

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 05/14/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Chateau LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</p> <p>Based on interview and document review, the facility failed to report allegations of stolen money immediately (within 24 hours) to the State Agency (SA) for 1 of 3 residents (R2) reviewed for abuse. In addition, the facility did not report the missing money to law enforcement.</p> <p>Findings include:</p> <p>R2's Medicare 5-Day Minimum Data Set (MDS) dated [DATE] indicated R2 was cognitively intact, had no behaviors, and had diagnoses that included multiple fractures and depression.</p> <p>R2's Grievance/Concern Form dated 4/8/25 indicated, Resident stated that 80 dollars was taken from her purse on the night of 4/7. This happened overnight when she was asleep. Resident stated she had her purse next to her, between her arm and window. When resident woke up on 4/8/25, her purse was located on the ground beside her bed. This is when resident became aware that 80 dollars was missing from her purse. The form was signed by social worker (SW)-A, and indicated R2 made a police report.</p> <p>On 5/13/25 at 3:35 p.m., R2 stated staff covered up a theft, and didn't file a police report for her after she filed a grievance for theft of \$80 from her purse. She was advised by SW-A she had to file her own police report and SW-A wouldn't assist.</p> <p>On 5/14/25 at 10:15 a.m., licensed practical nurse (LPN)-A stated missing money was reported to the SA, Only when it was confirmed [the resident] had the money the entire time.</p> <p>On 5/14/25 at 10:32 a.m., trained medication aide (TMA)-A stated the facility should report stolen money to the SA, and if the facility administration didn't report it, TMA-A could and should as a mandated reporter.</p> <p>On 5/14/25 at 10:43 a.m., SW-A stated if a resident reported money was taken, he would ask the resident if they wanted to file a grievance, and ask how much money was taken. He would also ask the resident if they wanted to file a police report, and if they wanted to file a police report, inform the resident they have to file the police report on their own. Typically, stolen money was not reported to the SA because it was not a harm issue. Further, financial abuse was when one individual was exploiting another. He would report stolen money if it was proven the money was in fact in the resident's possession.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/25 at 11:00 a.m., the director of nursing (DON) stated taking a resident's money could be considered financial abuse. R2 reported her money was taken, and the incident should have been reported to the SA.</p> <p>On 5/14/25 at 11:08 a.m., the administrator stated R2 reported the money as missing, and thought her roommate took her money. The incident was not reportable to the SA unless the facility could determine R2 actually had the money.</p> <p>On 5/14/25 at 5:03 p.m., during a subsequent interview, the administrator stated the facility could not file a police report on behalf of a resident, and the facility had to know if the resident had the money to report the incident to the SA. We investigated it at a facility level. We thought a room change and education was enough.</p> <p>The facility Abuse Prohibition/Vulnerable Adult Policy dated 4/25 directed suspicion of misappropriation of resident property must be reported to the OHFC (Office of Health Facility Complaints- [SA]) online reporting process no later than 2 hours if the incident resulted in serious bodily injury, and if suspicion of misappropriation of resident property did not result in serious bodily injury, the report should be made within 24 hours. The policy further directed administration or other designated staff will report to other officials in accordance with State Law.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</p> <p>Based on interview and document review, the facility failed to have a process in place for prior authorization (PA) of medications to ensure resident medications were re-ordered and refilled in a timely manner for 1 of 3 residents (R1) reviewed for medication administration.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, had no behaviors, and diagnoses that included diabetes and heart disease.</p> <p>R1's care plan revised 11/23/22, indicated R1 had a potential for alteration in blood sugar related to a diagnosis of diabetes. The care plan guided nursing staff to administer medication as ordered.</p> <p>R1's Medication Administration Record (MAR) dated 3/2025, indicated a noon medication pass that included Rybelsus (medication used to treat elevated blood sugar) 7 milligrams (mg) oral tablets given at noon daily, ordered 4/16/24. The MAR indicated missed doses continually from 3/13/25 to 3/31/25.</p> <p>R1's MAR dated 4/2025, indicated a noon medication pass that included Rybelsus 7 mg oral tablets given at noon daily, ordered 4/16/24. The MAR indicated missed doses continuously from 4/1/25 through 4/4/25.</p> <p>R1's MAR dated 5/2025 indicated a noon medication pass that included Rybelsus 7 mg oral tablets given at noon daily, ordered 4/16/24. The MAR indicated missed doses continuously from May 5, 2025, through May 9, 2025.</p> <p>On 5/13/25 at 11:57 a.m., the pharmacist (PH)-A stated the facility did not return prior authorizations timely to ensure R1 received all doses of his ordered Rybelsus. She gave an example of the authorization form for Rybelsus which was sent by the pharmacy to the facility on [DATE], and the facility did not returned until 4/1/25. Staff should order medications a week before they run out, and prior authorizations should have been returned timely to ensure medication doses were not missed. Additionally, even if medications were ordered, the pharmacy could not send them until the PA form was signed and returned to the pharmacy.</p> <p>On 5/13/25 at 1:56 p.m., trained medication aide (TMA)-A stated she didn't know how to order medications, and would inform the nurses when medications required refill, and the nurses would order them. TMA-A stated in May she faxed the request for the Rybelsus refill and waited for the medication. It didn't arrive, so she called the pharmacist the second day after she requested it. She was told the medication would be sent, but it didn't come because the PA was not complete. On 5/7/25, she informed the director of nursing (DON) the medication hadn't arrived, but acknowledged she didn't report it sooner, and didn't know why.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/25 at 1:59 p.m., the DON stated she was aware of the missing medication on 5/9/25 and completed an authorization form to authorize the medication indefinitely. The nurse practitioner (NP)-A was notified of the missing doses after R1 missed the first two doses in May. NP-A indicated he wanted to continue Rybelsus, and did not want to substitute another medication. She was not working for the facility during the time of the missing medications in March and April. It was discovered R1 was missing Rybelsus in an audit on 5/5/25 and the facility received the medication on 5/5/25.</p> <p>On 5/13/25 at 2:20 p.m., NP-A stated he was aware R1 missed Rybelsus for over a month, but didn't believe R1 was harmed by missing the Rybelsus doses. He completed prior authorization forms for R1, but the importance of the form, and how quickly it should be returned to the pharmacy had not been communicated with him. R1's cardiologist prescribed Rybelsus because it statistically improved the survivability rate for residents with congestive heart failure and diabetes.</p> <p>On 5/13/25 at 2:35 p.m., registered nurse (RN)-A stated if the facility ran out of medications for a resident, the nurses called the pharmacy and ordered it. If a medication required a PA, the nurse had to notify the provider, and the nurse manager, who would work together to obtain the medication. Sometimes medications ran out for residents, but nurses should order when there was one week of the medication left, instead of after it ran out. She didn't know the process for getting a PA.</p> <p>On 5/13/25 at 2:45 p.m., licensed practical nurse (LPN-A) stated when a medication required a PA, the pharmacist sent a form by email, and either the provider or the administrator was required to sign the form. The PA form was returned to the pharmacy by nursing staff. The process should take 2-3 days, or less.</p> <p>On 5/13/25 at 2:51 p.m., RN-B stated R1 missed Rybelsus doses from 3/13/25 to 4/4/25, but she wasn't aware of it until 5/13/25. She could not follow when the medication was missing in the progress notes, because many of the notes did not indicate the medication was missing. She was not aware R1 missed that many doses of Rybelsus and could not explain how that happened. Usually nurses managers would catch a missing medication and managed the PA, and she didn't know why this one was missed.</p> <p>On 5/14/25 at 1:15 p.m., R1 stated she missed doses of Rybelsus for about a month in March and April 2025, and missed some doses in May 2025, but was unable to remember the dates or how many doses were missed. Rybelsus was used to treat diabetes, and when the facility ran out of the medication, it was because the medication required prior authorization. If Rybelsus was not administered continuously, the medication would not be effective. Every time the medication was not available, the nurses told her it was not their domain to get it, and the medication had to be approved by the administrator. She had suggested to her provider to prescribe a different medication, but the provider wanted her to continue Rybelsus.</p> <p>The Medication Orders policy dated 8/19, directed medications would be administered upon a clear, complete, signed order of a person lawfully authorized to prescribe. The policy lacked information about the PA process.</p>		