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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082 Based on observation, interview and document review, the facility failed to follow policy of removing alcohol from residents' room and analyze underlying causes of resident increased aggression for 1 of 1 resident (R3) reviewed for behavioral health when R3 had continued alcohol intoxication with increased behaviors. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE] indicated no cognitive impairment however behaviors of physical behaviors toward others and rejects cares was identified. R3 activities of daily living indicated R3 was independent with mobility, dressing, transfers, eating and toileting. Medical diagnoses were alcohol dependence, alcohol abuse with intoxication, cocaine dependence, major depressive disorder. R3's Care Area Assessments (CAA) dated 8/20/24, triggered behavioral psychosocial wellbeing which indicated verbal behavioral symptoms directed toward others by threatening others, screaming at others, cursing at others. R3's care plan print dated 3/14/25, indicated R3 had a history of substance abuse of alcohol and cocaine. R3 will go into the community and drink with a friend. R3 had long history of drinking and no interest in treatment. R3 will have episodes of yelling and shouting when returning from leave of absence and intoxicated. Substance was found in residents' bathroom and had a resident-to-resident altercation while under the influence. The goal was for R3 to have a decrease in substance use and decrease in behaviors at the facility. The care plan identified interventions to hold all mood altering or all sedative medications when alcohol, illegal drugs and/or marijuana is suspected, monitor R3 for intoxication or impairment, offer community resources, notify provider of substance use while at facility, educate on substance abuse policy, R3 offered chemical dependency treatment but declined the program, R3 seen by psych services and updated with altercations, offer harm reduction approach regarding alcohol use and R3 had declined, speak with R3 using calm quiet tones to help deescalate yelling and shouting, staff to monitor and check vitals of R3 if under the influence of a substance and update nurse practitioner and/or medical doctor. (continued on next page)

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.

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 2/16/25 at 2:01 a.m., indicated R3 was combative with two other residents. The police were called and spoke with R3. Few minutes after the police had left, R3 started again. Police returned for the second time and took R3 to the hospital. Assessment was done with the residents who were attacked for health and safety. A progress note dated 2/17/25 at 10:41 a.m. indicated R3 was interviewed and reported the weekend was bad. R3 reported she did not remember being combative to other residents and admits to drinking but declined treatment. R3 stated she does not know what to do on the weekends and then starts having negative thoughts, which leads to alcohol use. Therapeutic recreation would be asked to put activities in R3 room for the weekend and R3 was open to this idea. A progress note dated 3/3/25 at 11:10 a.m., indicated R3 was having behaviors toward roommate and relocation worker who were packing up roommate's belongings for moving. Staff spoke with R3 who was animated but agreed to stay in her part of the room. A progress note dated 3/3/25 at 5:21 p.m., R3 had behaviors of throwing items in room and throwing some of roommate's items. R3 was also reported throwing trash, 911 called. Roommate was out of the room. Since R3 declined hospitalization earlier today, IDT discussed and moved R3 to a different floor until roommate discharge. Police talked to R3 about hospitalization , and it was declined. Later in the shift R3 returned to floor two and behavioral crisis was called and were coming to talk with R3. A progress note dated 3/11/25 at 11:41 p.m., indicated R3 was involved in a res to res with a peer. R3 was the perpetrator. A progress note dated 3/12/15 at 4:56 p.m. indicated social service went to see R3 for assessment and R3 was laying in her bed. A bottle of alcohol was visible and social service asked R3 about it and if it could be taken away. R3 declined. Social service asked R3 if she would be interested in a harm reduction approach, where an order would be sought from the provider to have a drink at night, instead of R3 having a large amount of alcohol. R3 declined this approach. TMA, floor nurse and nursing leadership updated on R3 having alcohol in her room. Observation on 3/11/25 at 4:32 p.m. R3 on elevator holding a tray with a plate of salad all over the tray and plate. R3 yelling on the elevator, slurred speech, and repeating statements. R3 left elevator and went to kitchen, yelling at staff stated, you work for me and demanded another salad. R3 then further yelled at other residents in the dining room while waiting for another salad. Observations of R3 room on 3/13/25 with R3 present was observed to have no alcohol bottles in areas R3 allowed for observations. R3 declined to have a suite case under her bed to be opened. During an interview on 3/12/25 at 1:15 0 p.m., licensed practical nurse (LPN)-A stated R3 would become intoxicated at the facility and in the community. LPN-A stated R3 was in an altercation with two other residents and R3 was intoxicated during the altercation but there were no injuries. LPN-A stated alcohol can only be removed if a resident gives permission. During an interview on 3/12/25 at 2:15 p.m., assistant director of nursing (ADON) stated when R3 was intoxicated staff were to assess R3 safety and what substance R3 had used, check R3 room and ask if the substance and/or alcohol could be removed if found. ADON stated we cannot take away alcohol forcibly, R3 has to give permission. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/25 at 4:10 p.m., nursing assistant (NA)-A stated R3 would have alcohol in her room and staff were instructed to ask R3 to remove the alcohol. During an interview on 3/13/25 at 9:23 a.m., director of social service (DSS) stated R3 had a long history of alcohol abuse and continued to use while at the facility. DSS stated R3 would go out into the community and drink and would come back with alcohol in her possession; we discourage R3 having alcohol but it could not be taken away unless R3 agreed. DSS explained staff were to assess R3 when intoxicated and increase checks, encourage R3 to rest, drink fluids and to keep R3 and other residents safe. DSS stated R3 behavior had changed the past month to becoming physically and verbally aggressive with staff and other residents and it was unknown why the behaviors had increased. DSS stated she had seen an alcohol bottle in R3 bed while completing an assessment, DSS asked to remove the bottle and R3 declined, and it was not removed we can't take it away if they won't let us, it's their right and their property. During an interview on 3/13/25 at 9:56 a.m., social service designee (SSD) stated staff cannot search a resident's room unless the resident gave permission, it was their right to refuse a search or removal of alcohol. During an interview on 3/13/25 at 12:15 p.m., R3 stated she did not have any alcohol in her room and felt safe at the facility. R3 became upset during interview when addressing drinking alcohol and stated why would you ask me that I have not hurt anyone when I drink. R3 stated it's my right if I want to drink; R3 then requested to end interview. During an interview on 3/13/25 at 12:24 p.m. nursing assistant (NA)-B stated when R3 was intoxicated staff were to check on her every 15 minutes, take vitals and update R3 physician. NA-B stated when seeing alcohol in R3 room it would be asked to remove it but if R3 declined we cannot remove it unless we have R3 permission. During an interview on 3/13/25 at 12:37 p.m., administrator stated R3 had been a resident at the facility since August 2024 and had been in and out of sobriety. Administrator stated R3 would walk to the liquor store or have her friends get her alcohol, R3 would bring back bottled of alcohol and be in her purse or come back to the facility intoxicated. Staff were to ask R3 to take the alcohol or search her room, R3 would have to be willing to give up the alcohol. Administrator stated the aggression is new behavior for R3 and a root cause had not been assessed. Administrator reviewed facility policy for room searches and verified the facility was not protecting the residents when R3 was aggressive by not removing alcohol that was visible, facility policy was not followed. Facility policy titled Room Searches for Safety Concerns/Violations revised date 10/22, indicated if facility staff identify items or substances that pose risks to residents' health and safety and are in plain view, they may confiscate them. If necessary, immediate measures may be put in place to assure the safety of those in the facility. These include but not limited to searches of the room any time the resident receives visitors or returns to the facility from a leave of absence, need for subsequent room searches if ongoing compliance is an issue, discussion for alternative placement and notice of involuntary discharge may be initiated.