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	05/14/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review the facility failed to ensure contracted hospice agency staff reported allegations of sexual abuse immediately to the administrator for 1 of 1 residents (R1) reviewed for allegations of abuse. Findings include:R1's face sheet dated 5/14/26, identified diagnoses of anxiety disorder, and schizoaffective disorder (schizophrenia and mood disorders).R1's care plan dated 2/12/26, identified R1 was a vulnerable adult and was at risk for decreased cognitive and physical abilities. Interventions included monitor for signs of emotional distress or mood and behavior changes, staff will follow the facility vulnerable adult and abuse reporting policy, local Ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.R1's care plan dated 5/9/26, identified R1 had hospice care related to end stage disease process. Interventions included maintain communication with hospice and keep them informed of R1's condition as needed, keep hospice informed of any changes in R1's condition, offer medication as needed, utilize hospice standing orders per policy, follow direction from hospice as needed, involve hospice care workers in care conference, hospice care workers as setup by hospice staff, increase 1:1 visits as needed, monitor for signs of increased depression or comments of suicidal ideation, see hospice plan of care and visit schedule, refer to psych services and/or clergy as needed.R1's physician visit progress note dated 5/12/26, identified R1 had recently readmitted to facility after a hospitalization with diagnoses of acute encephalopathy (brain dysfunction) and readmitted to facility with hospice order.During an interview with hospice nurse (date and time omitted intentionally) stated she was R1's hospice nurse, was not full time, and R1 did not have the ability to communicate. Nurse indicated on 5/12/26, the hospice aide found sex grease premium personal lubricant in R1's room and sent her a picture. After the report from the aide hospice nurse had not made a visit to do a sexual assault exam nor had she notified any facility staff or the administrator of the concern relating to the presence of personal lubricant in R1's room.During an interview on 5/14/26 at 10:34 a.m., nursing assistant (NA)-A stated he worked on 5/12/26, hospice staff were at facility and did not say anything about concerns of sexual abuse to him.During a phone interview on 5/14/26 at 12:32 p.m., registered nurse (RN)-B stated on 5/12/26, a hospice aide was at the facility performing cares for R1. Hospice aide did not report any concerns of sexual abuse she had when they talked.During an interview on 5/14/26 at 12:18 a.m., social worker (SW)-A stated she was the hospice liaison. The nurses and aides will communicate with the floor staff. SW-A typically had communication with hospice SW. SW-A expected someone from hospice would have communicated the concern of suspected abuse to her.During an interview on 5/14/26 at 12:12 p.m., director of nursing (DON) and regional nurse consultant (RNC)-A stated the hospice company trains their own staff as part of the contract they have with them. SW-A is the facility contact with hospice. DON stated the concern for sexual abuse should have been reported to her immediately by hospice staff so they could begin an investigation.During a phone interview on 5/14/26 at 11:23 a.m., hospice supervisor (HS)-A and B stated if their staff thought a resident was being sexually abused they should report immediately to the facility and then to them. The hospice protocol would be to get in touch with the facility, be aware, collaborate, and investigate. Hospice will triage with facility floor (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff before and after providing cares to residents on hospice. HS-A and B stated they were unaware of any situation involving sexual abuse at the facility and their staff did not report the situation to them.During an interview on 5/14/26 at 12:22 p.m., Administrator stated hospice staff are mandated reporters and hospice had the responsibility to report to the administrator and/or facility staff immediately for any concerns of abuse or neglect. The facility expectation was that the hospice agency trains their staff to competently care for the facility residents. Hospice staff are expected to check in and out with the floor nurse and discuss any changes so continuum of care is followed.The facility Inpatient Hospice Services Agreement dated 10/27/17, identified facility shall ensure all Inpatient Services are provided competently and efficiently. Inpatient Services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements. Hospice and facility shall communicate with one another regularly and as needed for each particular hospice patient. Upon execution of this agreement facility shall provide hospice with facility's established policies and protocols and shall promptly provide hospice with any amendments or modifications thereto. Facility shall fully cooperate with hospice in its effort to respond to and resolve any inquiry, audit, investigation, review or request. Either party shall immediately notify the other party of any of the following alleged incidents involving a hospice patient: mistreatment or neglect, verbal, mental, sexual, or physical abuse.The facility Sexual Abuse Allegations Procedure dated 6/2019, identified: 1. The Charge Nurse of the unit where the alleged victim resides will verify that anallegation of criminal sexual conduct has been made. The Charge Nurse will thenconduct an assessment of the alleged victim, initiate an Incident Report andimmediately call the Administrator and/or Director of Nursing to determine if 911should be called. The Charge Nurse will ensure that no potential evidence (bedlinens, resident undergarments) is touched, so as to protect against itscontamination.2. The Charge Nurse will take immediate steps appropriate to the situation to ensure theprotection and safety of the resident. If the alleged perpetrator is a staff member,the staff member will be immediately suspended, pending further investigation, andanother staff member will be assigned to complete care of the resident until aninvestigation is complete.3. The Charge Nurse will immediately notify the facility Administrator. In case ofabsence of the Administrator, follow the chain of command for notification. TheDirector of Nursing, Nurse Manager, Social Worker, and other department directorsshould be notified as needed. If the alleged perpetrator is one's supervisor ordepartment head, notify their supervisor.4. The Administrator, Director of Nursing, or Social Worker will notify MinnesotaDepartment of Health immediately. This notification MUST be made as soon aspossible after learning of the allegation.5. The Nurse or Nurse Manager will notify the physician and family regarding the facts ofthe situation. Inform them that an investigation is in progress.6. The Charge Nurse/Nurse Manager or the Social Worker will arrange for a physician toexamine the alleged victim as soon as possible, but no longer than 24 hours from thetime of initial knowledge the incident occurred has been received.7. The facility will fully cooperate with the investigation of external entities (local Police,Office of Health Facility Complaints, Survey and Certification Agency, etc.)NOTE: If abuse/neglect is substantiated following investigation by designated StateAgency, the facility is responsible for reporting the results to the licensing board orappropriate State Nursing Assistant Registry.The facility Abuse Prohibition/Vulnerable Adult Policy dated 11/2025, identified a supervisor would be notified immediately of suspected abuse and neglect and an internal investigation started. Suspected abuse shall be reported to the State Agency not later than 2 hours after forming the suspicion of abuse.