

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: The Estates at Château LLC Facility Address: 2106 2nd Avenue South Facility City: Minneapolis		Report Number: H5222070, H5222071, and —— H5222072	Date of Visit: May , 31, 2017	
		Time of Visit: 9:00 a.m to 4:00 p.m.	Date Concluded: October 23, 2017	
		Investigator's Name and To	- [itle:	
ZIP: 55404	County: Hennepin			
	ZIP:	ZIP: County:	H5222070, H5222071, and H5222072 Time of Visit: 9:00 a.m to 4:00 p.m. Investigator's Name and To Michele Strahan R.N. ZIP: County:	

⋈ Nursing Home

Allegation(s):

It is alleged that Resident # 1 was neglected when the facility failed to provide adequate supervision. Resident # 1 was struck with a blunt object at the back of the head by Resident # 2. Resident # 1 suffered a contusion and injury to left eye. Resident # 1 required hospitalization.

- ▼ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

Conclusion:

Based on preponderance of evidence the facility failed to provide adequate supervision when Resident #2 assaulted Resident #1. Resident #1 and Resident #2 had four altercations within five days, three of which were within the 24 hours prior to the assault. During the last altercation Resident #2 assaulted Resident #1. Resident #1 went to the hospital and was diagnosed with a broken arm, a swollen left eye, and facial abrasions.

Resident #1 resided in the facility for approximately three and a half months. Resident #1 had diagnoses that included depression, anxiety renal disease, and dependence on dialysis. S/he required minimal assistance of staff for activities of daily living most of the time. S/he was up and around the facility using a wheelchair, and was able to make his/her needs known. Resident #1 had a history of verbal aggression towards other residents. The facility had interventions in place to monitor Resident #1's behavior and redirect him/her.

Resident #2 was admitted to the facility with diagnoses that include depression, anxiety, psychosis, and a below the knee amputation . S/he required the assistance of one staff person for activities of daily living,

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was up in wheelchair independently, and was able to make his/her need known. Within the first month at the facility, Resident #2 had six documented resident to resident altercations.

Resident #1 and Resident #2 had a verbal altercation four days prior to the assault. Both residents yelled at each other, used foul language, made threats, and threatened to kill each other. Resident #2 called Resident #1 derogatory racial slurs, and ran at Resident #1 with his wheelchair.

Three days later, during the evening, Resident #1 and Resident #2 were on the patio with several other residents from the facility. Resident #2 had an altercation with another resident and pushed that resident to the ground. Resident #1 told Resident #2 not to treat others in that manner. Resident #1 and Resident #2 began arguing about the interaction that Resident #2 had with the other resident. Resident #2 called Resident #1 derogatory names and spit into Resident #1's face several times. That evening the police were called by an unknown individual. Both residents went back inside the facility and continued to argue. Both residents made threats, yelled at each other, used foul language, and called each other names. Staff were unable to redirect Resident #2 and unable to calm Resident #2. Resident #2 did not want to talk with staff about what happened on the patio. Resident #2 appeared intoxicated and slouched to the left side in his wheelchair. Staff called the police and the police were able to calm Resident #2 and deescalate the situation. Staff placed both residents on fifteen minute visual checks to prevent further incidents. The every fifteen minute visual checks began that morning for Resident #1 at 2:15 a.m., for Resident #2 at 1:45 a.m., and continued for both residents until that night at 11:15 p.m. when Resident #1 was sent to the hospital. There were no changes to either residents' care plans at this time.

The next day, at approximately 11:00 a.m., staff heard Resident #1 and Resident #2 arguing loudly near the nurse's station. Both residents were making accusations about each other, name-calling, and using foul language. Resident #1 informed the staff that he had issues with Resident #2 the evening before, stated that Resident #2 kept coming into Resident #1's room to start arguments, and that Resident #2's arguments were escalating against Resident #1. Resident #1 told two staff members he was afraid of what Resident #2 might do to him. Staff attempted to notify administration during afternoon. Staff did not get a response from administration and continued to monitor both resident with fifteen minute visual checks. There were no changes to either residents' care plans at this time. No new interventions were implemented to protect or keep either resident safe at this time.

That night, at approximately 11:15 p.m., the nurse was called to the unit by a staff person because Resident #2 had assaulted Resident #1. Police were called immediately. Staff found Resident #1 sitting in the hallway in his wheelchair and Resident #1 told staff that s/he was ambushed when s/he got off the elevator. Resident #1's left eye was swollen to the size of a golf ball, a large amount of blood was dripping from his/her face, and his/her left arm appeared deformed. As staff were assisting Resident #1, Resident #2 came out of his/her room yelling that Resident #1 was a liar, parked his/her wheelchair in front of Resident #1, and Resident #1 pulled out a heavy black object wrapped in tape from behind his back and began hitting Resident #2. Staff attempted to separated the residents, the police arrived at that moment, and assisted staff to separate the residents. Staff sent Resident #1 to the hospital for evaluation of his/her injuries. Resident #2 remained in the facility because he was not seriously injured.

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Resident #1 was interviewed and stated that Resident #2 called him names every day such fagot, gay, vicious, and various derogatory racial slurs. Resident #1 stated that Resident #2 hit him first. Resident #1 stated that no nurses were on the floor the evening of the assault for approximately two hours. S/he stated that Resident #2 chased him around the floor for about forty minutes before help arrived. S/he stated that it is a common occurrence to not see staff for extended periods of time.

Resident #2 was interviewed and stated that Resident #1 attacked him. S/he stated that Resident #1 was a bully and sometimes kicked or attempted to throw things at him/her. Resident #2 stated that s/he hurt Resident #1 and sent him to the hospital.

Several staff were interviewed and stated that fifteen minute visual checks of the residents location are completed to confirm that the residents are not together. Staff were unable to recall what the issues Resident #1 and Resident #2 were arguing about during their altercations. One staff person stated that Resident #1 appeared upset after an argument with Resident #2, and Resident #1 stated that Resident #2 was calling Resident #1's mother names. Another staff person stated that Resident #1 was upset that Resident #2 pushed another resident to the ground and after Resident #1 told Resident #2 not to do that, Resident #2 became angry. All staff stated that there was a staff person on the floor with both residents the evening of the assault, and all fifteen minute visual checks were completed. All fifteen minute visual checks were documented for both residents until Resident #1 was sent to the hospital.

The Director of Nursing was interviewed and stated that s/he was not aware of an argument or altercation between Resident #1 and Resident #2 prior to the assault. S/he was not aware that Resident #1 had expressed fear of Resident #2. S/he stated that she would have implemented one to one staffing for the residents to keep them safe.

Hospital records indicated that Resident #1 was diagnosed with a left ulna fracture, left eye swelling, and left eye abrasions. Resident #1 remains in the hospital, and his/her bed hold at the facility expired. Resident #2 remains in the facility.

Police records were reviewed and indicated that Resident #1 and Resident #2 had an altercation at the facility. The residents struck each other with blunt objects, and both residents were injured. Resident #1 was struck in the back of the head, had visible blood, and a left eye contusion. R1 reported that there were no staff on the unit for several hours.

Minnesota Vulnerable Adults Act (Minnesota Statutes	s, section 626.557)
Under the Minnesota Vulnerable Adults Act (Minnesota	ota Statutes, section 626.557):
☐ Abuse ☐ Neglect	☐ Financial Exploitation ☐ Inconclusive based on the following information:
Substantiated	

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the \(\sime\) Individual(s) and/or \(\sime\) Facility is responsible for the Neglect ☐ Financial Exploitation. This determination was based on the following: ☐ Abuse Although the facility had an abuse prevention policy in place to prevent resident abuse, including resident to resident altercations, the facility had no policy related to resident supervision in place. Even though staff were educated on the abuse prevention policy, and staff followed the care plan, this did not prevent Resident #2 from assaulting Resident #1. The facility failed to monitor staff, increase supervision, or implement care plan changes to prevent the assault. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C. Compliance: Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met. Deficiencies are issued on form 2567: 🗵 Yes ☐ No (The 2567 will be available on the MDH website.) State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met. State licensing orders were issued: x Yes \square No (State licensing orders will be available on the MDH website.) State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not □ No State licensing orders were issued: X Yes (State licensing orders will be available on the MDH website.) State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met. State licensing orders were issued: X Yes (State licensing orders will be available on the MDH website.) **Compliance Notes:**

Facility Name: The Estates at Château LLC

Report Number: H5222070, H5222071, and H5222072

Report Number: H5222070, H5222071, and H5222072 Facility Name: The Estates at Château LLC

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Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ▼ Medical Records
- Care Guide
- ▼ Medication Administration Records
- Weight Records
- Nurses Notes

Facility Name: The Estates at Château LLC	Report Number: H5222070, H5222071, and H5222072
▼ Assessments	
Physician Orders	
☐ Treatment Sheets	
Physician Progress Notes	
Social Service Notes	
Skin Assessments	
🔀 Facility Incident Reports	
★ Activities Reports	
■ Laboratory and X-ray Reports	
▼ Therapy and/or Ancillary Services Records	
Other pertinent medical records:	
O Yes ● No ○ N/A	
Specify:	
Interviews: The following interviews were conducted Interview with reporter(s) Yes No (Specify: If unable to contact reporter, attempts were made on	
Data	
Date: Time: Date: 05/03/2017 2:56 p.m. 06/07/2017	3:08 p.m. 06/19/2017 2:45 p.m.

Report Number: H5222070, H5222071, and H5222072 Facility Name: The Estates at Château LLC No ○ N/A Specify: No working telephone number available. Interview with family: O Yes Did you interview the resident(s) identified in allegation: ○ N/A Specify: O No Yes Did you interview additional residents?

Yes O No Total number of resident interviews: Eight Specify: \bigcirc N/A Interview with staff:

Yes O No Tennessen Warnings Tennessen Warning given as required:

Yes O No Total number of staff interviews: Fourteen Physician Interviewed: OYes No No Nurse Practitioner Interviewed: Physician Assistant Interviewed: OYes No Specify: N/A Interview with Alleged Perpetrator(s): O Yes O No Attempts to contact: Time: Date: Time: Date: Time: Date: ○ No If unable to contact was subpoena issued: O Yes, date subpoena was issued Were contacts made with any of the following: Emergency Personnel 🗵 Police Officers 🗌 Medical Examiner 🗍 Other: Specify Observations were conducted related to: x Personal Care Nursing Services Call Light ▼ Infection Control Cleanliness Dignity/Privacy Issues Safety Issues **Facility Tour** X N/A Was any involved equipment inspected: O Yes O No Was equipment being operated in safe manner: O Yes N/A O No

Specify:

No

Were photographs taken: O Yes

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Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Minneapolis Police Department

Hennepin County Attorney

Minneapolis City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		R	-C
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	H5222072. The E compliance with 42 requirements for L	H5222070, H5222071, and states at Chataeu LLC is in 2 CFR Part 483, subpart B, ong Term Care Facilities.					
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							(Ve) DATE
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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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	NH LICENSING	CORRECTION ORDER				
•	In accordance with	Minnesota Statute, section				
	144A.10, this corre	ction order has been issued				
	pursuant to a surve	ey. If, upon reinspection, it is ciency or deficiencies cited			1	
	herein are not corre	ected, a fine for each violation				
	not corrected shall	be assessed in accordance				
	with a schedule of	fines promulgated by rule of				
	the Minnesota Dep	artment of Health.				
	Determination of W	hether a violation has been				
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	number and MN R	ule number indicated below.				
	When a rule conta	ins several items, failure to				
	comply with any of	the items will be considered				
	lack of compliance	Lack of compliance upon any item of multi-part rule will				
	result in the assess	sment of a fine even if the item				
	that was violated d	uring the initial inspection was		,		
	corrected.					
		bearing on only apparaments				
	You may request a	hearing on any assessments m non-compliance with these				
	orders provided the	at a written request is made to				
	the Department wi	thin 15 days of receipt of a				
	notice of assessm	ent for non-compliance.				
		TO:				
	INITIAL COMMEN	ollow-up was completed to				
	follow up on correct	ction orders issued related to				
	complaint H52220	70, H5222071, and H5222072.				
	The Estates at Ch	ateau LLC was found in				
	compliance with st	tate regulations.				
	The facility is seen	lled in ePOC and therefore a				
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 11/28/17

Electronically Signed

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		R-C	
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Minnesota Department of Health STATE FORM

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	
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F 000	INITIAL COMMEN	TS	F	000			
F 223 SS=G	to investigate case H5222072. As a reare issued. The fatherefore a signature of the first page of Electronic submissive verification of com 483.12(a)(1) FREI ABUSE/INVOLUNUM 483.12 The resident has really register the resident and exploitation a includes but is not corporal punishmany physical or character the resident 483.12(a) The fact (a)(1) Not use very abuse, corporal pseclusion; This REQUIREM by: Based on interviting facility neglect prevent abuse of R2), reviewed where R1 retaliated assessible procession and diagonal retails and diagonal resident and diagonal retails and diagonal retails are discovered as the spoital retails as the spoital retails are discovered as the spoital retails are discovered as the spoital retails are discovered as the spoital retails as the spoital retails as the spoital retails are discovered as the spoital retails are discovered as the spoital retails are discovered as the spoital retails as the spoital retails are discovered as the spoital retails are discovered as the spoital retails are discovered as the spoital retails ar	E FROM ITARY SECLUSION the right to be free from abuse, priation of resident property, sidefined in this subpart. This tilmited to freedom from ent, involuntary seclusion and nemical restraint not required to significant symptoms. cility mustical mental, sexual, or physical unishment, or involuntary ENT is not met as evidenced ew and documentation review sted to supervise, and failed to two of six residents, (R1 and nen R2 assaulted R1 and then aulting R2. R1 was taken to the mosed with a broken arm, a	F	223			
	swollen eve, and	abrasions near his/her left eye. Irred during the third altercation					
	Findings include:						(Ve) DATE
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	E	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COM	E SURVEY IPLETED C
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	admitted to the fa	ord was reviewed. R1 was acility on 01/18/17. R1's ed depression, anxiety, end se, dialysis, and drug abuse. R1 ir for mobility.					
	independent with for toileting, and daily living. The or	02/06/17, indicated that R1 was locomotion, required two staff set up assistance for activities of care plan indicated that R1 fied monitoring related to be to multiple medications and depressants.					
	had incidents of residents. Interv redirect residents.	ated 02/28/17, indicated that R1 verbal aggression towards other entions included, de-escalate, from situation, separate R1 from call for assistance, and notify aviors that are potentially					
	admitted to the	cord was reviewed. R2 was facility 04/12/17. R2's diagnoses osis, depression, and anxiety.					
	during an argur (roommate) by resident's head	ort dated 04/15/17, indicated that nent R2 grabbed another resider the head and shook the other . After the incident staff moved to a new room.	nt				
	required the as	dated 05/01/17, indicated that Rassistance of one staff person for a ly living, and uses a power scoot took antidepressants and dication.	111				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION		E SURVEY IPLETED
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1112 2011			ID	131111	PROVIDER'S PLAN OF CORR	RECTION	(X5) COMPLETION
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F 223	An incident report indicated that R2 and threatened to harassing, and rur scooter. R2 calle Both residents we threats, and yelling placed on 15 mine evening and their touch each other. An incident report a.m., indicated than unnamed resit the ground outsic reported to staff to pushed him/her to patio. The residents care plimplemented to residents, safe. An incident report implemented to residents, safe. An incident report indicated that Ratio the ground was residents, safe.	dated 05/09/17, at 4:30 p.m. and R1 had a verbal altercation kill each other. R2 was verbally ning at R1 with his/her power dR1 derogatory racial slurs. For each other. Both were using foul language, making gat each other. Both were ute visual checks for the hight shift. The residents did not during this altercation. It dated 05/13/17, written at 1:15 at on the evening of 05/12/17, dent pushed another resident to be on the patio. This resident to be on the patio. This resident had that an unnamed resident had that an unnamed resident had that pushed this resident to not named in the incident report the regarding the incident, dated were no changes to this an and no interventions were keep this resident, or other It dated 05/13/17 at 1:15 a.m., I and R2 were arguing with each hing of 5/12/17. R1 and R2 were fon at each other, name-calling, of foul language. R2 refused to		223			
	discuss an ever where R2 pushe R2 appeared in deescalate the and the police of resumed 15-min time on both resident	It that took place on the pation of another resident to the ground accident to the ground toxicated, the staff were unable to situation. Staff called the police le-escalate R2's mood. The facil nute visual checks for the second idents. There were no changes intstrain the safety of either resident. No	ity d				sheet Page

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		, COV	MPLETED C
		245222	B. WING			/31/2017
	NAME OF PROVIDER OR SUPPLIER THE ESTATES AT CHATEAU LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL PREFIX TAG F 223 Continued From page 3 new interventions were implemented to prevent an altercation between R1 and R2. Nurses' notes dated 05/13/17, at 2:28 p.m., and 2:39 p.m., indicated that R1 and R2 were yelling at each other at the nurse's station and staff directed the residents away from each other. R1 informed staff that he had issues with R2 the evening before, R2 kept coming into R1's room and starting issues, and R2 was escalating issues against R1. R1 appeared tearful and shaky. The notes did not detail the issues. Staff advised both residents to avoid each other. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No new interventions were implemented to prevent an altercation between R1 and R2. An incident report dated 5/14/17, written at 1:11 a.m. indicated that staff were called to the 4th floor at approximately 11:15 p.m. R2 assaulted R1 with a heavy black object wrapped in tape. Staff found R1 sitting in his wheelchair in the haliway and R1 said, "Look what he did to my eye". R1's left eye was swollen to the size of golf ball, a large amount of blood was dripping from his face, and his left arm appeared deformed. As staff were assisting R1, R2 came out of his room yelling that R1 was lying, parked his wheelchair in the troof R1. Then R1 pulled out a heavy black by the deformed. As staff were assisting R1, R2 came out of his room yelling that R1 was lying, parked his wheelchair in the troof R1. Then R1 pulled out a heavy black by the deformed. As staff were assisting R1, R2 came out of his room yelling that R1 was lying, parked his wheelchair in the troof R1. Then R1 pulled out a heavy black by the case of th					
PRÉFIX	(EACH DESICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 223	new interventions an altercation betwoen altercation betwoen the staff that each other at the directed the residinformed staff that evening before, Found starting issue against R1. R1 anotes did not detaresidents to avoic changes to either increased supervesident. No new implemented to provide the staff found R1. An incident report a.m. indicated the floor at approxime R1 with a heavy Staff found R1 shallway and R1 seye". R1's left expelling that R1 with a large amount of R1. The object wrapped struck R2 three Staff separated and sent R1 to the spital records R1 suffered a left suffe	were implemented to prevent ween R1 and R2. ed 05/13/17, at 2:28 p.m., and ed that R1 and R2 were yelling he nurse's station and staff ents away from each other. R1 the had issues with R2 the R2 kept coming into R1's room es, and R2 was escalating issues appeared tearful and shaky. The fail the issues. Staff advised both deach other. There were no residents' care plans, and no rision for the safety of either winterventions were prevent an altercation between the dated 5/14/17, written at 1:11 at staff were called to the 4th eately 11:15 p.m. R2 assaulted black object wrapped in tape. It is wheelchair in the said, "Look what he did to my ye was swollen to the size of golf out of blood was dripping from a left arm appeared deformed. As in R1, R2 came out of his room was lying, parked his wheelchair in the R1 pulled out a heavy black in tape from behind his back and times in the back of the head. The residents, called the police,		223		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			COMPLI	
		245222	B. WING			07/31	/2017
	PROVIDER OR SUPPLIE	SUPPLIER ### A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MIN 55047 MARAPY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL STORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG From page 4					
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	X (EACH CO	RRECTIVE ACTION SHOUL ERENCED TO THE APPRO	_DBE '	(X5) COMPLETION DATE
F 223	hospital at this tir the facility. During an intervir NA-D stated that another resident reported the ground on the 05/12/17, incided afterwards R1 at that incident. At several times. No and R2 were on safety of both reresidents location ere not together. During an interviction of 13/17, at appresson called he between R1 and and then R1 stamight do to R1. Nursing (DON) text message redid not get a reresidents agreed Staff continued residents. No mimplemented to R1 and R2. During an interponental to R1 and R2. During an interponental to R1 and R2.	ew on 05/31/17, at 11:56 a.m., R2 was verbally abusive to NA-D stated that the other that R2 had pushed her/him to e patio during the evening of at report dated 05/13/17, and and R2 had an argument regarding that time R2 spat into R1's face A-D stated that afterwards R1 15 minute checks to ensure the sidents, staff visually checked the onto confirm that the residents, document, and sign each check iew on 06/06/17, 11:27 a.m. cal Nurse (LPN)-J stated that on proximately 11:00 a.m. a staff er to assist with an argument of R2. LPN-J sent R2 to his room atted that he was afraid of what R2 LPN-J called the Director of left a voice message, and sent a granding R2's statement. LPN-J turn call from the DON. Both and to avoid each other at that time visual 15-minute checks on both ew interventions were		223			not Page 5.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION		A. BUILD				С
		245222	B. WING		710 00D		31/2017
	PROVIDER OR SUPPLIER			2106	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE SOUTH NEAPOLIS, MN 55404	-	
(X4) ID PREFIX TAG	(EACH DESIGIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 223	statement of fear a during the day at a 05/13/17. DON-M made aware of an afternoon she wou R2 were safe. DO have implemented residents. The policy titled A Adult dated 04/20 indicated that the residents are not including other reany abusive situation.	age 5 after the altercation with R2 approximately 11:00 a.m. on stated that if she had been altercation on 05/13/17, in the uld have made sure that R1 and DN-M stated that she would d one to one supervision for the buse Prevention/Vulnerable 17, provided by the facility policy is to ensure that subjected to abuse by anyone sidents, to identify and remedy tions, and to prevent injuries. popolicy related to supervision of		223			

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING: __ AND PLAN OF CORRECTION C 07/31/2017 B. WING 00937 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2106 SECOND AVENUE SOUTH THE ESTATES AT CHATEAU LLC MINNEAPOLIS, MN 55404 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG 2 000 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: A complaint investigation was conducted to investigate complaint H5222070, H5222071, and H5222072. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	a Department of He	alth	(VO) MUITIBLE C	CONSTRUCTION	(X3) DATE SUR	VEY		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED				
MIND L FWIN	5, 55, 1, 125, 157,				С			
		00937	B. WING		07/31/2	017		
	DOVIDED OD SLIPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
	2106 SECOND AVENUE SOUTH							
THE EST	THE ESTATES AT CHATEAU LLC MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE							
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2 000	Continued From pa	age 1	2 000					
21850	obul.htm The Sta delineated on the a Department of Hea electronically. Alth necessary for Stat the word "correcte Then indicate in the process, under the date your orders we electronically subra Department of Hea	state.mn.us/divs/fpc/profinfo/infate licensing orders are attached Minnesota alth orders being submitted hough no plan of correction is a Statutes/Rules, please enter d" in the box available for text. The electronic State licensure the heading completion date, the will be corrected prior to mitting to the Minnesota alth. 4.651 Subd. 14 Patients &	21850					
	Residents shall be defined in the Vull "Maltreatment" mesection 626.5572 intentional and not physical pain or inconduct intended distress. Every mon-therapeutic except in fully do authorized in writeresident's physical period of time, and protect the resident's physical period of time, and protect the resident period of time, and period of ti	dom from maltreatment. e free from maltreatment as nerable Adults Protection Act. eans conduct described in , subdivision 15, or the on-therapeutic infliction of njury, or any persistent course of to produce mental or emotional esident shall also be free from chemical and physical restraints cumented emergencies, or as ting after examination by a ian for a specified and limited and only when necessary to ent from self-injury or injury to ement is not met as evidenced ew and documentation review the ensure residents were free from r two of six residents, (R1 and	,					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
VIAD I TWIA							
		00937	B. WING		07/3	31/2017	
			ODDECC CITY C	TATE ZIP CODE			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH							
THE EST	ATES AT CHATEAU						
	PROVIDER'S PLAN OF CORRECTION (X5)						
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21850	Continued From p	age 2	21850				
	D2) reviewed whe	en the facility neglected to					
1	supervise and pre	vent abuse. R2 assaulted R1					
	and then R1 retali	ated assaulting H2. H1 was	_				
	taken to the hosni	tal and diagnosed with a brokel	n I				
	arm, a swollen ey	e, and abrasions near his/her ault occurred during the third					
	eπ eye. The assa	ours between R1 and R2.	1				
	and out of the						
	Findings include:						
	The policy titled A	buse Prevention/Vulnerable					
	Adult dated 04/20	117, provided by the facility	`\				
	indicated that the	policy is to ensure that				!	
	residents are not	subjected to abuse by anyone sidents, to identify and remedy					
	any abusive situa	itions, and to prevent injuries.					
		o policy related to supervision o	Of				
	residents.						
	R1's medical rec	ord was reviewed. R1 was					
	admitted to the fa	acility on 01/18/17. R1's					
	diagnoses includ	led depression, anxiety, end	31				
	stage renal disea used a wheelcha	ase, dialysis, and drug abuse. F	``				
	R1's plan dated	02/06/17, indicated that R1 was	3				
	independent with	n locomotion, required two staff					
	for toileting, and	set up assistance for activities care plan indicated that R1	01				
	required unspec	ified monitoring related to					
	complications du	ue to multiple medications and					
	daily use of antic	depressants.					
			1				
	The care plan d	ated 02/28/17, indicated that R verbal aggression towards oth	er				
	residents Interv	ventions included, de-escalate,					
	redirect resident	t from situation, separate H1 fro	om				
ļ	other residents.	call for assistance, and notify					
	physician of bel	naviors that are potentially					

Minnesota Department of Health STATE FORM

			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION (A1) PROVIDENCE IDENTIFICAT		IDENTIFICATION NUMBER:	A. BUILDING: _			
		00037	B, WING		C 07/31/2017	
		00937	DRESS, CITY, ST	FATE ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		OND AVENUE			
THE EST	ATES AT CHATEAU I		OLIS, MN 55	404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE	
21850	Continued From pa	age 3	21850			
	harmful.					
	admitted to the fac	rd was reviewed. R2 was bility 04/12/17. R2's diagnoses s, depression, and anxiety.				
	during an argume	dated 04/15/17, indicated that nt R2 grabbed another resident head and shook the other After the incident staff moved a new room.				
	required the assis	ted 05/01/17, indicated that R2 tance of one staff person for all iving, and uses a power scoote ok antidepressants and ation.	r			
	indicated that R2 and threatened to harassing, and ruscooter. R2 calle Both residents we threats, and yelling placed on 15 min evening and the	t dated 05/09/17, at 4:30 p.m. and R1 had a verbal altercation will each other. R2 was verball anning at R1 with his/her powered R1 derogatory racial slurs. Here using foul language, making at each other. Both were nute visual checks for the night shift. The residents did not during this altercation.	3			
	a.m., indicated the an unnamed resisting the ground outsing reported to staff pushed him/her patio. The resident the ground was or the nurses no 05/13/17. There	It dated 05/13/17, written at 1:19 hat on the evening of 05/12/17, ident pushed another resident to the patio. This resident that an unnamed resident had to the ground outside on the ent that pushed this resident to not named in the incident reportes regarding the incident, date were no changes to this lan and no interventions were	o l			

Minnesota Department of Health STATE FORM

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ С B. WING 07/31/2017 00937 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2106 SECOND AVENUE SOUTH THE ESTATES AT CHATEAU LLC MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ΙD (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 4 implemented to keep this resident, or other residents, safe. An incident report dated 05/13/17 at 1:15 a.m., indicated that R1 and R2 were arguing with each other in the evening of 5/12/17. R1 and R2 were making accusation at each other, name-calling, velling, and using foul language. R2 refused to discuss an event that took place on the patio where R2 pushed another resident to the ground. R2 appeared intoxicated, the staff were unable to deescalate the situation. Staff called the police and the police de-escalate R2's mood. The facility resumed 15-minute visual checks for the second time on both residents. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No new interventions were implemented to prevent an altercation between R1 and R2. Nurses' notes dated 05/13/17, at 2:28 p.m., and 2:39 p.m., indicated that R1 and R2 were velling at each other at the nurse's station and staff directed the residents away from each other. R1 informed staff that he had issues with R2 the evening before, R2 kept coming into R1's room and starting issues, and R2 was escalating issues against R1. R1 appeared tearful and shaky. The notes did not detail the issues. Staff advised both residents to avoid each other. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No new interventions were implemented to prevent an altercation between R1 and R2. An incident report dated 5/14/17, written at 1:11 a.m. indicated that staff were called to the 4th floor at approximately 11:15 p.m. R2 assaulted R1 with a heavy black object wrapped in tape.

PRINTED: 08/08/2017 FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 07/31/2017 00937 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2106 SECOND AVENUE SOUTH THE ESTATES AT CHATEAU LLC MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21850 Continued From page 5 21850 Staff found R1 sitting in his wheelchair in the hallway and R1 said, "Look what he did to my eve". R1's left eye was swollen to the size of golf ball, a large amount of blood was dripping from his face, and his left arm appeared deformed. As staff were assisting R1, R2 came out of his room. velling that R1 was lying, parked his wheelchair in front of R1. Then R1 pulled out a heavy black object wrapped in tape from behind his back and struck R2 three times in the back of the head. Staff separated the residents, called the police. and sent R1 to the hospital. Hospital records dated 05/14/17, indicated that R1 suffered a left ulna fracture, left eye swelling and left eve abrasions. R1 remains in the hospital at this time, and his bed hold expired at the facility. During an interview on 05/31/17, at 11:56 a.m., NA-D stated that R2 was verbally abusive to another resident. NA-D stated that the other resident reported that R2 had pushed her/him to the ground on the patio during the evening of 05/12/17, incident report dated 05/13/17, and afterwards R1 and R2 had an argument regarding that incident. At that time R2 spat into R1's face several times. NA-D stated that afterwards R1 and R2 were on 15 minute checks to ensure the safety of both residents, staff visually checked the residents location to confirm that the residents ere not together, document, and sign each check.

Minnesota Department of Health STATE FORM

During an interview on 06/06/17, 11:27 a.m. Licensed Practical Nurse (LPN)-J stated that on 05/13/17, at approximately 11:00 a.m. a staff person called her to assist with an argument between R1 and R2. LPN-J sent R2 to his room and then R1 stated that he was afraid of what R2 might do to R1. LPN-J called the Director of

PRINTED: 08/08/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00937 07/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH THE ESTATES AT CHATEAU LLC MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21850 Continued From page 6 21850 Nursing (DON), left a voice message, and sent a text message regarding R2's statement. LPN-J did not get a return call from the DON. Both residents agreed to avoid each other at that time. Staff continued visual 15-minute checks on both residents. No new interventions were implemented to prevent an altercation between R1 and R2. During an interview on 06/07/17, at 12:52 p.m., DON-M stated that she she was not aware of an altercation between R1 and R2 on 05/13/16, in the afternoon at approximately 11:00 a.m. DON-M stated that she did not receive a voicemail or text from staff regarding R1's statement of fear after the altercation with R2 during the day at approximately 11:00 a.m. on 05/13/17. DON-M stated that if she had been made aware of an altercation on 05/13/17, in the afternoon she would have made sure that R1 and R2 were safe. DON-M stated that she would have implemented one to one supervision for the residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.