



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 7, 2025

Administrator

The Estates at Chateau LLC
2106 SECOND AVENUE SOUTH
MINNEAPOLIS, MN 55404

RE: CCN: 245222

Cycle Start Date: June 6, 2025

Dear Administrator:

On June 25, 2025 we notified you a remedy was imposed. On July 11, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 23, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 10, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 25, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 6, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 25, 2025

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

RE: CCN: 245222
Cycle Start Date: June 6, 2025

Dear Administrator:

On June 6, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 6, 2025, the situation of immediate jeopardy to potential health and safety cited at F0610 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 10, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 10, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 10, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider

The Estates At Chateau LLC

June 25, 2025

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agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 6, 2025. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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. If you have not already provided the 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 Sections 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 June 6, 2025. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 their 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

The Estates At Chateau LLC

June 25, 2025

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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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 6, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to **tamika.brown@cms.hhs.gov**.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and **Minnesota Statute 144A.10 subd 15**, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along

The Estates At Chateau LLC

June 25, 2025

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with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 25, 2025

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

Re: Event ID: 7H9N11

Dear Administrator:

The above facility survey was completed on June 6, 2025 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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Chateau LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 5/30/35, 6/3/25, 6/4/25, 6/5/25, and 6/6/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were reviewed:H52225870C (MN00113396), and H52226210C (MN00113541) . NO</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/06/2025
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20000	Continued from page 1 licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Chateau LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55404	
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F0000	<p>INITIAL COMMENTS</p> <p>On 5/30/35, 6/3/25, 6/4/25, 6/5/25, and 6/6/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.</p> <p>The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F600 began on 5/24/25, when R4 received a trespass notice from the facility but continued to have access into the facility and made non-consensual contact and kissed a resident on the forehead.</p> <p>The administrator, and director of nursing (DON), regional director of operations, corporate nurse leader, and regional social services were notified of the IJ on 6/5/25 at 3:09 p.m. The IJ was removed on 6/6/25 at 1:00 p.m.</p> <p>The above findings constituted Substandard Quality of Care and an extended survey was conducted on 6/6/25.</p> <p>The following complaints were reviewed: H52225870C (MN00113396), and H52226210C (MN00113541) with a deficiencies cited at F610.</p> <p>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 be used as verification of compliance.</p> <p>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.</p>	F0000		
F0610	Investigate/Prevent/Correct Alleged Violation	F0610	F610 - Investigate Allegations	06/23/2025
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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/06/2025
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F0610 SS = SQC-L	<p>Continued from page 1</p> <p>CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to prevent physical abuse from occurring to 2 of 2 residents (R1 and R2) when R3 had a physical and verbal altercation with R1 and proceeded to have a second verbal altercation with R1, which led to a physical altercation with R2 later the same day.</p> <p>R1's face sheet dated 5/31/25, identified diagnoses of multiple fractures of pelvis, alcohol abuse, and open wound on left lower leg.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 4/2/25, identified no cognitive issues. R1 had verbal behavior issues directed at others, was independent with all self-cares, and used a wheelchair for mobility.</p> <p>R1's care plan identified that she would remain free from abuse or neglect. Interventions included monitoring for signs of emotional distress or mood and behavior changes, safety monitoring will be implemented as needed to ensure residents safety, staff will continue to follow the facility vulnerable adult and abuse reporting policy.</p>	F0610	<p>Continued from page 1</p> <p>Immediate Corrective Action:</p> <p>FR4 was discharged from the facility on 5/22/2025, FR4 was issued a trespass notice by facility on 5/24/25.</p> <p>A Restraining Order was issued against FR4 6/27/2025, FR4 cannot be within 0.25 miles of the facility.</p> <p>R5 remains in the facility, no further incidents or lasting mental anguish, and continues with normal behaviors. R5 initially did not want to proceed with a restraining order or police report despite staff requests. Staff were able to convince R5 to complete a police report. Staff were not able to convince R5 to complete a restraining order until 6/19/25 due to R4's friendship with FR4.</p> <p>R1 and R2 remain in the facility. There have been no further incidents, no lasting mental anguish. OHFC was filed on 5/26/25, facility completed internal investigation.</p> <p>R3 discharged from the facility on 5/26/25.</p> <p>24/7 Front Door Monitor was put in place and is continuing at this time. Front door is the only door that is unsecured and used by residents. Facility has one other door that is coded 24/7 and not usable by residents.</p> <p>No-trespass binders updated for each floor and front desk and visitor log created for front door. Staff were educated on how to read trespass binders and ensuring all visitors sign in/out.</p> <p>R7 discharged from facility on 6/12/25.</p> <p>Corrective Action as it applies to others:</p> <p>The Abuse/Vulnerable Adult Policy was reviewed and remains current.ζ</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Chateau LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55404	
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F0610 SS = SQC-L	<p>Continued from page 2</p> <p>R1's progress note dated 5/26/25 at 11:37 p.m., identified at 6:00 p.m., registered nurse (RN)-D was alerted to a verbal altercation in R3's room. Upon entering, R1 and R3 were observed arguing and screaming. R1 appeared visibly upset, crying and said R3 took her phone and hit her. No visible injuries on assessment, no active bleeding or bruising at time of assessment. Residents were separated.</p> <p>R1's progress note dated 5/29/25, identified a Risk vs Benefits was completed with R1 regarding boundaries with other residents.</p> <p>R1's Risk vs Benefits dated 5/29/25, identified Respecting others personal space and boundaries. Respecting personal boundaries offers numerous benefits for individuals and relationships, including fostering trust, enhancing well-being, and reducing stress. However, it also presents potential risks, such as the possibility of misunderstandings or damaging relationships. Disrespecting boundaries can damage relationships but creating a sense of distrust and disrespect, potentially leading to conflict or avoidance. Resident is to leave other residents spaces (rooms) when asked or resident risks losing the privilege/ability to spend time on other floors/units in the facility.</p> <p>R2's face sheet dated 5/30/25, identified diagnoses of major depressive disorder, altered mental status, and alcohol dependence.</p> <p>R2's quarterly MDS dated 4/2/25, identified R2 had no cognitive issues, no behaviors, and was independent with all self-cares, walked with no assistive devices.</p> <p>R2's care plan dated 7/22/24, identified R2 was a fall risk related to history of fractures, history of falls, alcohol dependence.</p> <p>R2's progress note dated 5/26/25 at 11:29 p.m., identified at approximately 7:00 p.m., RN-D was informed there was a physical altercation between residents which occurred in the elevator. On assessment no injuries were found. Neurological check was clear. R2 was clear, calm, and under no emotional distress. Residents were separated.</p>	F0610	<p>Continued from page 2</p> <p>The Visitor Policy was reviewed and remains current.</p> <p>Residents educated on visitor policy including their rights to visitors and the facilities right to monitor their visitors behaviors as stated in the visitor policy.</p> <p>Staff educated on front door monitoring expectations, no-trespass binder, and visitor log including visitor sign-in/out expectations.</p> <p>Staff educated on Abuse Policy which includes reporting/investigating guidelines.</p> <p>Staff educated on calling 911, personally escorting trespassers out of the facility, and alerting Administrator/on-call/MOD who would then update trespass binder.</p> <p>No-trespass binder is updated as needed.</p> <p>Date of Compliance: 6/23/2025</p> <p>Recurrence will be prevented by:</p> <p>The Administrator/DON/ or designee will review all allegations to ensure all were properly investigated.</p> <p>3 audits weekly x4 weeks to ensure that the visitor sign-in log has been completed.</p> <p>4 staff members per week will be quizzed x4 weeks on front door monitor and no-trespass binder.</p> <p>No-trespass binder will be updated with description and picture (if able) as needed.</p> <p>The results of weekly audits and quizzes will be shared</p>	

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F0610 SS = SQC-L	<p>Continued from page 3</p> <p>R2's physician visit note dated 5/27/25, did not identify the physical altercation with R3 on 5/26/25.</p> <p>R2's progress note dated 5/29/25, identified a Risk vs Benefits was completed with R2 regarding being involved voluntarily in a resident-to-resident altercation.</p> <p>R2's Risk vs Benefits dated 5/29/25, identified getting involved in other residents altercations. Risks related to getting involved in other altercations could include physical and or emotional injury affecting overall wellbeing, possible arrest if law enforcement is to be involved, and even death. Furthermore, injury to your person could result in hospitalization. When another resident to resident altercation is taking place, R2 should contact and inform staff members to handle the situation.</p> <p>R3's face sheet dated 6/2/25, identified absence of left lower limb below knee, depression, anxiety, post traumatic stress disorder (PTSD), opioid dependence, and fall from non-moving wheelchair.</p> <p>R3's quarterly MDS dated 4/10/25, identified R3 had no cognitive deficits, no behavior issues, independent with all self-care activities and used a wheelchair for mobility.</p> <p>R3's care plan dated 7/28/24, identified interventions to monitor for signs of emotion distress, or mood and behavior changes.</p> <p>R3's progress note dated 5/26/25 at 7:42 p.m., identified Administrator was notified by nursing staff that R3 was arrested after other residents reported that R3 was being verbally and physically aggressive with them. When police attempted to detain R3, he began assaulting the officers. Administrator filled out a Notice of Involuntary Discharge to the jail where R3 was taken. A copy was sent to the Ombudsman. Administrator called the jail to notify them of R3's discharge and updated physician.</p> <p>R3's progress note dated 5/26/25 at 10:20 p.m., identified at approximately 6:00 p.m., registered nurse</p>	F0610	Continued from page 3 with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	

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F0610 SS = SQC-L	<p>Continued from page 4</p> <p>(RN)-D was alerted to a verbal altercation in R3's room. Upon entering, R1 and R3 were observed arguing and screaming. R1 appeared visibly upset, crying and said R3 took her phone and hit her. No visible injuries on assessment, no active bleeding or bruising at time of assessment. Residents were separated.</p> <p>R3's progress note dated 5/30/25, identified R3 was released from jail and stopped at the facility this morning. Informed social service director (SSD)-A that he would be back on 6/3/25, to pick up his belongings.</p> <p>During an interview on 5/30/25 at 12:07 p.m., R2 stated he was not sure what was going on between R1 and R3 but he was trying to break it up. They were swinging at each other and yelling. The facility is usually pretty mellow and R2 had never witnessed anything like this during his stay. R2 and R3 rode the elevator together after R2 intervened between R1 and R3 outside. While in the elevator R3 became verbally aggressive towards R2, leaned towards R2 and got two surprise punches to R2's face before R2 tipped R3 over in his wheelchair to stop the altercation. R2 had a discolored area under his right eye and stated his right jawline hurt to the touch. R2 was unsure if the area under his right eye was from when R3 punched him.</p> <p>During an interview on 6/3/25 at 12:23 p.m., R1 had a cell phone in her hand. R1 stated it happened so fast and she does not want anything done about it. R3 was having a bad day and he hit her and she is just over it. R3 was letting R1 use his old cell phone and he accused R1 of stealing his found and R1 found out he sold it and that was what the whole argument was about. When the staff separated R1 and R3, R1 left the room and went out to the smoking patio. The staff did not tell me not to hang out with R3. R2 and R3 also were outside and R1 thought R3 was going to hit her and R2 stepped in between them. R1 thought R3 was going to hit R2 so she wheeled away and called 9-11. R3 was physical with R2 outside and staff were present. R1 thought NA-A was outside and was not sure who the other NA would have been.</p> <p>During an observation on 5/30/25 at 12:22 p.m., R1 was not in the room. The overbed table was next to the bed and had untouched cereal, juice, milk, a mighty shake in its container, and an unopened glazed honey bun on it.</p>	F0610		

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F0610 SS = SQC-L	<p>Continued from page 5</p> <p>During an interview on 5/30/25 at 12:24 p.m., nursing assistant (NA)-A stated R1 can get violent and rowdy when she is drunk, which happens a lot when R1 is out of the facility. NA-A stated R1 was drunk on 5/26/25, and she had confiscated a bottle of alcohol from her. NA-A was unsure how R1 got the alcohol.</p> <p>During an observation on 6/3/25 at 11:53 a.m., R1 was not in her room.</p> <p>On 6/3/25 at 1:04 p.m., attempted to call R3 and the phone number was not in service.</p> <p>During an interview on 6/3/25 at 1:07 p.m., licensed practical nurse (LPN)-D stated that to her knowledge, R1 was not intoxicated on 5/26/25. R1 and R3 were dating and she spent most of her time with him and would only come to her floor for medication.</p> <p>During a phone interview on 6/3/25 at 3:38 p.m., trained medication aide (TMA)-C stated he heard noise from R3's room and went in the room. R1 was sitting at the foot of the bed and R3 was sitting at the head of the bed facing each other. R1 and R3 both said they were hit by each other. TMA-C told them they were both friends and left the room. TMA-C heard screaming coming from the room and called the nurse on fourth floor to intervene. RN-D went in and talked to them and came out and told TMA-C that it does not seem like they are going to stop the argument. RN-D called someone on the phone to find out what to do next. After RN-D made the call, R1 went outside to the smoking patio. R3 went out to the smoking patio too. TMA-C saw R3 a short time later leaving the elevator quickly and going to his room. The police came and R3 would not let them in his room. R3 went wild on the police and they had to handcuff him and put a mask on his face. TMA-C did not think that R1 or R3 were drunk or on drugs during the incident.</p> <p>During a phone interview on 6/3/25 at 3:57 p.m., RN-D stated he heard screaming coming from R3's shut room door. RN-A went in the room and R1 told him that R3 was trying to take her phone. R1 stated R3 hit her. R3 got in his wheelchair and left the room and went to the elevator to go outside to the smoking patio. R1 remained sitting on R3's bed. RN-D checked R1 for injuries, got in her wheelchair and left. RN-D was busy</p>	F0610		

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F0610 SS = SQC-L	<p>Continued from page 6 with medication administration and was told later that R1 had also went to the smoking patio and R1 and R3 were arguing again. RN-D thought this was about an hour after the initial incident. The NA's informed RN-D that R2 and R3 had been in a fight in the elevator. RN-D went to R2 and R2 told him he was fine, no black eye, did not say he was punched in the face; only that his wrist was sore. RN-D inferred that R2's wrist was sore from the fight. RN-D had notified the Director of Nursing (DON) of the incident and was told that R1 and R3 were in a relationship, and they would get over it quickly. RN-D was not worried at the time that the incident would escalate.</p> <p>During an interview on 6/3/25 at 3:48 p.m., NA-A stated she was called down to address R1 and the incident. NA-A went to the smoking patio and R1 had already called the police. Neither R2 or R3 were outside at this time. NA-A went to the elevator, and it opened to R2 and R3 in the elevator. R3 was clinging to R2 and R3's wheelchair was tipped sideways against the wall. R2 did not hit R3 while NA-A was insight. NA-A had R2 get off the elevator and go outside and they kept R3 in the elevator to cool down for a minute. NA-A was unaware of any interventions in place from this incident.</p> <p>During a phone interview on 6/3/25 at 1:35 p.m., NA-G stated she was notified that R1 had been in a physical altercation. NA-G and NA-A went down to the smoking patio and to R1. R1 stated that R3 hit her in the face three times and she had already called the police. NA-G walked in the building and could hear arguing from the elevator. R2 and R3 were in the elevator. R3 was on the floor with his wheelchair tipped and R3 is swinging at R2 and R2 is kicking at R3 to get R3 off of him. R2 left the elevator and went toward the back of the building and R3 got back in his wheelchair and went out the front of the building where R1 was located. R3 was talking to the police in the entry way.</p> <p>During an interview on 6/3/25 at 3:04 p.m., Administrator, SSD-A, and SSD-B stated they were unaware if R1 was assessed for intoxication or alcohol risk, that was not in the immediate risk management. Immediate interventions done for R1 and R3 included R3 sent out of the room and R1 assessed for injuries. R2 and R3 got in the altercation while RN-D was with R1. Administrator, SSD-A, and SSD-B were unaware of any protections put in place to protect other residents from R3 after the altercation with R1. Administrator</p>	F0610		

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F0610 SS = SQC-L	Continued from page 7 felt the staff could have worked harder to keep R1 and R3 separated after the incident. The staff could have followed R3 down to the patio and had R1 go to her room to cool down for an appropriate time after the incident. Career users or drinkers are very hard to notice if they have been drinking or using, they are able to cover it well, it is hard to recognize. The facility Resident-to-Resident Altercation Reporting Guidelines undated, identified to to report threats of violence, intimidation, and willful actions including hitting, and kicking.	F0610		