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| 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 06/06/2025 |
| 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) |
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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident safety by allowing former resident FR4, who had been discharged, to repeatedly gain unauthorized entry through an unsecured door without staff awareness, resulting in non-consensual contact (a kiss) involving Resident R5 and misappropriation of property from Resident R7; this systemic failure placed all 61 residents at risk and resulted in a finding of Immediate Jeopardy. In addition, the facility failed to protect two residents (R1 and R2) from abuse when R3 had a verbal and physical altercation with R1, which escalated to a physical incident with R2 later that day.</p> <p>The Immediate Jeopardy (IJ) began on 5/24/25 after a FR4 was issued a no trespass order but failed to ensure entrances were secured and protect residents from allegation of abuse. This resulted in FR4 continuously entering the building without staff knowledge. The Administrator, Director of Nursing (DON), regional director of operations, corporate nurse leader, and regional social services were notified of the IJ on 6/5/25 at 3:09 p.m. The IJ was removed on 6/6/25 at 1:00 p.m. but non-compliance remained at a lower scope and severity of a level E indicating no actual harm but potential for more than minimal harm that is no immediate jeopardy.</p> <p>Findings include:</p> <p>The nursing home incident report (NHIR) dated 5/31/25, identified a man FR4 came into R5's room at 4:30 a. m., and R5 woke up to the man kissing her on the forehead. This created difficulty sleeping and mental anguish for R5.</p> <p>FR4's face sheet dated 6/5/25, identified FR4 had diagnoses of major depressive disorder, alcohol dependence in remission, generalized anxiety disorder, and mild cognitive impairment.</p> <p>FR4's comprehensive MDS dated [DATE], identified FR4 had resided at the facility for almost one year. FR4 had no cognitive impairment, no behaviors towards other residents or staff. FR4 was independent with all cares.</p> <p>FR4's progress notes from 5/13/25-5/21/25, identified FR4 had increased behaviors towards staff and residents, and FR4 was frequently intoxicated.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>FR4's progress note dated 5/22/25, identified FR4 was asked to leave another unit as he was not allowed on the unit due to behaviors towards female residents and staff. FR4 attempted to enter a female resident's room who was not in the building currently. FR4 became verbally aggressive and said he was going to have the nurses fired. FR4 continued to be verbally aggressive and abusive to staff until he went to his own unit.</p> <p>FR4's progress note dated 5/22/25 at 4:59 p.m., identified nurse manager, social services director (SSD), and Administrator met with FR4 and FR4's family. Discussed disobeying rules of the facility and potentially putting other residents at risk, which he had been previously educated on. The note indicated FR4 agreed to in-patient treatment, declined a bed hold, but signed a form indicating he was discharging against medical advice (AMA). FR4 was stated he was not coming back. FR4 loaded belongings into a car with his family and left facility at 5:08 p.m.</p> <p>During an interview on 6/4/25 at 9:44 a.m., Administrator and social services designee (SSD) stated FR4 was on the independent floor of the facility and had been working towards relocation with SSD. FR4 had spent most of his time in his room until the past 3-4 months. FR4 had a monumental shift in his behavior and personality. FR4 created friendships with residents that would give him something in return. While he was here FR4 became the alcohol runner; the liquor store is three blocks from the facility, he would hide alcohol in his backpack or dispense on the smoking patio. On 5/22/25, they had a care conference with family involved and FR4 did not want to go to inpatient treatment at the beginning of the meeting by the end of it he was excited and packed his bags. FR4 said he was not going to return to the facility after inpatient treatment and we had him sign an AMA. FR4 left in a taxi with his family. FR4 showed up to the facility the evening of 5/23/25, Administrator had a long talk with him. FR4 said he changed his mind on treatment and wanted to come back to the facility. Administrator explained this was not a good environment for FR4 and that he needed an alternative option. FR4 said he would figure it out. Since then, it has been a constant battle with FR4 sitting across the street, on the smoking patio, in front of the patio and trying to sneak in the building. FR4 brought alcohol to residents on 5/24/25, and SSD provided FR4 with a trespass order. FR4 would not sign the trespass notice and threw it away and kept walking around the building. The staff were notified of the trespass notice and knew to keep him out of the building and signs were posted for awareness. On 5/27/25, it was becoming an increasing issue and FR4 knew if he was on the sidewalk in front of the patio it was not facility property, and he would not be considered trespassing. FR4 would hang out with residents for a couple of hours and disappear and then return. On 5/27/25, the police were called because FR4 kept saying the facility was his home, refusing to leave and bringing alcohol to the residents on the patio. FR4 was given another trespass notice by the police</p> <p>During a phone interview on 6/4/25 at 1:25 p.m., police officer (PO)-A stated the police are only able to respond to FR4 trespassing. If the facility has physical evidence, they can arrest FR4 and charge him with a misdemeanor, and release FR4 the next day. The facility was given advice to change the door codes. The residents that smoke leave the door propped open. PO-A stated when responding to police calls at the facility, it takes a long time for the doorbell to be answered, and voiced understanding of why the residents prop the door open when smoking and would not prevent intruders from walking into the facility unseen.</p> <p>In review of FR4's record in conjunction with facility trespass documentation, and police call records identified FR4 was able to enter the facility multiple times without the awareness of staff and without implementation of interventions to stop FR4 from gaining access into the facility. The records identified the following:</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>The police public record incidence for calls made from the facility regarding FR4 to the police identified reports were made on:</p> <p>-5/23/25 at 11:26 p.m.,</p> <p>-5/24/25 at 6:20 a.m. and at 9:05 p.m.</p> <p>-5/26/25 at 11:08 a.m. and at 11:03 p.m.</p> <p>-5/27/25 at 6:35 a.m. and 9:04 a.m.</p> <p>-5/28/25 at 1:55 p.m., at 3:53 p.m., at 5:22 p.m., and at 6:21 p.m.</p> <p>-5/30/25 at 9:29 p.m.</p> <p>-5/31/25 at 10:50 a.m.</p> <p>-6/2/25 at 9:20 a.m., 12:02 p.m., and 4:34 p.m.</p> <p>-6/5/25 at 7:00 a.m., and 12:19 p.m.</p> <p>The facility reported timeline, undated, for trespassing incidents involving FR4 included:</p> <p>-5/24/25 at 11:33 a.m., SSD was at facility when FR4 attempted to enter. FR4 was informed that he was trespassed from the facility and given a copy of the notice that he threw away. FR4 left facility and staff were informed.</p> <p>-5/27/25 at 4:30 p.m., Administrator called 9-11 for FR4 being on the smoking patio. FR4 did not enter the building. Police arrived and FR4 was no on scene. Officers informed Administrator that unless FR4 is on scene when they get there or on the property there is nothing they can do. Officers did present FR4 with a trespass order in addition to the one the facility provided FR4 and explained the rules to him. Officer gave Administrator and email for crime preventionist to reach out regarding a Geofence trespass order.</p> <p>-5/28/25 at 8:51 a.m., Administrator sent email to crime preventionist.</p> <p>-5/28/25 at 5:20 p.m., Administrator called 9-11 due to FR4 being outside facility. At 5:36 p.m., officer arrived on scene and FR4 was sitting out front on the sidewalk. Officer talked to FR4 and staff and educated FR4 on the trespass orders. FR4 took his chair and moved across the street. At 6:50 p.m., officer arrived on scene again after another call of FR4 being in front of the facility. Officer told FR4 not to move and while in the facility, FR4 sat down on the smoking patio. Officer arrested FR4 for violating the trespass order and threatening staff. At 8:21 p.m., FR4 was booked at the county jail on trespassing charges.</p> <p>-5/29/25 at 4:17 p.m., FR4 was released from county jail.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>-5/30/25 at 9:00 a.m., FR4 was in front of the facility but not on facility property. At 3:00 p.m., Maintenance Director changed the stairwell code to first floor and residents were not given the code.</p> <p>-5/31/25 at 11:00 a.m., R5 reported that FR4 was in her room around 4:30 a.m., and she awoke to FR4 kissing her forehead. At 12:31 p.m., Trespass notice sign posted at all nurses stations, staff on shift were verbally educated on FR4 being trespassed.</p> <p>-6/2/25 at 8:00 a.m., interdisciplinary team (IDT) discussed the reported incident, risk vs benefits were done with all residents who use the patio to smoke or socially on the risks of putting stuff in the front door which prevents it from properly locking. Maintenance investigated the front door and confirmed that the door does lock from the outside and functions properly when residents use it correctly. The administrator collected staff statements and working with human resources on proper corrective action. At 9:18 a.m., FR4 attempted to enter facility via the front staircase and when unable to do that, attempted to run to the elevator. Staff in the front office intervened and escorted FR4 outside and educated on the trespass orders. 9-11 was called. At 1:00 p.m., 9-11 was called for FR4 being on front sidewalk. Officers were unable to arrest as FR4 was not on scene when they arrived. Administrator was given a new email for crime preventionist. At 4:17 p.m., 9-11 was called for FR4 being out front and previously entering facility in the morning with video proof. At 4:47 p.m., officer arrived on scene and FR4 was outside of the facility and arrested at 5:12 p.m. at 6:51 p.m., FR4 was booked at county jail.</p> <p>-6/3/25 at 4:30 p.m., Administrator implemented hourly checks on the front door to ensure residents were not leaving it propped open. Facility staff were educated on completing hourly checks on the door. At 5:35 p.m., FR4 was released from county jail.</p> <p>-6/4/25, FR4 hung around facility most of the day but did not cross the property line. At 4:25 p.m., Administrator sent a follow-up email to crime preventionist. At 5:30 p.m., front door was locked on the outside. Maintenance disabled the push bar on the front door from the inside, 1:1 was placed on the door next to the handicap button to let residents in and out. 1:1 kept log on residents that entered and exited the door, and the duration of time residents were outside on the patio smoking. At 6:00 p.m., maintenance director reached out to fire company on changing door and floor codes. At 11:00 p.m. front doorbell education was started with all staff along with additional trespass education. Administrator emailed all staff a copy of the education and continues to individually educate staff that are working.</p> <p>-6/5/25 at 4:30 a.m., FR4 stepped one foot on smoking patio and facility staff stood up and FR4 ran across the street. 9-11 was notified. At 8:00 a.m., FR4 was out front, 9-11 was called. At 8:30 a.m., officers arrived on scene. FR4 was at the park down the street watching. Officers were not able to pursue at the time. 9:15 a.m., officers looking for FR4. 10:00 a.m., maintenance director reset the front and back door codes. At 12:00 p.m., FR4 is outside the facility, 9-11 was called.</p> <p>-FR4 has not entered the facility since 6/2/25.</p> <p>R5's face sheet dated 6/5/25, identified diagnoses of hemiplegia and hemiparesis affecting left dominant side (paralysis on one side of the body/weakness on one side of the body), cerebral palsy (affects movement and posture caused by brain damage before birth), alcohol and nicotine dependence.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>According to the facility reported timeline on 6/2/25 at 8:00 a.m., interdisciplinary team (IDT) discussed the reported incident, risk vs benefits were done with all residents who use the patio to smoke or socially on the risks of putting stuff in the front door which prevents it from properly locking. Maintenance investigated the front door and confirmed that the door does lock from the outside and functions properly when residents use it correctly. The administrator collected staff statements and working with human resources on proper corrective action. At 9:18 a.m., FR4 attempted to enter facility via the front staircase and when unable to do that, attempted to run to the elevator. Staff in the front office intervened and escorted FR4 outside and educated on the trespass orders. 9-11 was called. At 1:00 p.m., 9-11 was called for FR4 being on front sidewalk. Officers were unable to arrest as FR4 was not on scene when they arrived. Administrator was given a new email for crime preventionist. At 4:17 p.m., 9-11 was called for FR4 being out front and previously entering facility in the morning with video proof. At 4:47 p.m., officer arrived on scene and FR4 was outside of the facility and arrested at 5:12 p.m. at 6:51 p.m., FR4 was booked at county jail.</p> <p>An email from the Administrator to crime preventionists dated 6/2/25, identified a subject of a Geofence. The body of the email included FR4 will not leave the premise. FR4 had been trespassed for a week and a half by the facility and was given a formal trespass by the police department. FR4 refuses to leave, camera footage shows him attempting to enter the facility multiple times, sneaking up the stairwells, taking the elevator, going into resident rooms. When the police are notified, as soon as FR4 sees or hears them, he will walk down the street. Multiple residents are scared of him. On 5/31/25, he was accused of entering a female resident's room and kissing her on the forehead and it was not consensual. He has threatened residents and staff, providing alcohol and potentially drugs, sleeping across the street in the backyard of an apartment complex. Administrator was running out of ways to protect the residents and was looking for solutions. Multiple residents want to file a restraining order against him due to his threats and inappropriate behavior.</p> <p>According to the facility reported timeline on 6/3/25 at 4:30 p.m., Administrator implemented hourly checks on the front door to ensure residents were not leaving it propped open. Facility staff were educated on completing hourly checks on the door. At 5:35 p.m., FR4 was released from county jail.</p> <p>During an interview on 6/4/25 at 1:36 p.m., R6 was in his room. R6 explained FR4 has been in the building since he was discharged . FR4 would get into the building through the front door and usually went to the fourth floor because he believed FR4 had a girlfriend on fourth floor. R6 stated FR4 was in the facility last night (6/3/25) on the second floor halls, probably around 8:00-9:00 p.m. R6 did not notify staff that he saw FR4.</p> <p>R6's face sheet dated 6/5/25, identified diagnoses of alcohol dependency and mild cognitive impairment.</p> <p>R6's Risk vs Benefits dated 6/3/25, identified area of concern was propping the front door open so it does not fully close after hours, using signs, paper, bricks, rocks etc. Risks related to the non-compliance included anyone from the community can come into the building during the evening or overnight making it less safe for residents. Staff are no [not] watching the front door 24/7 so they are not able to monitor who comes into the facility. The front door camera is on the third floor and when the residents use the button it will ring on the third floor and the staff can see who is at the door and let them in. R6's corresponding progress note identified R6 refused to sign the document.</p> <p>R7's face sheet dated 6/5/25, identified diagnoses of alcohol abuse and dependance.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>R7's record identified the same Risk vs Benefits for as R6. The form was dated 6/3/25 and was not signed by R7.</p> <p>During an interview on 6/4/25 at 12:48 p.m., R7 stated when he first met FR4 he was a nice guy, and it seemed he started going down a steep hill very quickly and lost his mind. FR4 would yell at people on the smoking patio. FR4 was in his room on 5/29/25 and took a can of chewing tobacco. Another time, R7 could not recall what day, but knew it was after R4 had been discharged from the facility. R7 had woken up around 2:30-3:00 a.m., and found FR4 had reorganized his desk and was cleaning his room. R7 reported this instance to the SSD.</p> <p>During an observation from the second-floor window on 6/4/25 at 11:01 a.m., FR4 was across the street at an apartment complex on the back patio, however then moved off the patio and started pacing around the apart complex grounds. An unidentified facility staff member was outside on the facility patio.</p> <p>During an observation and interview on 6/4/25 at 11:03 a.m., FR4 had walked across the street and behind the facility fence. FR4 had two clear plastic cups with a gas station logo on them. One cup was half full of clear bubbly fluid like soda and the other cup was half full of a thicker viscosity clear fluid. While there was no staff present, FR4 placed the non-bubbled clear liquid on the fence that was opposite of the smoking patio, towards the street and asked a resident in a wheelchair for a cigarette. The resident balanced the cigarette on the fence so FR4 could reach it without going onto the facility property. Another wheelchair resident handed a thick plastic travel mug to FR4 and said, thanks for the coffee and laughed. There was a light brown liquid in the mug that was not consistent with coffee. FR4 stated he was not a resident at the facility, he had been arrested twice for trespassing. When he tried to sneak in, he was unable to get past the front door because facility scheduler (FS)-A and nursing assistant (NA)-A were always watching him from windows. It was not worth going to jail. A facility staff member came outside and went to the clear plastic cup that was sitting on the outer fence, picked it up, sniffed it, and dumped it in the grass. FR4 began to get upset but then took a drink from the travel mug. FR4 stuttered while he talked and was telling stories that ranged in subjects from the past to current. FR4 migrated back towards the facility entrance and continued to talk with the residents who were outside. FR4 got another cigarette from a resident but did not light it. FR4 denied being inside the facility except for his attempts where he was caught by FS-A.</p> <p>During an interview on 6/4/25 at 1:54 p.m., NA-C stated the staff keep an eye on the exit doors on each end of the units and the elevator doors for R4. NA-C could recall two times when she worked that FR4 was on her unit after he was discharged . When FR4 would be spotted in the facility, he would go to multiple floors and when approached would tell staff that he was looking for someone or wanted to do favors for someone. Staff would remind FR4 he was not allowed in the facility, and he would respond I know. FR4 would try to go in rooms and staff chased FR4 around the unit until they could get him onto the elevator. NA-C stated staff would not escort FR4 out of the building after he was on the elevator because all the nurses knew what they were supposed to do. Last week, NA-C could not recall the date, but thought it was the day FR4 received the trespass notice, she saw FR4 by the entrance while she was leaving work. This morning (6/4/25), NA-C came to work between 6:30-7:00 a.m., and the front door was propped open with a wet floor sign.</p> <p>An email from the Administrator to crime preventionists dated 6/4/25, identified FR4 was arrested on 6/2/25 and released on 6/3/25 and had been back at the facility at 5:00 a.m.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>During an interview on 6/4/25 at 9:44 a.m., Administrator and social services designee (SSD) stated the residents were very active at night, almost more during the night than during the day. The front door is locked by 5:00 p.m. every day and the residents were supposed to push the button on the door, and it would send a video feed and ring for the staff on third floor to open the door. Administrator identified that after hours the residents would put all sorts of things including a walker, brick, wet floor sign, and shirt in the door to keep it propped open. A risk vs benefits was done with all residents that go outside and education provided that the facility was unable to monitor who was coming and going in the facility if this practice is done. There was a large homeless population and people walking around this area, the residents could not be kept safe if the door continued to be propped open. The Administrator and SW believe this is how FR4 entered the building on 5/31/25. FR4 knew the facility very well and knew where to hide and sneak around. FR4 has a bond with the residents on the smoking patio, he knew R5 from when he was a resident and would give her a ride to her room. The facility began a log for one-hour checks on the door to make sure no one is propping it open on 6/3/25.</p> <p>During an observation on 6/4/25 at 3:18 p.m., FR4 was in front of the building, not on the property, on the sidewalk in front of the fence. FR4 had his travel mug in one hand and a package in the other, a brown paper bag is on the ground next to him. A resident on the smoking patio gave FR4 a cigarette. FS-A came outside and FR4 began walking away from the facility.</p> <p>During an observation and interview on 6/5/25 at 8:10 a.m., PO-B and PO-C came to the facility. PO-B stated the station had received two calls on FR4 being in the building at 3:00 a.m.</p> <p>During an interview on 6/5/25 at 12:25 p.m., Administrator stated that FR4 did not enter the building at 3:00 a.m. or 8:00 a.m. FR4 had stepped onto the property in the smoking area at 3:00 a.m., when the staff member providing 1:1 at the door stood up, FR4 ran away. At 8:00 a.m., FR4 put one foot over onto the property and Administrator called the police.</p> <p>During a phone interview on 6/5/25 at 9:21 a.m., medical director (MD)-A stated the facility has a specific population that have a comradery between each other with lifestyle choices and struggles that they face. It is harder for them to cope with new trauma or assault. MD-A stated this is a sad situation, much like children, you want to give them some freedom and not make them feel like they are locked up, they are adults and able to move freely in and out and make bad decisions. In the end, the best that can be done is try to protect them.</p> <p>The facility abuse prohibition policy revised 3/2024, identified the purpose was to protect residents against abuse by anyone, including, but not limited to, facility staff, and other residents. Abuse will be reported to the SA no later than two hours and immediately to supervisors</p> <p>The IJ began that began on 5/24/25 was removed on 6/6/25 at 1:00 p.m., when the facility implemented the following actions:</p> <ul style="list-style-type: none"> -1:1 staff at the front door to ensure visitors are signing in/out and to monitor the smoking patio for unwanted visitors including FR4. -Education completed including front door monitoring expectations including the smoking patio, how to respond to unwanted visitors, abuse policy, visitation policy, filling out the 15 minute check form to verify staff are present at the front door/patio area 24 hours each day. <p>(continued on next page)</p> | | |

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| 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 06/06/2025 |
| 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. | | | |
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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>-Trespass binder at each nurses station and the front door. Trespassed people will have the trespass notice and picture (if available) in the binder including name, description, reason for trespass. Staff will be alerted by email of any new trespassed individuals including name, description, reason for trespass, and photo if available.</p> <p>Resident to Resident:</p> <p>R1's face sheet dated 5/31/25, identified diagnoses of multiple fractures of pelvis, alcohol abuse, and open wound on left lower leg.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified no cognitive issues. R1 had verbal behavior issues directed at others, was independent with all self-cares, and used a wheelchair for mobility.</p> <p>R1's care plan identified that she would remain free from abuse or neglect. Interventions included monitoring for signs of emotional distress or mood and behavior changes, safety monitoring will be implemented as needed to ensure residents safety, staff will continue to follow the facility vulnerable adult and abuse reporting policy.</p> <p>R1's progress note dated 5/26/25 at 11:37 p.m., identified at 6:00 p.m., registered nurse (RN)-D was alerted to a verbal altercation in R3's room. Upon entering, R1 and R3 were observed arguing and screaming. R1 appeared visibly upset, crying and said R3 took her phone and hit her. No visible injuries on assessment, no active bleeding or bruising at time of assessment. Residents were separated.</p> <p>R1's progress note dated 5/29/25, identified a Risk vs Benefits was completed with R1 regarding boundaries with other residents.</p> <p>R1's Risk vs Benefits dated 5/29/25, identified Respecting others personal space and boundaries. Respecting personal boundaries offers numerous benefits for individuals and relationships, including fostering trust, enhancing well-being, and reducing stress. However, it also presents potential risks, such as the possibility of misunderstandings or damaging relationships. Disrespecting boundaries can damage relationships but creating a sense of distrust and disrespect, potentially leading to conflict or avoidance. Resident is to leave other residents spaces (rooms) when asked or resident risks losing the privilege/ability to spend time on other floors/units in the facility.</p> <p>During an interview on 6/3/25 at 1:07 p.m., licensed practical nurse (LPN)-D stated that to her knowledge, R1 was not intoxicated on 5/26/25. R1 and R3 were dating and she spent most of her time with him and would only come to her floor for medication.</p> <p>During an interview on 6/3/25 at 12:23 p.m., R1 had a cell phone in her hand. R1 stated it happened so fast and she does not want anything done about it. R3 was having a bad day and he hit her and she is just over it. R3 was letting R1 use his old cell phone and he accused R1 of stealing his found and R1 found out he sold it and that was what the whole argument was about. When the staff separated R1 and R3, R1 left the room and went out to the smoking patio. The staff did not tell me not to hang out with R3. R2 and R3 also were outside and R1 thought R3 was going to hit her and R2 stepped in between them. R1 thought R3 was going to hit R2 so she wheeled away and called 9-11. R3 was physical with R2 outside and staff were present. R1 thought NA-A was outside and was not sure who the other NA would have been.</p> <p>(continued on next page)</p> | | |

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| 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 06/06/2025 |
| NAME OF PROVIDER OR SUPPLIER The Estates at Chateau LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 2106 Second Avenue South Minneapolis, MN 55404 | |
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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>R2's face sheet dated 5/30/25, identified diagnoses of major depressive disorder, altered mental status, and alcohol dependence.</p> <p>R2's quarterly MDS dated [DATE], identified R2 had no cognitive issues, no behaviors, and was independent with all self-cares, walked with no assistive devices.</p> <p>R2's care plan dated 7/22/24, identified R2 was a fall risk related to history of fractures, history of falls, alcohol dependence.</p> <p>R2's progress note dated 5/26/25 at 11:29 p.m., identified at approximately 7:00 p.m., RN-D was informed there was a physical altercation between residents which occurred in the elevator. On assessment no injuries were found. Neurological check was clear. R2 was clear, calm, and under no emotional distress. Residents were separated.</p> <p>R2's physician visit note dated 5/27/25, did not identify the physical altercation with R3 on 5/26/25.</p> <p>R2's progress note dated 5/29/25, identified a Risk vs Benefits was completed with R2 regarding being involved voluntarily in a resident-to-resident altercation.</p> <p>R2's Risk vs Benefits dated 5/29/25, identified getting involved in other residents altercations. Risks related to getting involved in other altercations could include physical and or emotional injury affecting overall wellbeing, possible arrest if law enforcement is to be involved, and even death. Furthermore, injury to your person could result in hospitalization. When another resident to resident altercation is taking place, R2 should contact and inform staff members to handle the situation.</p> <p>During an interview on 5/30/25 at 12:07 p.m., R2 stated he was not sure what was going on between R1 and R3 but he was trying to break it up. They were swinging at each other and yelling. The facility is usually pretty mellow and R2 had never witnessed anything like this during his stay. R2 and R3 rode the elevator together after R2 intervened between R1 and R3 outside. While in the elevator R3 became verbally aggressive towards R2 and was surprised when R3 punched him twice in the face. R2 then tipped R3 over in his wheelchair to stop the altercation. and got two surprise punches to the face before R2 tipped R3 over in his wheelchair to stop the altercation. R2 had a discolored area under his right eye and stated his right jawline hurt to the touch. R2 was unsure if the area under his right eye was from when R3 punched him.</p> <p>R3's face sheet dated 6/2/25, identified absence of left lower limb below knee, depression, anxiety, post traumatic stress disorder (PTSD), opioid dependence, and fall from non-moving wheelchair.</p> <p>R3's quarterly MDS dated [DATE], identified R3 had no cognitive deficits, no behavior issues, independent with all self-c[TRUNCATED]</p> | | |