Electronically delivered
May 18, 2021

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

RE: CCN: 245222
Cycle Start Date: May 10, 2021

Dear Administrator:

On May 10, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On April 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the</u>

following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Estates At Chateau Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 10, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 05/10/2021

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	INITIAL COMMENTS On 5/5/21 and 5/6/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5222115C (MN72386) with a deficiency cited at F600 The following complaint was found to be UNSUBSTANTIATED: H5222116C (MN65822) The abbreviated standard survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ began on 4/29/21, when the facility was made aware nursing assistant (NA)-A sexually abused R1 at NA-A's personal residence. The administrator, regional director of operations and director of nursing (DON) were notified of the IJ for R1 on 5/6/21, at 4:10 p.m. The facility immediately implemented correction action on 4/30/21, and F600 is being issued at past non-compliance. The above findings constituted substandard quality of care, and an extended survey was conducted from 5/7/2021 to 5/10/21. The facility's plan of correction (POC) will serve 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	F 000		

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

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.

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R1) reviewed for abuse allegations. This failure placed R1 at risk for serious harm when a staff member, nursing assistant (NA)-A, engaged in sexual activity with R1. The immediate jeopardy began on 4/29/21 when the facility was notified NA-A had engaged in sexual activity with R1, at NA-A's personal residence. The director of nursing (DON), social	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2 service director (SSD), regional director and administrator were notified of the immediate jeopardy at 4:10 p.m. on 5/6/21. The immediate jeopardy was removed, and the deficient practice corrected on 4/30/21, prior to the start of the survey and was therefore Past Non-compliance, as a result of immediate corrective action taken by the facility. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/24/20, identified R1 was cognitively intact and had behavioral symptoms, not directed at others, during one to-three days during the seven day assessment period. R1 required limited assist of one staff for bed mobility, walking in room, locomotion on and off the unit, dressing, eating and personal hygiene. R1 required supervision and one person physical assist for toilet use and walking in corridor. R1 required supervision with set up help from staff for transfers between surfaces. R1's discharge MDS, dated 12/20/20, revealed R1 was discharged on 12/20/20, with a discharge location of "other." R1's care area assessment (CAA), dated 9/3/20, identified R1 triggered for potential concerns related to cognitive loss and psychosocial well being. R1 had behavior symptoms and used socially inappropriate language with staff. R1 triggered for actual concerns related to staff dependence to assist him with activities of daily living. R1's care plan, dated 9/9/20, identified R1 was a vulnerable adult related to dependencies care planned and was subject to laws of V.A [vulnerable adult]. NA-A was noted to participate	F 600		

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F 600	Continued From page 3	F 600		

in the development and review of the care plan as the role of nursing assistant. R1 had care planned concerns including history of suicide attempt, substance abuse, aggressive behavior, alteration in cognition, supervision and assistance with activities of daily living, socially inappropriate language and psychosocial well being.

R1's mental health therapist visit, dated 11/11/20, provided a recommendation, that is was important to create clear boundaries with R1 to ensure maximum therapeutic benefit.

R1's physician progress note, dated 12/3/20, revealed diagnoses and treatment concerns that included, history of traumatic brain injury, Hepatitis C positive, adjustment disorder with depressed mood, anxiety disorder, and current methamphetamine use disorder.

Release of Responsibility for Leave of Absence, dated 8/30/20 through 12/18/20, revealed R1 went on multiple leave of absences, and included over night leave of absences throughout his stay 8/25/20 through 12/20/20.

Review of an email sent to the administrator from R1, dated 4/29/21, that showed a picture of R1 and NA-A lying next to each other on their sides. R1 was lying behind NA-A. Both NA-A and R1 had their eyes shut. The email included a note from R1 that while he was a resident at the facility, he would go to R1's home on his leave of absences. There was no time or date indicated on the picture.

Review of a written statement from NA-A, dated 4/29/21, identified she had a "sexual relationship" with R1 while he was a resident at the facility.

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NA-A noted she had known R1 prior to his admission and gave him her personal phone number when he was admitted.

The facility's incident report, dated 4/29/21, identified an email was sent to the administrator by a former resident, R1, on 4/29/21. The email included a picture with him in bed with someone he stated was an employee of the facility, NA-A. NA-A acknowledged she had a "relationship" with R1 outside of the facility. The nature of the "relationship" was not specified to be sexual in nature in the investigative summary.

During a phone interview on 5/5/21, at 12:50 p.m. NA-A reported she was a nursing assistant at the facility while R1 was a resident at the facility. NA-A reported she knew R1 from a few years back, as they both lived near each other and were previously acquaintances. NA-A reported she gave R1 her phone number so that he could check in with them. NA-A then developed a "friendship" with R1 and then saw R1 outside of the facility, at restaurants and then at her own place of residence. NA-A reported she saw R1 outside of work towards the end of his stay at the facility, approximately in December. NA-A reported she had sexual intercourse with R1 while he was a resident at the facility and she was a nursing assistant on the floor he resided. The sexual intercourse occurred while R1 was on a leave of absence and R1 went to her personal residence. NA-A reported she had not disclosed to facility management that she knew R1 prior to his admission to the facility, that she gave her phone number to R1 or that she had contact with R1 outside of the facility, that included sexual intercourse. NA-A reported she was aware it was against facility policy to have contact with

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F 600	Continued From page 5 residents outside of the facility and to have sex with residents. On 5/5/21, at 12:32 p.m. the director of nursing (DON) reported she was informed of an email sent to the administrator on 4/29/21, from R1, a former resident, that showed him in bed with a staff member, NA-A. DON reported NA-A gave her a statement that NA-A had contact with R1 outside of the facility, that included sexual contact. DON reported staff were not allowed to have sexual interactions with residents. The facility policy Abuse Prohibition/Vulnerable Adult Plan, dated 7/5/19, directed staff, To ensure that residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. The policy further directed, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.	F 600		

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F 600	Continued From page 6 The past noncompliance immediate jeopardy began on 4/29/21. The immediate jeopardy was removed and the deficient practice corrected by 4/30/21, after the facility implemented a systemic plan that included the following actions: The AP was placed on suspension on 4/29/21, when the facility was made aware of the incident. A full house audit was completed on 4/30/21, to ensure all employees had current background studies to work with vulnerable adults and had a current MN State licensure related to their position at the facility. All like residents at the facility were interviewed on 4/29/21, specific to if they had encountered or witnessed any relationship between staff members and residents. No resident confirmed any consensual or non-consensual sexual abuse. Anyone who worked after 4/29/21, and before their next shift, was provided education on boundaries and provided education on appropriate and professional relationships between staff and residents. Staff interviews were conducted on 5/5/21, from approximately 11:45 a.m. to 4:20 p.m. and again on 5/6/21, from approximately 11:25 a.m. to 1:20 p.m. with staff that included; RN's LPN's NA's, housekeeping, kitchen staff and physical therapist assistants. Staff identified education was provided to them on professional boundaries that included individual boundaries (emotional, physical and sexual) as well as personal relationship boundaries and professional boundaries. Review of the facility education confirmed the facility implemented corrective action and therefore this will be cited at past noncompliance.	F 600		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 18, 2021

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

Re: Event ID: E3IV11

Dear Administrator:

The above facility survey was completed on May 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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REVISED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/24/2021

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