



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2021

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

RE: CCN: 245222
Cycle Start Date: November 30, 2021

Dear Administrator:

On November 30, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 1, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 30, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 12/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/30/2021
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT CHATEAU LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>On 11/29/21, to 11/30/21, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct multiple complaint investigations. The Estates of Chateau was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>The following complaints were found to be substantiated:</p> <p>H5222125C (MN63136); however, no deficiencies cited due to prior action taken. H5222134C (MN78723); with incidental non-compliance cited at F609. H5222137C (MN64907); however, no deficiencies cited due to prior action taken. H5222138C (MN62836); however, no deficiencies cited due to prior action taken.</p> <p>The following complaints were found to be unsubstantiated:</p> <p>H5222124C (MN58978) H5222126C (MN46326) H5222127C (MN47683) H5222128C (MN49715) H5222129C (MN53734) H5222130C (MN56527) H5222131C (MN56529) H5222132C (MN56531) H5222133C (MN77508) H5222135C (MN74099) H5222136C (MN72564) H5222139C (MN62528)</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/21/2021

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

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F 000	Continued From page 1 H5222140C (MN57337) H5222141C (MN56701) H5222142C (MN56628) H5222143C (MN78787)	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		12/29/21	

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F 609	<p>Continued From page 2 for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) immediately, but not later than two hours, for 2 of 3 residents (R16, R21) reviewed for abuse.</p> <p>Findings include:</p> <p>R16's quarterly Minimum Data Set (MDS) dated 10/12/21, indicated R16 was cognitively intact, was independent with mobility, and had no upper or lower extremity impairment. R16's diagnoses included alcohol dependence, hypertension, and cardiovascular disease.</p> <p>R16's progress note dated 11/21/21, at 10:52 p.m. indicated R16 and R21 were arguing and trying to hit each other. R16 stated R21 came into his room and R16 hit R21 in self-defense. The residents were separated and staff called 911. Further, the director of nursing (DON) and the administrator were notified.</p> <p>R16's progress note dated 11/22/21, at 8:30 a.m. indicated a report was filed with the SA.</p>	F 609	<p>F609 (D) Reporting of Alleged Violations</p> <p>All residents have the potential to be affected by the facility failing to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and other offices, including State Survey Agency and adult protective services.</p> <p>Immediate Corrective Action:</p> <p>OHFC report was filed on 11/22/21 at 10:39am.</p> <p>Education on facility Abuse Prohibition/Vulnerable adult plan was</p>		

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F 609	<p>Continued From page 3</p> <p>R21's quarterly MDS dated 10/28/21, indicated R21 had a moderate cognitive impairment, was independent with mobility, and had no upper or lower extremity impairment. R21's diagnoses included alcohol dependence, hypertension, stroke, and traumatic brain injury.</p> <p>R21's progress note dated 11/21/21, at 10:27 p.m. indicated R16 and R21 were screaming at each other in R16's room. Staff "rushed" to the room and separated the residents.</p> <p>R21's progress note dated 11/22/21, at 8:15 a.m. indicated a report was filed with the SA.</p> <p>A Nursing Home Incident Report submitted to the SA on 11/22/21, at 10:39 a.m. identified an allegation of potential resident to resident physical abuse and indicated the incident took place on 11/21/21, at 10:52 p.m. The report was submitted 11 hours and 47 minutes after the allegation of abuse.</p> <p>During an interview on 11/30/21, at 11:24 a.m. the director of social services (DSS) stated allegation of abuse occurred on the evening of 11/21/21, and she was notified of the incident on the morning of 11/22/21. She stated she investigated the event and then report it. She stated the DON was notified Sunday night (11/21/21) and confirmed the allegation of abuse was not reported within two hours and should had been reported to the SA right away.</p> <p>During an interview on 11/30/21, at 11:40 a.m. the DON confirmed she received a call regarding the incident between R16 and R21 on the night of 11/21/21. The DON stated the allegation of abuse should had been reported to the SA within two</p>	F 609	<p>provided to Director of Nursing and confirmed by Administrator.</p> <p>Action as it applies to others:</p> <p>Facility policy and procedure, Abuse Prohibition/ Vulnerable adult plan remains current.</p> <p>All staff will be re-educated and quizzed on facility policy and procedure as it relates to Abuse Prohibition and Vulnerable Adult Plan.</p> <p>Date of Completion: December 29, 2021</p> <p>Recurrence will be prevented by:</p> <p>Audits will occur indefinitely to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and other offices, including State Survey Agency and adult protective services. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits.</p> <p>The Correction will be Monitored by:</p>		

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F 609	Continued From page 4 hours. The facility administrator was off-site and unavailable for interview. The facility policy Abuse Prohibition/Vulnerable Adult Plan, dated 7/5/19, indicated suspected abuse shall be reported to the Office of Health Facility Complaints not later than two hours after forming the suspicion of abuse.	F 609	Administrator/ Social Serivces Director		



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December 15, 2021

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

Re: Event ID: MW5G11

Dear Administrator:

The above facility survey was completed on November 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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