Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 16, 2026

Administrator
The Estates at Chateau LLC
2106 SECOND AVENUE SOUTH
MINNEAPOLIS, MN 55404

RE: CCN: 245222
Cycle Start Date: May 14, 2026

Dear Administrator:

On June 5, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 19, 2026

Administrator
The Estates at Chateau LLC
2106 SECOND AVENUE SOUTH
MINNEAPOLIS, MN 55404

RE: CCN:245222
Cycle Start Date: May 14, 2026

Dear Administrator:

On May 14, 2026, a survey was completed at your facility by the Minnesota Department of Health 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.

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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 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 August 14, 2026 (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 November 14, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

Administrator
The Estates at Chateau LLC
2106 SECOND AVENUE SOUTH
MINNEAPOLIS, MN 55404

Re: Event ID: 23219B-H1

Dear Administrator:

The above facility survey was completed on May 14, 2026 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	**2106 SECOND AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0000	INITIAL COMMENTS On 5/14/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52222366C (3012016) with deficiencies issued at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/26/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 for	F0609	F609 – Reporting of Alleged Violations Immediate Corrective Action: R1 passed away on 5.17.26 Corrective Action as it applies to others: The Vulnerable Adult Policy was reviewed and remains current. Full house audit regarding allegations of abuse for the past 30 days. Facility Nursing staff (RNs, LPNs, CNAs, IDT) educated on recognizing abuse and	05/26/2026

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 reverse for further 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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F0609 SS = D	Continued from page 1 jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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: 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	F0609	Continued from page 1 reporting immediately to DON/Admin/Designee. Moments Hospice Nursing staff educated on recognizing abuse and reporting immediately to facility and employer. Date of Compliance: 5/26/26 Recurrence will be prevented by: Hospice consultant and Admin will discuss and review any abuse allegations weekly x4 weeks to ensure any allegations were reported to facility staff and to OHFC if applicable. Quiz 4 chateau facility staff members and 4 hospice nurses weekly x4 weeks regarding abuse policy and timely reporting. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit.	05/26/2026

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F0609 SS = D	Continued from page 2 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 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	F0609		05/26/2026

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F0609 SS = D	Continued from page 3 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 an allegation of criminal sexual conduct has been made. The Charge Nurse will then conduct an assessment of the alleged victim, initiate an Incident Report and immediately call the Administrator and/or Director of Nursing to determine if 911 should be called. The Charge Nurse will ensure that no potential evidence (bed linens, resident undergarments) is touched, so as to protect against its contamination. 2. The Charge Nurse will take immediate steps appropriate to the situation to ensure the	F0609		05/26/2026

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F0609 SS = D	Continued from page 4 protection and safety of the resident. If the alleged perpetrator is a staff member, the staff member will be immediately suspended, pending further investigation, and another staff member will be assigned to complete care of the resident until an investigation is complete. 3. The Charge Nurse will immediately notify the facility Administrator. In case of absence of the Administrator, follow the chain of command for notification. The Director of Nursing, Nurse Manager, Social Worker, and other department directors should be notified as needed. If the alleged perpetrator is one's supervisor or department head, notify their supervisor. 4. The Administrator, Director of Nursing, or Social Worker will notify Minnesota Department of Health immediately. This notification MUST be made as soon as possible after learning of the allegation. 5. The Nurse or Nurse Manager will notify the physician and family regarding the facts of the situation. Inform them that an investigation is in progress. 6. The Charge Nurse/Nurse Manager or the Social Worker will arrange for a physician to examine the alleged victim as soon as possible, but no longer than 24 hours from the time 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	F0609		05/26/2026

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F0609 SS = D	Continued from page 5 investigation by designated State Agency, the facility is responsible for reporting the results to the licensing board or appropriate 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.	F0609		05/26/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/14/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H52222366C (3012016). No orders were issued. Minnesota Department of Health is documenting the	20000		05/26/2026

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

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20000	Continued from page 1 State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		05/26/2026