9:21 a.m., registered nurse (RN)-A stated nursing was responsible for applying hand splints and ROM for R44 and verified that it was in the care plan and RN-A did not apply any hand splints or perform ROM exercises to R44 for 8/1/22 when RN-A was responsible for R44 care during day shift. During observation on 8/3/22 at 1:19 p.m., no hand splints were applied to R44. When interviewed on 8/3/22 at 3:19 p.m., the director of nursing (DON) stated nursing staff were responsible for following care plan and to apply the splints and perform ROM and to document if R44 declines. DON confirmed this was not followed per care plan and documentation not present for R44 declinations. DON confirmed specific exercises were not provided in care plan or care sheets for staff to follow. Interview with OT-A on 8/4/22 at 8:50 a.m., stated residents with contractures to hands and arms benefit from regularly wearing splints and ROM exercises. Failure to do so, "would cause the contractures to be worse and potentially more	F 688	Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 painful." A policy on splints was requested but not provided.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide oxygen therapy consistent with professional standards of practice resulting in hypoxia for 1 of 1 resident (R15) reviewed for oxygen use. Findings include: R15's Admission Record printed 8/5/22, indicated R15 was admitted to the facility on 12/11/21. R15's admission Minimum Data Set (MDS) dated 6/15/22, lacked any indication R15 required oxygen (O2)therapy. R15's hand-written hospice order sheet dated 8/2/22 indicated R15 should have O2 (oxygen) delivered by nasal cannula (NC) at 2-4 liters/minute (L/min) but this had not been entered in to the electronic medical record (EMR) where	F 695	F695 (D) Respiratory/ Tracheostomy Care and Suctioning Corrective action for residents found to have been affected by the deficient practice: R15's head of bed was raised, and oxygen applied at the time this was identified. Oxygen orders were obtained and entered. Identify other residents having the potential to be affected by the same deficient practice: Full house audit of residents on oxygen was completed to ensure active orders are in place and care planned appropriately.	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 36 staff could see the orders. R15's provider orders dated 8/5/22, lacked orders for O2 therapy. R15's care plan dated 12/8/21, indicated, administer O2 as ordered, but had not been oxygen administration had not been included in the current orders. During observation on 8/03/22, at 08:43 a.m. R15 was sitting up to eat in bed, the O2 tank was on at 5 L/min (greater than the ordered level), and the nasal cannula was above his nose, on his forehead. During observation on 08/03/22, at 9:34 a.m. two nursing assistants came out of R15's room. R15 was observed to be lying on his back with the O2 tubing behind his head. When interviewed on 08/03/22, at 9:54 a.m. licensed practical nurse (LPN)-B stated there was no order in the electronic medical record (EMR) for O2, and expected it to be in place prior to using O2. LPN-B stated the facility had standing orders for O2, but the order still needed to be entered in the EMR. LPN-B further stated the order should be indicated in the care plan as well, and verified there were no orders for O2, nor was the care plan updated indicating R15 was using O2. When interviewed on 08/03/22, at 9:57 a.m. assistant director of nursing (ADON) stated R15's O2 should be titrated to be above 90%, and the O2 would be utilized as needed to keep R15's O2 level above 90%.	F 695	Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Nursing staff to be educated on oxygen use policy, including what to do if a resident needs O2 and does not have order, and what to do if a resident pulls their tubing off Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit 5 residents weekly x4 weeks, then monthly x2 months of residents that oxygen is being administered correctly per physician order. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 37 During observation on 08/03/22, at 9:58 a.m. the ADON verified R15's O2 tubing was under R15's head. The ADON checked R15's O2 level by pulse oximeter on R15's right forefinger and found R15's O2 saturation level at 43%. The ADON tried another finger and the O2 saturation level was 39%. The ADON stated R15 did not appear to be in respiratory distress, his color was baseline, and was not short of breath more than his baseline. The ADON applied the oximeter to R15's left hand, and found the O2 saturation rate to be 60%. The ADON stated he would get another oximeter to ensure that rate was correct. The ADON replaced the oxygen NC in proper placement under R15's nose and verified the O2 was set at 5 L. During observation on 08/03/22, at 10:11 a.m. R15's O2 saturation was 57% while R15 was lying flat and with using a different oximeter. The ADON raised the head of R15's bed and stated the aides should have repositioned the tubing for correct placement. The ADON verified R15 had no order to have O2 in the EMR, and stated he would expect to see an order if O2 were in use. The ADON indicated some of the paper charts had not been moved to the electronic record, and he would try to find the order in the paper chart. The ADON indicated he would not expect nurses to look in the paper chart of O2 orders. When interviewed on 8/03/22, at 2:12 p.m. the director of nursing (DON) stated R15's orders indicated R15 should have an oxygen saturation greater than 90%. The DON stated her expectations were for O2 orders to be in the electronic medical record, to be followed as written, and to be recognized in the care plan. Further the DON stated standing house orders	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 38 could be utilized for 3 days, but would still be entered in the EMR. Additionally, the DON stated if R15's O2 was on 5 L instead of 2-4 L, it was a medication error, and stated the care plan for R15 needed improvement. The DON indicated the policy for oxygen was to ensure the order was in the electronic medical record, ensure the tubing was placed correctly, and oxygen use would be mentioned in the care plan. An oxygen use policy was requested but not provided.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and develop interventions to ensure implemented pain-relief interventions were effective and pain was adequately managed for 1 of 2 residents (R39) reviewed for pain management. Findings include: R39's significant change Minimum Data Set (MDS), dated 6/29/22, identified R39 had intact cognition and required limited to extensive assistance with most activities of daily living (ADLs). Further, the MDS outlined R39 had arthritis and received scheduled, as needed (PRN), and non-pharmacological interventions for	F 697	F697 (D) Pain Management Corrective action for residents found to have been affected by the deficient practice: Pain assessment was completed for R39 on 8/5/2022. Provider updated on reported pain and no changes were made to orders. Identify other residents having the potential to be affected by the same deficient practice: Residents pain assessment were reviewed to ensure proper pain	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 39 pain which she reported as having frequently with moderate severity. R39's most recent MHM (Monarch Healthcare Management) Pain Evaluation, dated 6/28/22, identified R39 frequently had pain or hurting present in the past five days which caused R39 to limit her day-to-day activities. R39 had scheduled Lyrica (nerve pain medication), Lidocaine (topical pain medication) patches and Icy-Hot applied. R39 had as-needed (PRN) medication available which was listed as Tylenol 650 milligrams (mg) every 4 hours PRN, along with several non-medication interventions including rest and repositioning. The assessment concluded with a section labeled, "Comments," which identified, " ... [R42] has diagnosis of chronic pain syndrome, fibromyalgia (A disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances), and osteoarthritis ... receiving scheduled [Lyrica] (a medication used to treat seizures and/or nerve pain); along with scheduled topical ointment which have been effective ... complains of pain to a variety of different places ... received PRN Tylenol a few times in the past month. PRN Tylenol has been effective at managing residents increased pain. [R42] has no complaints about current pain management regimen at this time. No MD [physician] referral needed." R39's care plan, dated 1/26/22, identified R39 had a history of wanting to repeatedly be sent to the hospital and complaining about pain but then declining pain medication when offered. The care plan outlined R39 had to limit her day-to-day activities due to pain and listed a goal which read, " ... will have adequate relief from pain ..." along with several interventions to help R39 meet this	F 697	management. Provider updated if pain is reported as not controlled. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Nursing staff to be educated on pain identification and follow-up. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit weekly x4 weeks, then monthly x2 months of 5 residents to ensure proper pain management in place. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 40 goal, including application of a TENS unit (application or mild electric current) two to four times daily, providing pain medication as ordered, and documenting the effectiveness of pain medications provided. On 8/1/22 at 4:09 p.m., R39 was observed seated in an electric wheelchair in her room. R39 had no visible grimacing or other physical sign of pain present. However, when interviewed at this time, R39 stated she had "really bad fibromyalgia" which caused a burning pain in her back. R39 stated she consumed medication, including acetaminophen and Lyrica however, R39 did not feel her current pain medication regimen was sufficient. R39 expressed her physician team would not provide her narcotic medication as "it's addictive," however, R39 reiterated she felt her pain medication needed to be reviewed as, in the past, when R39 consumed narcotic medications her pain was "immensely" better managed. R39's progress notes, dated 6/28/22 to 8/3/22, identified the following recorded entries: On 7/12/22, R39 called 911 due to shoulder pain. The note outlined staff offered R39 pain cream and she refused. R42 was transported to the hospital and returned with new orders for Tylenol and meloxicam (a non-steroidal anti-inflammatory medication), and recommendations to follow up with physical therapy. On 7/15/22, R39 was seen at U of M (University of Minnesota) Orthopedics (branch of medicine dealing with the correction of deformities of bones or muscles) for a diagnostic procedure. However, the note recorded, "Procedure was aborted related to pain intolerance. Resident will need to	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 41 follow up with her primary care provider ..." On 7/18/22, R39 was recorded as complaining of pain in her left arm. R39 called the paramedics and was taken to the hospital and returned. R39's Medication Administration Record (MAR), dated 7/2022, identified R39 consumed pain-related medications for the month period. This included 1) Lidocaine Pain Relief 4% Patch to be applied topically daily and be on for 12 hours. This order listed a start date of 6/29/22 and was discontinued on 7/1/22. 2) Meloxicam 15 mg orally every morning. This listed a start date of 7/13/22 and remained active. The administration had a corresponding section labeled, "Pain Level," which recorded a numeric value of R39's pain rating on a zero to 10 scale. This recorded R39's pain from two to six; with nine of the 19 administrations recording R39's pain being at "5" or above. 3) Nortriptyline (an antidepressant and nerve pain medication) 25 mg daily at bedtime. This listed a start date of 5/7/21 and remained active. 4) Icy Hot Cream 10-30% applied topically every morning and bedtime. This listed a start date of 4/30/22 and remained active. 5) Lidocaine Gel 4% applied topically twice daily. This listed a start date of 7/1/22 and remained active. 6) Cyclobenzaprine (medication used to treat muscle spasms) HCL 20 mg three times daily. This listed a start date of 5/2/22 and remained active. 7) Lyrica 100 mg orally scheduled three times a day. This listed a start date of 5/27/21 and remained active. Further, an additional Lyrica 100 mg orally every 24 hours PRN was listed as provided on 7/1/22, with effective results. 8) Tylenol 650 mg orally every four hours PRN. This listed a start date of 6/8/21 and was discontinued on 7/26/22, however, two	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 42 doses were recorded as being given with corresponding pain levels of five and six being recorded, respectively. However, the MAR identified only one of the PRN doses was effective with the other being marked, "I = Ineffective." R39's MAR, dated 8/2022, identified R39's consumed pain-related medications for the month period thus far. This included 1) Meloxicam (arthritis medication) 15 mg orally every morning. This listed a start date of 7/13/22 and remained active. The administration had a corresponding section labeled, "Pain Level," which recorded a numeric value of R39's pain rating on a zero to 10 scale. This recorded R39's pain from two to 10; with two of the four administrations recording R39's pain being at "5" or above. 2) Nortriptyline (an antidepressant and nerve pain medication) 25 mg daily at bedtime. This listed a start date of 5/7/21 and remained active. 3) Icy Hot Cream 10-30% applied topically every morning and bedtime. This listed a start date of 4/30/22 and remained active; however, was recorded as being refused three times. 4) Lidocaine Gel 4% applied topically twice daily. This listed a start date of 7/1/22 and remained active; however, was recorded as being refused three times. 5) Cyclobenzaprine HCL 20 mg three times daily. This listed a start date of 5/2/22 and remained active. 6) Lyrica 100 mg orally scheduled three times a day. This listed a start date of 5/27/21 and remained active. 7) Tylenol ES 500 mg orally every fours hours PRN. This listed a start date of 7/12/22 and remained active; however, one dose was administered so far on 8/3/22, with a corresponding pain level recorded as "5." The effectiveness of the medication was recorded as, "Unknown."	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 43 When interviewed on 8/3/22 at 2:19 p.m., nursing assistant (NA)-C stated R39 would "regularly" voice complaints of pain to the staff which they, in turn, would notify the nurse about and let them address it. NA-C stated, at times, R39 would be provided heat packs and explained R39's pain seemed to vary in frequency and severity. NA-C expressed the "most I've heard" is R39 voicing "her back hurting," when helping her and providing care. Further, NA-C stated she could not say if R39's pain seemed better or worse in the past several weeks as R39 typically would just go to the nurse with her complaints. R39's medical record was reviewed and lacked evidence R39 had been comprehensively reassessed for pain since 6/28/22, despite having new orders placed for pain medication on 7/12/22; R39 being unable to complete scheduled offsite diagnostic appointments due to reported pain; R39 continuing to voice complaints of pain to the direct care staff; and, R39 having multiple repeated episodes of recorded pain levels at five or above despite the adjusted medications on 7/12/22. When interviewed on 8/4/22 at 11:18 a.m., licensed practical nurse (LPN)-B stated R39 routinely complained about having pain which LPN-B described as "almost never managed." R39 often will voice "nothing ever works" despite the staff attempts, and LPN-B stated she believed R39 wanted "something a little bit stronger" to help reduce her pain aside from just scheduled meloxicam and Lyrica. LPN-B stated she had been told R39 taking stronger medications (i.e., narcotics) "wasn't an option," however, was unsure why adding, "That's a good question." R39	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 44 reported pain "mostly in the neck and shoulder" and the interventions they had, including Icy Hot and the TENS unit, did help but "doesn't last very long." LPN-B stated staff just try to routinely follow-up with R39 to help meet her pain needs. When questioned on the facility' process for comprehensively reassessing pain, LPN-B responded "all of us [staff]" were responsible and should be assessing a resident for pain. On 8/4/22 at 12:42 p.m., licensed practical nurse manager (LPN)-C was interviewed. LPN-C explained the nurses were to monitor and document pain levels on residents "every shift" and should be documenting in the medical record if medications or interventions aren't working to relieve pain. LPN-C stated a comprehensive pain assessment was completed on a quarterly basis and as needed, and included looking at scheduled medications, diagnoses, indicators of pain and PRN use, to help determine if the pain management is effective or not. If "new pain" or "increased pain" is noticed, then the physician should be updated and a new assessment completed. LPN-C reviewed R39's collected 'pain level' scores from June 2022 to current, and stated the scores indicated the pain seemed to be worsening and "she [R39] does need to have her pain reassessed" as the current interventions are apparently "not working." LPN-C stated nurses, in her opinion, should be ensuring pain is reassessed within two weeks after new interventions are placed to ensure their efficacy and effectiveness. Further, LPN-C stated it was important to ensure pain needs were assessed and acted upon to ensure interventions were helping and effective. When interviewed on 8/4/22 at 1:16 p.m., the	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 45 director of nursing (DON) stated the nurse management team typically reviews a resident's progress notes on a daily basis and add they should be identifying any trends or patterns with increasing pain. The DON expressed R39 was hard to assess accurately given her behavioral history, however, acknowledged it was important to ensure timely pain intervention reassessment happened as, "We don't want them in pain." A policy on pain management was not requested, but not received.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 46 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nurse staffing information was posted on the weekend and in a timely manner at the start of the shift. This had potential to affect all 61 residents, staff, and visitors who could wish to review this information. Findings include: During entrance to the nursing home, on Monday, 8/1/22 at 11:35 a.m., a clear plastic holder was observed attached to a glass window present at the main reception desk. This contained a document titled, "The Estates at Chateau Direct Hands-On Nursing Staff Posting." However, the document displayed was dated, "Saturday 7/30/2022 [two days prior]." The form contained the actual and total hours of registered nurses, licensed practical nurses, trained medication aides, and certified nursing assistants which was broken down into each respective shift (i.e., day shift, evening shift, night shift). There was no visible nurse staffing information posted or displayed for Sunday, 7/31/22, or Monday, 8/1/22.	F 732	F732 (C) Posted Nursing Staffing Information Corrective action for residents found to have been affected by the deficient practice: Monday 8/1/22 staffing hours were immediately displayed after noted deficient practice. Staffing coordinator was immediately educated on nursing staff hours posting policy. Identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by deficient practice. Measures put into place, or systemic changes made, to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 47 During subsequent observation, on 8/1/22 at 12:12 p.m., the same posting from 7/30/22 remained displayed. At this time, scheduler (SC)-A was present behind the glass panel and verified the posting was dated 7/30/22 and there were no other nurse staff information postings present. SC-A was interviewed, and he explained he manually changed the posting during the week; however, the nurses were responsible to change it on the weekends adding it was likely not changed since 7/30/22, if it was not posted. Further, SC-A stated he had not yet completed the schedule for Monday, 8/1/22, so he could not yet post the information on the nurse staffing posting sooner. On 8/4/22 at 10:46 a.m., the administrator was interviewed and explained the night shift should was responsible to replace the posted hours on weekends. They also should make any adjustments, if needed. The administrator stated the information should be posted so residents and families could review the information and the nursing home could demonstrate they have "the correct number of staff to care for them." A provided Nurse Hours Posting policy, dated 1/2014, identified the nurse staffing data should be posted on a daily basis " ... at the beginning of each shift ..." The posted data should include the facility name, current date, total and actual hours worked of each discipline (i.e., RN, LPN), and the resident census. The policy directed Federal law required this information be posted.	F 732	deficient practice will not recur: Staffing coordinator educated on nursing staff hours policy and process. Nursing staff educated on nursing staff hours policy and process. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit daily x 4weeks and monthly x2 to ensure correct day nursing staff hours are posted. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Administrator or designee	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i)	F 770		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 48 §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician-requested laboratory testing was completed in a timely manner for 1 of 2 residents (R42) reviewed for pressure ulcer care and services. Findings include: R42's quarterly Minimum Data Set (MDS), dated 6/30/22, identified R42 had severe cognitive impairment and required extensive to total assistance to complete her activities of daily living (ADLs). Further, the MDS identified R42 was at risk of developing pressure ulcers, however, had no current stage one or higher unhealed pressure ulcers. R42's progress note, dated 6/30/22, identified R42 received a bed bath and skin check. The note recorded, " ... has skin breakdown on their coccyx ... cleaned and covered with a foam dressing ... informed nurse manager and will update evening shift." A Vohra Wound Physician Wound Evaluation & Management Summary, dated 7/6/22, identified R42 was assessed by the wound physician who recorded R42 presented with a wound on her	F 770	F770 (D) Laboratory Services Corrective action for residents found to have been affected by the deficient practice: On 8/4/2022 R42 had labs completed as ordered. Identify other residents having the potential to be affected by the same deficient practice: Nursing management reviewed the last 3 weeks of lab orders to ensure all labs were completed per orders. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Nurse leadership was reeducated regarding reviewing and following up on Vohra dictation. Licensed nurses were reeducated to the lab process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 49 posterior sacrum which was recorded as, "SHEAR WOUND OF THE POSTERIOR SACRUM PARTIAL THICKNESS," and recorded measurements of 2.1 centimeters (cm) long X 0.2 cm wide X 0.1 depth. Further, a section labeled, "Clinical Data And Materials Reviewed," identified the physician recommended several labs be completed including a prealbumin (used to ensure enough nutrients, namely protein, is being consumed) and a hemoglobin A1C (measures the amount of blood glucose attached to hemoglobin). However, R42's medical record was reviewed and lacked evidence these laboratory tests had been acted upon or obtained despite the recommendations of the physician on 7/6/22. When interviewed on 8/3/22 at 1:14 p.m., licensed practical nurse manager (LPN)-C stated R42 still had a current pressure ulcer on her sacrum. LPN-C reviewed R42's medical record and verified the requested laboratory tests were not acted upon or completed. LPN-C added, "They weren't done." LPN-C stated the physician typically writes out orders on a separate form; however, he must have added these laboratory test recommendations after rounds were done and LPN-C had missed them when she reviewed the completed summary. LPN-C added, "That was my bad." On 8/3/22 at 2:55 p.m., registered nurse regional nurse consultant (RNC)-A was interviewed and verified she had reviewed R42's medical record. RNC-A stated the physician recommended laboratory tests were not completed and, as a result, they were going to adjust the process when the physician rounds to ensure such orders	F 770	Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit lab orders for 5 resident Weekly x 4 and monthly x 2 of 5 residents to ensure labs are being completed per orders. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 50 were captured in the future. RNC-A verified the facility used an outside laboratory service who was onsite weekly and could have completed the laboratory tests sooner had the recommendations been identified in the wound summary. Further, RNC-A stated it was important to ensure ordered laboratory testing was completed timely as it will help improve the resident's health. A provided Lab and Diagnostic Test Results - Clinical Protocol policy, dated 11/2018, directed staff would process test requisitions and arrange for the tests to be completed.	F 770		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 51 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a menu that met the needs of 1 of 1 residents (R49) who was blind, and unable to read the menu. Findings include: R49's quarterly MDS dated 7/7/22, indicated R49 had intact cognition and had little energy and a poor appetite or overeating 2-6 days during the assessment period. R58 required supervision for bed mobility, transfers, toileting, and personal hygiene and limited assistance for eating, and dressing. R49's diagnoses included end stage chronic kidney disease requiring renal dialysis, below the left knee amputation, insomnia, major depressive disorder, high cholesterol, gastro-esophageal reflux (GERD), high blood pressure, legal blindness, methicillin-resistant staphylococcus aureus (MRSA) in a wound, and diabetes. R49's significant change MDS dated 10/15/21, indicated it was somewhat to very important for R49 to decide on his preferences for customary and routine activities. R49's significant change CAA dated 10/15/22, indicated R49 triggered for visual function, communication, ADLs, and nutritional status. R49's care plan dated 7/14/22, R49 was a vulnerable adult related to blindness.	F 803	F803 (D) Menus Meet Residents Need Corrective action for residents found to have been affected by the deficient practice: Facility completed weekly menu with resident R49. Identify other residents having the potential to be affected by the same deficient practice: Audit of residents was completed to note any resident who needs staff assistance in completing weekly menu. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Social services designee will complete a weekly menu for residents who were identified in facility audit as needing assistance. Social services designee educated on new facility process. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 52 Interventions included social workers responding to R49's needs and assisting R49 with problem solving. R49 also had impaired vision due to blindness. Interventions included providing set up and cueing as necessary. The care plan also indicated R49's first language was Spanish. Staff were to communicate through an interpreter to avoid R49 becoming upset when he is not understood and offer assistance to resolve issues most likely to cause R49 anxiety/agitation. Staff were also to help R49 maintain his preferences in his daily living. During an interview on 8/2/22, at 8:46 a.m. R49 (through an interpreter) stated he got the same food all the time and when he asked for alternatives the staff told him there were none. R49 also stated no one read the menus to him so he did not know what was being served or what the options were. During an interview on 8/2/22, at 2:29 p.m. registered nurse (RN)-C stated she was aware that R49 had complained often about not getting the food he wanted or getting the same thing and not having any choices. RN-C stated the nursing assistants brought the menus to the residents and should have helped R49 fill out his menu for the week because he was blind. During an interview on 8/3/22, at 1:58 p.m. the dietary director (DD) stated nursing staff should help fill out menus for residents who needed assistance. DD verified R49 needed assistance to fill out his menu because he was blind, and that his menu had not been filled out for the week of 7/31/22, to 8/6/22. DD further stated she did not contact R49 for his meal preferences and should have. DD stated menus were distributed the	F 803	Audits weekly x 4 and monthly x 2 of all resident's weekly menus who need assistance to ensure completion. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 53 Wednesday prior to the Sunday they started on. No facility policy was provided on assisting residents who were unable to make food choices for themselves.	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure food substitutes were offered during breakfast when it was discovered the facility menu excluded breakfast as a meal with food alternatives. This had the potential to affect all 61 residents who ate at the facility. Findings include: R11's admission Minimum Data Set (MDS) dated 6/3/22, indicated R11 had intact cognition. R11 had a poor appetite or overeating for 2-6 days during the assessment period and diagnoses included high blood pressure, gastro-esophageal reflux (GERD), arthritis, traumatic brain injury, and pneumonia. The ability to choose preferences for customary routines and activities was somewhat to very important.	F 806	F806 (D) Resident Allergies, Preferences, Substitutes Corrective action for residents found to have been affected by the deficient practice: R11, R36, and R58 breakfast meal preferences updated per their requests. Identify other residents having the potential to be affected by the same deficient practice: Audit of resident to ensure breakfast preference has been completed upon admission and is accurate per their preferences.	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 54 R11's admission Care Area Assessment (CAA) dated 6/3/22 indicated R11 triggered for nutritional status, dehydration, pressure ulcers, and psychosocial wellbeing. R36's admission MDS dated 7/4/22, indicated R36 had mild cognitive deficits and had little interest or pleasure in doing things, felt down, depressed, or hopeless, and had trouble falling or staying asleep for 2-6 days during the assessment period. R36 had diagnoses that included coronary artery disease, high blood pressure, stroke, and diabetes. R36's admission CAAs dated 7/4/22, indicated R36 triggered for psychosocial wellbeing, nutritional status, and pressure ulcers. R36's weekly menu dated 7/31/22, to 8/6/22, indicated R36 had requested all alternative menu items, every day for both lunch and dinner instead of just the cheeseburger. The menu items were as follows: Cheeseburger or Chicken Drumsticks White Rice or Potato Chips Lettuce/tomato/onion or Small Dinner Salad R58's quarterly MDS dated 7/12/22, indicated R58 had intact cognition and required supervision with toileting and personal hygiene. R58 was independent with all other activities of daily living (ADLs). R58's MDS also indicated it was very important for R58 to choose his preferences for customary routines and activities. R58's diagnoses included major depressive disorder, displaced fracture of the left wrist, and diabetes. R58's significant change Care Area Assessment	F 806	Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Upon admission, all residents are interviewed for breakfast preferences, and this is reflected in their plan of care. This is updated PRN and annually. Staff educated on facility dietary preference policy. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audits weekly x 4 and monthly x 2 on 10 residents to breakfast preferences are accurate and they are receiving items per their preference. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 55 (CAA) dated 1/22/22, indicated R58 triggered for nutritional status, ADLs, and psychosocial well-being. R58's care plan dated 1/21/22, indicated R58 was on a therapeutic diet. Interventions included obtaining/Updating food and beverage preferences, a selective menu, and snacks per resident preference. R58's weekly menu dated 7/31/22, through 8/6/22, did not include breakfast as a meal and lacked choices for breakfast including sausage, bacon, or other meats. R58's progress note dated 7/12/22, indicated R58 stated he was trying to avoid foods that raised his blood sugars and had been feeling tired. During an interview on 8/1/22, at 1:08 p.m. R11 stated he would like to have sausage links for breakfast, but they don't serve meat for breakfast. R11 stated "it's the same thing every day". R11 didn't bother asking for meat because "if that's what they're going to feed us, that's what we get". During an interview on 8/1/22, at 5:22 p.m. R36 stated breakfast was the same thing every day, scrambled eggs and toast. The staff don't ask if you want meat, it just showed up "every once in a while". R36 further stated he wanted a cheeseburger 90% of the time but he never got what he requested so why should he bother filling out the menu? "What a bummer." During an interview on 8/1/22, at 12:39 p.m. R58 stated he only got scrambled eggs and toast for breakfast and had not received any breakfast meat for months. When meat was requested,	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 56 staff would tell R58 if they gave meat to him, they would have to offer it to everyone, and the facility didn't have any. During an interview on 8/3/22, at 12:49 p.m. R58 stated he was served eggs for breakfast and no meat. R58 was told "corporate" determined the menu and R58 could not have meat for breakfast. R58 stated "I think that is wrong". During an interview on 8/3/22, at 1:58 p.m. the dietary director (DD) stated breakfast was only eggs and toast and there was no alternative; therefore, breakfast was not listed on the menu. Occasionally pancakes or waffles would be served, and cereal was always an option. DD also stated she thought sausage, ham, or bacon was an option every other day, but was not sure; however, since the menu did not have breakfast listed, residents would not know what they would be served each day or what their options were. DD stated if a menu was filled out incorrectly with both alternative items circled every day (i.e. a cheeseburger and chicken drumsticks) instead of just one, DD would alternate the menu items every other day instead of clarifying the request with the resident. DD further stated the facility's corporation set the menus and she had only seen them with lunch and dinner listed. A facility policy on food preferences, alternative food choices, and menus was requested but not received.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be	F 808		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 57 prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide food in the appropriate form as prescribed by the dietician for 1 of 1 residents (R51) reviewed for therapuetic diet. Findings include: R51's annual Minimum Data Set (MDS) dated 7/14/22, lacked indication R51 required a special diet although R51 had no natural teeth or dentures. R51's provider orders dated 6/16/22, indicated a mechanical soft texture diet. R51's care plan updated 7/28/22, indicated R51 was edentulous (without teeth) and required a mechanical soft textured diet with mechanically altered meat. R51's Clinical Nutrition Evaluation dated 7/17/22, indicated R51 was edentulous and required a mechanical soft diet. R51's meal ticket provided with meal service on 8/1/22, indicated R1 should receive a mechanically soft diet with ground egg salad sandwich on his menu.	F 808	F808 (D) Therapeutic Diet Prescribed by Physician Corrective action for residents found to have been affected by the deficient practice: R51 diet was upgraded to a regular diet per resident preference and doctor order. Identify other residents having the potential to be affected by the same deficient practice: Facility audit completed to identify all residents on altered diet and cross reference to residents' meal ticket to ensure their diet is followed per doctors' order. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Staff educated on following residents diet order per doctors' order and facility policy. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 58 R51's medical record lacked a risk versus benefits form indicating R51 had been educated and understood the risks of not following the prescribed diet. During observation on 8/1/22, at 12:15 p.m. R51 was eating baked chicken legs on the bone instead of the egg salad sandwich he was supposed to have been served. When interviewed on 8/1/22, at 12:16 p.m. cook (CK)-A acknowledged chicken on the bone was not a mechanically altered meat choice. When interviewed on 8/03/22, at 11:42 a.m. registered nurse (RN)-A stated R51 was non-compliant with his all his dietary restrictions for renal diet, fluid restrictions, and for mechanically altered diet. RN-A stated R51 had been provided a risk versus benefits for the renal diet and fluid restrictions, but not the mechanically altered diet. RN-A further stated R51 did not have teeth, and the risks for not following the mechanically altered diet order were choking on food and aspiration if R51 could not chew his food. When interviewed on 8/03/22, at 2:19 p.m. the director of nursing (DON) stated she expected if staff had seen R51 eat chicken on the bone against dietary orders, there would be an additional assessment completed for his ability to eat what he desired, or a risk versus benefits form with education completed. The DON acknowledged the risk for R51 was choking on food he could not chew because R51 was edentulous. When interviewed on 8/04/22, at 8:27 a.m. the	F 808	Audits weekly x4 and monthly x2 on all residents who are on altered diet to ensure their meal ticket matches the doctors order and they are being served the correct diet. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 59 corporate culinary director (CCD)-A stated chicken on the bone is not mechanically soft and choking was the risk of eating it when prescribed a mechanically soft diet. The CCD-A acknowledged R51 had not received a risk versus benefit education about eating a non-mechanically altered meat as prescribed. CCD-A indicated R51 would receive the proper diet going forward. Diet Manual and Diet Orders policy (undated) indicated a diet order is a prescription written by the attending physician to establish a patient's diet. Further the policy indicated every effort would be made to educate the resident on the risks and benefits of diet order refusal.	F 808		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishware was cleaned and sanitized in a manner to reduce the risk of cross contamination and/or foodborne illness. This had potential to affect all 61 residents residing in the facility at the time of survey. Findings include: On 8/1/22 at 11:39 a.m., an initial tour of the main production kitchen was completed. At the back of the kitchen, a single Hobart commercial dishwasher was in use with cook (CK)-A present rinsing items to be washed, and removing cleaned items from the machine. CK-A opened the machine and removed a hard plastic rack of cleaned items which included several large, metallic serving spoons and other various dishes. CK-A then placed an empty hard plastic rack on the counter of the machine and placed a used cutting board and chopping knife inside before loading it into the machine. The dishwasher activated when the door was closed and CK-A stated, "I believe it's both," a high-temp and chemical sanitization process used in the machine. The machine had a red-colored digital gauge present which displayed wash cycle temperatures along with rinse cycle temperatures. The machine completed it's cleaning cycle; however, the gauge displayed a rinse temperature of only 172 degrees Fahrenheit (F). CK-A stated she was unaware what temperature the wash or rinse cycles should be reaching to ensure sanitization, and added she had never been directed or told to watch the gauge before while doing dishes. At the request of the surveyor, CK-A re-ran the hard plastic rack	F 812	F812 (F) Food Procurement, Store/ Prepare/ Serve- Sanitary Corrective action for residents found to have been affected by the deficient practice: Dishwasher temperature log immediately added to the dishwasher. Identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility have potential to be affected by the deficient practice. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: Culinary staff educated on dishwasher temperature log and proper dishwasher temperatures. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audits weekly x4 and monthly x2 of dishwasher temperature log to ensure record keeping and safe temperatures. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 61 of dishes through the machine. However, again, a final rinse temperature of only 173 F was recorded on the digital gauge. CK-A reiterated she had never been told to check the gauge before while doing dishes. Immediately following this, dietary aide (DA)-A presented to the dishwasher and was interviewed. DA-A stated the machine was solely a high-temperature sanitization machine and a final rinse temperature of at least 180 F should be reached. DA-A verified the machine was not using any chemical sanitization process, nor were staff using any litmus-strips or other mechanisms to test for chemical cleaning processes in the machine. DA-A stated they used to record the temperature on the machine during the wash and rinse cycles to ensure it was reaching the required temperatures, but they had stopped several weeks ago when a new kitchen supervisor took over and no more sheets were provided. DA-A then provided the surveyor a blue-colored clipboard which was posted on the wall. This contained a form labeled, "DISH MACHINE TEMP LOG," however, the form was dated June 2022 (two months prior). The form listed several columns to record the date, wash temperature, rinse temperature, and initials of the staff for each meal (i.e., breakfast, lunch, dinner); along with directions on the bottom which outlined to record the temperatures for each meal, " ... to insure [sic] that the wash and rinse temperatures are properly monitored and controlled." The directions continued and outlined, "Wash Temp needs to be 150 degrees and Rinse Temp needs to be 180 degrees." However, the form had only seven dates when the dinner meal was even recorded; and further, a total of seven recorded times on the meals posted rinse temperatures	F 812	Date of completion: 9/12/2022 Monitored by: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 62 below 180 F. There was no written or recorded evidence on the form of what, if any, actions were taken when these low temperatures were identified; and the last recorded date any documentation was provided demonstrating the temperatures had been monitored and/or documented was 6/29/22. Immediately following, CK-B joined the interview. CK-B stated the dishwasher should be at or above 180 F during a rinse cycle, and the machine was likely just cool as it had not been used much since breakfast-time. CK-B then ran multiple loads through the machine at request of the surveyor. However, none of the rinse cycles reached 180 F. CK-B verified the observed temperatures were too low and explained staff were still checking the temperatures but just not recording them on the clipboard. CK-B stated she was unaware the machine was not reaching 180 F on it's rinse-cycle and added she would notify maintenance immediately to have the machine inspected. The following day on 8/2/22 at 9:44 a.m., CK-B and DA-A were observed doing dishes using the same Hobart machine. CK-B stated maintenance had inspected the machine and "had to adjust something" to get the rinse temperature back up to 180 F. Further, they were now provided with new log sheets to record the dishwasher wash and rinse temperatures on going forward. On 8/2/22 at 3:16 p.m., the maintenance director (MTD) was interviewed and explained he had to adjust the heater element behind the dishwasher to fix the issue with the low rinse temperatures. MTD explained "the past couple few months" there had been various issues with the machine	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 63 and, as a result, they needed to have various contractors come and work on it. MTD stated one of them had likely turned the temperature down, and it never had been raised back up to where it needed to be set. MTD verified a final rinse temperature of at least 180 F should be attained on their machine to ensure proper sanitization of the dishware. Further, MTD stated he was unaware of the recorded low rinse temperatures back in June 2022, and if staff had recorded those then they should have notified him so the machine could be inspected. On 8/4/22 at 10:33 a.m., the dietary director (DD) and corporate culinary director (CCD) were interviewed. CCD verified the dishwasher was solely a "high temp" sanitization process and a final rinse temperature of at least 180 F should be reached to ensure proper sanitization of the dishware. CCD stated they had already started working on some training for the staff and placed new temperature log forms to be completed, so it would be better monitored going forward. Further, CCD stated if staff were seeing and recording low rinse temperatures on the form, they should immediately inspect the machine and contact maintenance so it could be addressed. CCD reiterated the need for training, and she stated it was important to ensure the dishwasher was reaching 180 F on a final rinse cycle to "kill all the germs" which could be present on the dishware. A provided Dishwashing Machine Use policy, dated 3/2010, identified dishwasher machine hot-water sanitization rinse temperatures must not be less than 165 F for a stationary rack, single temperature machine or, "180 F for all other machines."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 64	F 883		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 65 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: During interview and record review the facility failed to ensure residents' vaccination status was verified for 1 of 5 residents (R47), and failed to ensure the influenza vaccine was offered for 1 of 5 residents (R24) reviewed for immunizations. Findings include: R24's Admission Record printed 8/5/22, indicated he was 55 years old, and had been admitted to the facility on 3/15/22. R24's quarterly Minimum Data Set (MDS) dated 6/21/22, documented R24 indicated the influenza vaccination was not offered. R24's Minnesota Immunization Information Connection (MIIC) report indicated his last influenza vaccine was on 6/14/76.	F 883	F883 (D) Influenzas Pneumococcal Immunizations Corrective action for residents found to have been affected by the deficient practice: R47 vaccination status was verified. The facility is unable to offer the Influenza vaccine to R24 at this time due to it being prior to influenza season. R24 will be offered the influenza vaccine when available. Identify other residents having the potential to be affected by the same deficient practice: Current resident’s immunization records were reviewed for COVID and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 66 R24's progress note dated 3/15/2022, at 6:58 p.m. indicated R24 gave verbal consent for immunizations. R24's medical record lacked evidence R24 was offered or received the influenza vaccination, or education on the influenza vaccination. R47's Admission Record printed 8/5/22, indicated she was 64 years old, and was admitted to the facility on 7/7/22 . R47's MIIC report was not present in R47's medical record. R47's medical record lacked evidence R47 was reviewed for vaccination status. When interviewed on 08/03/22, at 1:11 p.m. the director of nursing (DON) stated she had recently reviewed which residents were vaccinated for influenza, pneumonia, and COVID-19, and who needed additional vaccination support. The DON stated she designed a spread sheet for reference, but had not yet followed through on vaccination for residents who were not vaccinated or required additional vaccination. The DON stated it was her responsibility to get resident immunization records from the MICC website and there were facility processes with immunizations that still required improvement. Review of the Influenza and Influenza-Like Illness Policy dated 5/18/21, indicated between October 1st and March 31st each year the influenza vaccine would be offered to residents upon admission unless medically contraindicated or the resident had already been vaccinated.	F 883	Pneumococcal Vaccine and are up to date. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur: COVID and Pneumococcal immunizations will be reviewed upon admission and influenza vaccines will be included during influenza season. Vaccines will be administered to those required who are consenting. Influenza vaccines will be offered when available at beginning of the influenza season. Staff educated on COVID and Pneumococcal immunization policy. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Audits weekly x 4 and monthly x 2 on 10 residents to ensure vaccinations are up to date. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: DON or designee	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245222	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **8/2/2022**
NAME OF PROVIDER OR SUPPLIER **THE ESTATES AT CHATEAU LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/02/2022 between 09:00 AM and 11:15 AM, it was revealed by observation that there was a coffee maker and a microwave plugged into a power strip in the business office which was removed at the time of discovery. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	**2106 SECOND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/02/2022. At the time of this survey, The Estates At Chateau LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 08/26/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	**2106 SECOND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	**2106 SECOND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 60 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain one hazardous room per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/02/2022 between 09:00 AM and 11:15 AM, it was revealed by observation that the door to the storage room near the Administrators office was propped open with a door wedge and the door wouldn't latch when the wedge was removed.	K 223	K223 (D) Doors with Self-Closing Devices Corrective action taken to correct deficiency: Self-closing device was added to the door to the storage room and wedge was removed. Door remains in closed position at all times. Measures put into place, or systemic changes made, to ensure that the deficient practice will not recur:	9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	**2106 SECOND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 3 An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 223	Full house audit was completed to ensure doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position. Maintenance director educated that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Full house audit to be completed weekly X4 and monthly X2 to ensure doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Maintenance Director or Designee	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	**2106 SECOND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain one hazardous room per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/02/2022 between 09:00 AM and 11:15 AM,	K 321	K321 (D) Hazardous Areas- Enclosure Corrective action taken to correct deficiency: Self-closing device was added to the storage room door. Measures put into place, or systemic changes made, to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	**2106 SECOND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 5 it was revealed by observation that the smoking room had been turned into a storage room and the door did not have a self closer on it. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 321	deficient practice will not recur: Full house audit was completed to ensure hazardous areas are protected by a fire barrier and doors are self-closing or automatic closing. Maintenance Director educated that hazardous areas must protected by a fire barrier and doors are self-closing or automatic closing. Monitoring corrective actions to ensure that the deficient practice is being corrected and will not recur: Full house audit to be completed weekly X4 and monthly X2 to ensure hazardous areas are protected by a fire barrier and doors are self-closing or automatic closing. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of completion: 9/12/2022 Monitored by: Maintenance Director or designee	