Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 10, 2024

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

RE: CCN: 245222
Cycle Start Date: August 15, 2024

Dear Administrator:

On September 27, 2024, we notified you a remedy was imposed. On October 9, 2024 the Minnesota Departments of Health and Public Safety 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 October 4, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 15, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 27, 2024, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 15, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 4, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

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

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October 10, 2024

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

Re: Reinspection Results
Event ID: JTX212

Dear Administrator:

On October 9, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 18, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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September 27, 2024

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

RE: CCN: 245222
Cycle Start Date: August 15, 2024

Dear Administrator:

On August 22, 2024, we informed you that we may impose enforcement remedies.

On September 18, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 15, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 15, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 15, 2024.

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 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.

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

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 $12,924, 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.

If you have not achieved substantial compliance by November 15, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Chateau Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 15, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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 an "E"tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 - Health Regulation Division 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 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 February 15, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

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

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 09/18/2024

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 9/17/24 and 9/18/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52228138C (MN00106510) with a deficiency issued at F656, F677, and F726. 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. 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		10/4/24

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

Electronically Signed | 09/30/2024

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 656	Continued From page 1 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to produce a care plan that was consistent for one of four residents (R4)	F 656	F656: Develop/Implement Comprehensive Care Plans ¿	

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F 656	Continued From page 2 reviewed for care plans. R4's care plan stated two staff members were to provide cares for R4 while further down in the care plan it stated one staff was to assist R4 with bathing, dressing, and personal hygiene. Findings include: During an observation on 9/18/24 at 10:02 a.m., nursing assistant (NA)-B changed R4's incontinent brief. NA-B was the only aide who changed R4's incontinent brief. R1's face sheet indicated R4 was admitted to the facility on 9/27/23 with a primary diagnosis of cerebral infarction due to embolism of bilateral anterior cerebral arteries. R4's additional diagnoses included hemiplegia affecting left dominant side, repeated falls, panic disorder, adjustment disorder with anxiety, and other stimulant abuse. R4's care plan dated 9/29/23 indicated resident needed an assistant of one for bathing, dressing, and personal hygiene. R4's care plan dated 1/11/24 indicated resident needs two care givers when assisting with cares. R4's brief interview for mental status (BIMS) dated 6/25/24 indicated R4 scored twelve, which indicated R4 was cognitively moderately impaired. R4's minimum data set (MDS) dated 6/25/24 indicated R4 required dependence of staff members for bathing, dressing, and personal hygiene. The MDS indicated R4 needed substantial/moderate assistance with toileting and	F 656	Immediate Corrective Action:¿ Resident 1's care plan was updated and resident 1 has since passed away on hospice. ¿ Corrective Action as it applies to others:¿ Care Plan Policy was reviewed and remains current. Full house audit completed to identify other residents who require two caregivers for care. Education completed with social services and nurse management about care planning two caregivers. ¿ Recurrence will be prevented by:¿ Weekly audits completed for all residents requiring two caregivers x4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.¿ ¿ Corrections will be monitored by:¿ Administrator/designee¿and DON/Designee Date of Compliance:¿ ¿10/4/24	

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F 656	Continued From page 3	F 656		

partial/moderate assistance with oral hygiene. The MDS indicated R4 needed assistance with setup or clean-up assistance with eating.

Facility's nursing care sheets dated 8/14/24 indicated R4 was an assist of one with pivot transfers, dressing, grooming, and bathing. The nursing care sheet indicated R4 could have aggressive behaviors.

R4's special instructions in R4's profile indicated resident was a two-person caregiver and to not go in R4's room alone.

During an interview on 9/18/24 at 10:51 a.m., NA-C stated now that R4 was admitted to hospice, he only needed one person to change his incontinent brief.

During an interview on 9/18/24 at 11:00 a.m., registered nurse (RN)-A stated R4 was "really easy" to care for. RN-A stated R4 was an assist of one with toileting, bathing, and "cares all together".

During an interview on 9/18/24 at 11:05 a.m., NA-B stated she had always used just one person to change his incontinent brief or "doing anything for him". NA-B stated from her knowledge R4 always needed just one person to assist R4.

During an interview on 9/18/24 at 12:16 p.m., nurse manager (NM) stated she would expect care plans to be updated regularly when something changed in a resident cares or preferences and based on the assessments that were done. NM stated she would expect care plans to match when talking about assistance

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F 656	Continued From page 4 with activities of daily living (ADL). During an interview on 9/18/24 at 12:31 p.m., the director of nursing (DON) stated her expectation was care plans should be matching throughout the care plan. DON stated she would expect that care plans would be updated according to resident's current abilities and preferences. DON stated social services (SS)-A put the intervention into R4's care plan stating R4 required two care givers to assist with cares. During an interview on 9/18/24 at 12:48 p.m., SS-A stated she was the one who put the care plan intervention about R4 needed two care givers to assist with cares after reports of abuse. SS-A stated the intervention should have been removed from R4's care plan because it no longer applied to R4. During an interview on 9/18/24 at 1:04 p.m., the administrator stated all staff in the facility uses a resident's care plans. Administrator stated she would expect care plans to match throughout the care plan. Care plan policy and procedure was requested, and none was received.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 677	F677: ADL Care Provided for Dependent	10/4/24

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F 677	Continued From page 5 review, the facility failed to use aseptic technique when providing pericare for one of four residents (R2) observed for pericare, provide timely incontinent cares for two out of four (R1, R4) residents, and provide weekly showers for one of four (R1) residents reviewed for activities of daily living. Findings include: During an observation on 9/18/24 at 9:51 a.m., nursing assistant (NA)-C changed R1's incontinent brief. NA-C did not use aseptic technique while washing R1's perineal area. NA-C wiped R1's perineal from back to front and then took the same washcloth and reused the same washcloth she used for pericare to wash her labia. During an observation on 9/18/24 at 10:02 a.m., NA-B was changing R4's incontinent brief. R4's brief had been saturated with urine. NA-B wiped R4 from back to front using the same washcloth. During the observation NA-B stated R4's linens had been saturated with urine and she needed to change R4's bed linens. NA-B stated she did not know the last time R4 had his incontinent brief checked and changed. NA-B proceeded to change R4's bed linens. R4's incontinent brief was not checked and changed until 3:43 p.m. During the incontinent brief change that time, NA-B performed perineal care while wiping from back to front using the same washcloth. R4's bed linens were saturated with urine and bed linens had to be changed. During an observation on 9/18/24 at 10:24 a.m., NA-C was giving R2 a bed bath. NA-C asked R2 to expand her legs as much as possible so that	F 677	Residents ¿ Immediate Corrective Action:¿ CNA received corrective action for incorrect incontinence cares. ¿ Corrective Action as it applies to others:¿ Activities of Daily Living (ADLs)/Maintain Abilities Policy was reviewed and remains current. Full house audit completed to ensure care plans matched care sheets and matched nursing assessments. Incontinence and pericare competencies completed for nursing staff. Education completed with nurse management about ensuring care plans match care sheets and match with nursing assessments. Education completed with nursing staff regarding following the care sheets and care plans. ¿ Recurrence will be prevented by:¿ Weekly audits completed on all new residents and significant changes to ensure care plans match the care sheets and match the nursing assessments x4 weeks. Audits on ADLs and pericares to be completed on 6 residents per week x4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.¿ ¿ Corrections will be monitored by:¿ DON/designee¿	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 6 she could wash her perineal area. R2 expanded her legs as much as she could. NA-C washed R2's perineal area from back to front. NA-C did not use different parts of the washcloth with each stroke. After NA-C washed R2's perineal area, R2 turned to her side. NA-C washed R2's back with a different washcloth. NA-C did not wash R2's buttocks. R2 rolled back on her back. NA-C assisted R2 in getting dressed. R1's admission record indicated R1 was admitted to the facility on 9/5/24 with a primary diagnosis of encounter for open fracture type I or II. R1's additional diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, history of traumatic brain injury, acquired absence of left leg above knee, anxiety disorder, and multiple fractures of pelvis without disruption of pelvic ring. R2's admission record indicated R2 was admitted to the facility on 10/31/23 with a primary diagnosis of osteomyelitis. R2's additional diagnoses included morbid obesity, schizoaffective disorder (bipolar type), anxiety disorder, and peripheral vascular disease. R4's admission record indicated R4 was admitted to the facility on 9/27/23 with a primary diagnosis of cerebral infarction due to embolism of bilateral anterior cerebral arteries. R4's additional diagnoses included dysphagia, weakness, hemiplegia, and generalized anxiety disorder. R4's care plan dated 9/29/24 indicated R4 required an assist of one staff member for bathing, dressing, and personal hygiene. R4's care plan dated 10/4/23 indicated R4 had functional and mixed urinary incontinence that	F 677	Date of Compliance:¿ ¿10/4/24	

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	245222	A. BUILDING _____ B. WING _____	C 09/18/2024

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

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F 677	Continued From page 7	F 677		

required staff to check R4's incontinent brief every two to three hours. R4's care plan intervention dated 1/11/24 indicated R4 needed two care givers when assisting with cares.

R2's bladder evaluation assessment dated 11/1/23 indicated R2 has urinary stress incontinence and utilized incontinent briefs.

R2's bowel evaluation assessment dated 11/1/23 indicated R2 was incontinent of her bowels and utilized incontinent briefs.

R4's bladder evaluation assessment dated 1/17/24 indicated R4 had functional incontinence and would be checked and changed every two to three hours.

R4's bowel evaluation assessment dated 1/17/24 indicated R4 had bowel incontinence and would be checked and changed every two to three hours.

R4's minimum data set (MDS) dated 6/25/24 indicated R4 was dependent upon staff for bathing, dressing, and personal hygiene. MDS indicated R4 required substantial/maximal assistance with toileting.

R4's brief interview for mental status (BIMS) dated 6/25/24 indicated R4 had a score of twelve, which indicated R4 was cognitively moderately impaired.

R2's BIMS dated 7/11/24 indicated R2 had a BIMS score of 15, which indicated R2 was cognitively intact.

R2's care plan dated 8/13/24 indicated R2

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F 677	Continued From page 8 required an assist of one to two staff members for bathing, dressing, and toileting. The care plan indicated R2 required assistance with personal hygiene. The care plan indicated R2 preferred to take bed baths. R1's weekly skin inspection dated 9/6/24 indicated R1 received a bed bath. R1's care plan dated 9/6/24 indicated R1 required an assist of two with toileting, movement in bed and in/out of bed, and transfers, and assist of one with ambulation. R1's care plan does not indicate her bathing preferences. R1's interdisciplinary team care conference form dated 9/9/24 indicated R1 bathing preference was to take a shower. R1's bladder evaluation assessment dated 9/11/24 indicated R1 was incontinent of her bladder. The assessment indicated R1 had urge incontinence and utilizes incontinent briefs. R1's bowel evaluation assessment dated 9/11/24 indicated R1 was incontinent of her bowels and utilized incontinent briefs. R1's BIMS dated 9/12/24 indicated R1 scored fifteen, which indicated R1 was cognitively intact. R1's weekly skin inspection dated 9/13/24 indicated R1 had "refused" a bath because she was out of the facility for an appointment. R4's hospice progress note dated 9/17/24 indicated the nursing assistant (NA) from the hospice company visited R4 for a routine visit. NA stated that upon her arrival R4's sheets and brief	F 677		

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F 677	Continued From page 9	F 677		

was soaked with urine. The progress note indicated NA had to change his bed linens and brief.

R1's bathing documentation indicated R1 required total dependence from staff for bathing on 9/8/24 and R1 required physical help in part of the bathing activity on 9/9/24. No additional bathing was documented.

During an interview on 9/17/24 at 9:22 a.m., R1 stated she wore incontinent briefs. R1 stated staff did not check her incontinent brief and change regularly. R1 stated the aides do not wash her up in the morning. R1 stated staff did not change her clothes every day.

During an interview on 9/17/24 at 9:47 a.m., registered nurse (RN)-A stated R1 used her call light to let the staff know she was incontinent and that she needed to have a brief change. RN-A stated R1 was in her hospital gown frequently and R1 had "never asked me to change her clothes.".

During an interview on 9/17/24 at 9:56 a.m., NA-A stated that was her only time working with R1. NA-A stated she did not clean up or bathe R1 during morning cares.

During an interview on 9/17/24 at 10:03 a.m., NA-B stated she did not know "too much" about R1. NA-B stated she had changed R1's incontinent brief but that was "mostly it". NA-B stated she was the only one caring for R1 and none of the other aides helped her. NA-B stated she had not given R1 a bed bath or shower.

During an interview on 9/17/24 at 10:59 a.m., family member (FM)-A stated she had bathed R1

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F 677	Continued From page 10 every time she had visited R1 since the time R1 was admitted to the facility. FM-A stated R1 was in the same hospital gown for a week after she was admitted to the facility. FM-A stated she asked R1 if the staff had bathed her since her admission and R1 told FM-A that the staff had not bathed her. During an interview on 9/17/24 at 1:03 p.m., R1 stated the staff did not offer to get her dressed for the day but did change her incontinent brief. During an interview on 9/17/24 at 2:56 p.m., nurse manager (NM) stated the resident's weekly skin inspections correlates with the showers. NM stated her expectations is if a resident has refused their shower or bed bath, there should be a risk versus benefit form for that resident. NM stated R1 had a shower on 9/6/24 but on the weekly skin inspection dated 9/13/24 the NA's had refused to give R1 her shower due to her being out of the facility for an appointment. During an interview on 9/17/24 at 4:33 p.m., FM-B stated when she was visiting R4 the day prior, she was ready to leave the facility and she had told one of the NA's that R4 needed to have his incontinent brief changed prior to her leaving. FM-B stated the NA said that she would get to R4 in "a little bit". FM-B stated the NA would only change R4's incontinent brief after asking the NA for the third time. FM-B stated R4 was on hospice, and she wanted R4's incontinent brief to be checked and changed frequently. During an interview on 9/18/24 at 9:56 a.m., social services (SS)-B stated a hospice NA visited R4 the previous day and had noted R4's bed linens were saturated with urine. SS-B stated the	F 677		

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hospice NA changed R4's incontinent brief and bed linens.

During an interview on 9/18/24 at 10:51 a.m., NA-C stated when she gave R2 her bed bath, she washed her perineal area by wiping R2's perineal sides first and then would "wash moving up". NA-C stated she would "try" to use a different side of the washcloth each time you use it. NA-C stated R1 "usually" has her incontinent brief checked and changed every hour or two. NA-C stated R1 would activate her call light if she needed her incontinent brief changed.

During an interview on 9/18/24 at 11:00 a.m., RN-A stated R4 was "really easy" to assist with daily cares. RN-A stated he is a one assist with toileting, bathing, and "cares all together.".

During an interview on 9/18/24 at 11:05 a.m., NA-B stated if she were to wash a resident's perineal area, she would wash using a washcloth and she would start wiping the outside of the perineal first and then working her way to the inside of the perineal. NA-B stated then she would wash the resident's buttocks. NA-B stated you do not have to switch out the washcloth during the perineal cares. NA-B stated she has always assisted R4 with cares by herself.

During an interview on 9/18/24 at 12:16 p.m., NM stated she would expect NA's to be performing perineal cares while wiping front to back. NM stated NAs should be changing the washcloth with each stroke. NM stated residents should have their incontinent brief checked and changed once every two to three hours or as needed.

During an interview on 9/18/24 at 12:31 p.m., the

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F 677	Continued From page 12 director of nursing (DON) stated she would expect NAs to use aseptic technique, performing perineal cares while wiping from front to back. DON stated she would expect the NAs to use a different part of the washcloth or a different washcloth every stroke they make on a resident while performing perineal cares. DON stated she would expect residents incontinent brief to be checked and changed at least every two to three hours and as needed. DON stated the NA's "should know" which residents needs to have their incontinent brief checked and changed prior to the two to three hours. During an interview on 9/18/24 at 1:04 p.m., the administrator stated she would expect NAs to perform perineal cares while wiping from front to back. The facility's "Activities of Daily Living (ADLs)/Maintain Abilities" policy and procedure dated 3/31/23 stated the facility would provide the necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrates that such diminution was unavoidable. The policy and procedure stated the facility would ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The policy and procedure stated the facility would provide care and services for the following activities of daily living: bathing, dressing, grooming, oral care, transfer and ambulation, toileting, eating, and communication.	F 677		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		10/4/24

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F 726	Continued From page 13 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure licensed staff were trained on wound vacuum-assisted closure (VAC) for five of sixteen licensed staff. R1 was admitted to the facility with a wound vac.	F 726	F267: Competent Nursing Staff ¿ Immediate Corrective Action:¿ Nursing competencies completed for all licensed nurses. ¿	

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F 726	Continued From page 14 Findings include: R1 was admitted to the facility on 9/5/24 with a primary diagnosis of encounter for open fracture type I or II. R4's additional diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and acquired absence of left leg above knee. R1's wound care progress note dated 9/6/24 indicated advanced practice registered nurse (APRN) order staff to change the wound vac every Monday, Wednesday, and Friday and as needed. R1's care plan dated 9/6/24 indicated R1 had surgical wounds that required the use of a wound vac. R1's provider progress note dated 9/10/24 indicated R1's wound vac had fluid seen in underneath the suction device and stabilizer applicator plastic remained present. The provider indicated the plastic should have been removed with application and that the wound vac would need to be reapplied. R1's treatment administration record (TAR) indicated staff was to change the small wound vac dressing to R1's left anterior leg every Tuesday and the orthopedic clinic would change every Friday. All treatment were checked off completed by registered nurse (RN)-H and RN-A. R1's TAR indicated staff would remove the dressing, complete wound cares, and reapply a new dressing twice a day. All treatments were checked off completed by RN-A, RN-C, RN-D, RN-G, RN-H, RN-I, license practical nurse (LPN)-A LPN-B, LPN-C, LPN-G, and LPN-H.	F 726	Corrective Action as it applies to others:¿ Any new nurses will get competencies completed before starting on the floor. ¿ Recurrence will be prevented by:¿ DON or designee to ensure any new staff who start at the facility will have a wound vac competency completed x4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.¿ ¿ Corrections will be monitored by:¿ DON/designee Date of Compliance:¿ ¿10/4/24	

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F 726	Continued From page 15 The facility was able to provider wound vac education competencies for nurse manager (NM), RN-A, RN-B, RN-D, and LPN-E. During an interview on 9/17/24 at 9:22 a.m., R1 stated she has a wound vac on her right leg due to an amputation. R1 stated licensed staff does not know how to change the wound vac because every time the wound vac machine sends an alert, the licensed staff stated they did not know how to change the wound vac. During an interview on 9/17/24 at 9:47 a.m., RN-A stated R1 had a wound vac. RN-A stated R1's wound vac would get changed every Friday when she goes to her orthopedic appointment. RN- A stated if a wound vac comes off or has a blockage, she would change the wound vac. RN-A stated if there was an alert on the wound vac machine, she would change the tubing to ensure there was not a kink or if the wound vac came off. RN-A stated if there was drainage in the wound vac, you would have to start the dressing process over. During an interview on 9/17/24 at 10:59 a.m., family member (FM)-A stated she visits R1 frequently and stated the wound vac alarm goes off frequently. FM-A stated during one of those visits, the wound vac machine alarm was going off and FM-A put a piece of clear tape over the hole on the machine to make the alarm stop and then the alarm started because it wasn't sealed for longer than two hours, the wound vac needed to be changed. FM-A stated she had talked to a licensed nurse stating the alarm was going off because the secretions were "too thick" and R1 had to give the licensed nurse directions on to	F 726		

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F 726	Continued From page 16 change the wound vac. FM-A could not recall the date this happened. During an email correspondence on 9/17/24 at 2:24 p.m., the director of nursing (DON) stated either the administrator, the DON, or NMs would be responsible for education at the facility. DON stated who provides the education is based on what needs to be educated. During an interview on 9/17/24 at 2:39 p.m., the DON stated she was not sure if licensed staff were educated on wound vacs and stated she would have to refer to the licensed staff's education. DON stated wound vacs were not a new treatment for this building; wound vacs had been in the facility since she could recall. DON stated, "We aren't going to have wound vac competencies for all of the nurses." And that most nurses knew how to do the wound vac treatments. DON stated she would guess that the facility did not have any competencies for wound vacs for any of the licensed nurses in the facility. DON stated the facility would not be able to train licensed nurses on "every little thing". DON stated that all wound vac treatments are done during the daytime and "all" management knows how to work the wound vac, and if it needs to be done on the weekend, there would always be a management staff on call. DON stated the licensed nursing staff would tell management if they did not know how to perform wound vac cares. During an interview on 9/17/24 at 2:56 p.m., NM stated she would expect the facility to train all licensed staff on wound vacs. NM stated R1's wound vac does not need to be changed most of the time. NM stated her wound vac alarm kept	F 726		

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F 726	Continued From page 17 going off during the day and night, and she would educate the licensed nurses on problem solving the wound vac machine. During an interview on 9/17/24 at 4:09 p.m., the administrator stated she did not have any more licensed nurse's skill competencies besides the five she had provided for LPN-E, RN-A, RN-B, RN-D, and NM. During an interview on 9/17/24 at 4:29 p.m., RN-C stated she had not been trained on wound vacs at the facility. RN-C stated she was trained on wound vac at a different facility "many years ago". RN-C stated if there was an error message on the wound vac, she would call another nurse, the DON, or the machine's manufacturer. During an email correspondence on 9/18/24 at 12:20 p.m., the administrator stated the facility did not have instructions, policy, and procedure on wound vacs.	F 726		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: JTX211

Dear Administrator:

The above facility was surveyed on September 17, 2024 through September 18, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00937	A. BUILDING: _____ B. WING _____	C 09/18/2024

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 9/17/24 and 9/18/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 09/30/24

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H52228138C (MN00106510) with a licensing order issued at 0565 and 0300. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure licensed staff were trained on wound vacuum-assisted closure (VAC) for five of sixteen licensed staff. R1 was admitted to the facility with a wound vac. Findings include: R1 was admitted to the facility on 9/5/24 with a primary diagnosis of encounter for open fracture type I or II. R4's additional diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and acquired absence of left leg above knee. R1's wound care progress note dated 9/6/24 indicated advanced practice registered nurse (APRN) order staff to change the wound vac every Monday, Wednesday, and Friday and as	2 300	corrected	10/4/24

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2 300	Continued From page 3 needed. R1's care plan dated 9/6/24 indicated R1 had surgical wounds that required the use of a wound vac. R1's provider progress note dated 9/10/24 indicated R1's wound vac had fluid seen in underneath the suction device and stabilizer applicator plastic remained present. The provider indicated the plastic should have been removed with application and that the wound vac would need to be reapplied. R1's treatment administration record (TAR) indicated staff was to change the small wound vac dressing to R1's left anterior leg every Tuesday and the orthopedic clinic would change every Friday. All treatment were checked off completed by registered nurse (RN)-H and RN-A. R1's TAR indicated staff would remove the dressing, complete wound cares, and reapply a new dressing twice a day. All treatments were checked off completed by RN-A, RN-C, RN-D, RN-G, RN-H, RN-I, license practical nurse (LPN)-A LPN-B, LPN-C, LPN-G, and LPN-H. The facility was able to provider wound vac education competencies for nurse manager (NM), RN-A, RN-B, RN-D, and LPN-E. During an interview on 9/17/24 at 9:22 a.m., R1 stated she has a wound vac on her right leg due to an amputation. R1 stated licensed staff does not know how to change the wound vac because every time the wound vac machine sends an alert, the licensed staff stated they did not know how to change the wound vac. During an interview on 9/17/24 at 9:47 a.m., RN-A	2 300		

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2 300	Continued From page 4 stated R1 had a wound vac. RN-A stated R1's wound vac would get changed every Friday when she goes to her orthopedic appointment. RN- A stated if a wound vac comes off or has a blockage, she would change the wound vac. RN-A stated if there was an alert on the wound vac machine, she would change the tubing to ensure there was not a kink or if the wound vac came off. RN-A stated if there was drainage in the wound vac, you would have to start the dressing process over. During an interview on 9/17/24 at 10:59 a.m., family member (FM)-A stated she visits R1 frequently and stated the wound vac alarm goes off frequently. FM-A stated during one of those visits, the wound vac machine alarm was going off and FM-A put a piece of clear tape over the hole on the machine to make the alarm stop and then the alarm started because it wasn't sealed for longer than two hours, the wound vac needed to be changed. FM-A stated she had talked to a licensed nurse stating the alarm was going off because the secretions were "too thick" and R1 had to give the licensed nurse directions on to change the wound vac. FM-A could not recall the date this happened. During an email correspondence on 9/17/24 at 2:24 p.m., the director of nursing (DON) stated either the administrator, the DON, or NMs would be responsible for education at the facility. DON stated who provides the education is based on what needs to be educated. During an interview on 9/17/24 at 2:39 p.m., the DON stated she was not sure if licensed staff were educated on wound vacs and stated she would have to refer to the licensed staff's education. DON stated wound vacs were not a	2 300		

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2 300	Continued From page 5 new treatment for this building; wound vacs had been in the facility since she could recall. DON stated, "We aren't going to have wound vac competencies for all of the nurses." And that most nurses knew how to do the wound vac treatments. DON stated she would guess that the facility did not have any competencies for wound vacs for any of the licensed nurses in the facility. DON stated the facility would not be able to train licensed nurses on "every little thing". DON stated that all wound vac treatments are done during the daytime and "all" management knows how to work the wound vac, and if it needs to be done on the weekend, there would always be a management staff on call. DON stated the licensed nursing staff would tell management if they did not know how to perform wound vac cares. During an interview on 9/17/24 at 2:56 p.m., NM stated she would expect the facility to train all licensed staff on wound vacs. NM stated R1's wound vac does not need to be changed most of the time. NM stated her wound vac alarm kept going off during the day and night, and she would educate the licensed nurses on problem solving the wound vac machine. During an interview on 9/17/24 at 4:09 p.m., the administrator stated she did not have any more licensed nurse's skill competencies besides the five she had provided for LPN-E, RN-A, RN-B, RN-D, and NM. During an interview on 9/17/24 at 4:29 p.m., RN-C stated she had not been trained on wound vacs at the facility. RN-C stated she was trained on wound vac at a different facility "many years ago". RN-C stated if there was an error message on the wound vac, she would call another nurse,	2 300		

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2 300	Continued From page 6 the DON, or the machine's manufacturer. During an email correspondence on 9/18/24 at 12:20 p.m., the administrator stated the facility did not have instructions, policy, and procedure on wound vacs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 300		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to produce a care plan that was consistent for one of four residents (R4) reviewed for care plans. R4's care plan stated two staff members were to provide cares for R4 while further down in the care plan it stated one staff was to assist R4 with bathing, dressing, and personal hygiene. Findings include:	2 565	corrected	10/4/24

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2 565	Continued From page 7 During an observation on 9/18/24 at 10:02 a.m., nursing assistant (NA)-B changed R4's incontinent brief. NA-B was the only aide who changed R4's incontinent brief. R1's face sheet indicated R4 was admitted to the facility on 9/27/23 with a primary diagnosis of cerebral infarction due to embolism of bilateral anterior cerebral arteries. R4's additional diagnoses included hemiplegia affecting left dominant side, repeated falls, panic disorder, adjustment disorder with anxiety, and other stimulant abuse. R4's care plan dated 9/29/23 indicated resident needed an assistant of one for bathing, dressing, and personal hygiene. R4's care plan dated 1/11/24 indicated resident needs two care givers when assisting with cares. R4's brief interview for mental status (BIMS) dated 6/25/24 indicated R4 scored twelve, which indicated R4 was cognitively moderately impaired. R4's minimum data set (MDS) dated 6/25/24 indicated R4 required dependence of staff members for bathing, dressing, and personal hygiene. The MDS indicated R4 needed substantial/moderate assistance with toileting and partial/moderate assistance with oral hygiene. The MDS indicated R4 needed assistance with setup or clean-up assistance with eating. Facility's nursing care sheets dated 8/14/24 indicated R4 was an assist of one with pivot transfers, dressing, grooming, and bathing. The nursing care sheet indicated R4 could have	2 565		

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2 565	Continued From page 8 aggressive behaviors. R4's special instructions in R4's profile indicated resident was a two-person caregiver and to not go in R4's room alone. During an interview on 9/18/24 at 10:51 a.m., NA-C stated now that R4 was admitted to hospice, he only needed one person to change his incontinent brief. During an interview on 9/18/24 at 11:00 a.m., registered nurse (RN)-A stated R4 was "really easy" to care for. RN-A stated R4 was an assist of one with toileting, bathing, and "cares all together". During an interview on 9/18/24 at 11:05 a.m., NA-B stated she had always used just one person to change his incontinent brief or "doing anything for him". NA-B stated from her knowledge R4 always needed just one person to assist R4. During an interview on 9/18/24 at 12:16 p.m., nurse manager (NM) stated she would expect care plans to be updated regularly when something changed in a resident cares or preferences and based on the assessments that were done. NM stated she would expect care plans to match when talking about assistance with activities of daily living (ADL). During an interview on 9/18/24 at 12:31 p.m., the director of nursing (DON) stated her expectation was care plans should be matching throughout the care plan. DON stated she would expect that care plans would be updated according to resident's current abilities and preferences. DON stated social services (SS)-A put the intervention	2 565		

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2 565	Continued From page 9 into R4's care plan stating R4 required two care givers to assist with cares. During an interview on 9/18/24 at 12:48 p.m., SS-A stated she was the one who put the care plan intervention about R4 needed two care givers to assist with cares after reports of abuse. SS-A stated the intervention should have been removed from R4's care plan because it no longer applied to R4. During an interview on 9/18/24 at 1:04 p.m., the administrator stated all staff in the facility uses a resident's care plans. Administrator stated she would expect care plans to match throughout the care plan. Care plan policy and procedure was requested, and none was received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		