*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
June 6, 2025

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

RE: CCN: 245222
Cycle Start Date: June 6, 2025

Dear Administrator:

On June 4, 2025, 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 22, 2025

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

RE: CCN: 245222
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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, 2025 (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, 2025 (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

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Electronically delivered

May 22, 2025

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

Re: Event ID: KMFP11

Dear Administrator:

The above facility survey was completed on May 14, 2025 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 CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245222 | A. BUILDING ______ B. WING ______ | C 05/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE ESTATES AT CHATEAU LLC | 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 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 |
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| F 000 | INITIAL COMMENTS<br><br>On 5/13/25 through 5/14/25, 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.<br><br>The following complaint was reviewed: H52223889C (MN00112720) with deficiencies issued at F609 and F658.<br><br>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.<br><br>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. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§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 | F 609 | | 5/30/25 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/30/2025

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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| F 609 | Continued From page 1<br>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 jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>R2's Medicare 5-Day Minimum Data Set (MDS) dated 3/6/25 indicated R2 was cognitively intact, had no behaviors, and had diagnoses that included multiple fractures and depression.<br><br>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 | F 609 | F609 Reporting of Alleged Violations<br><br>Immediate Corrective Action:<br><br>Administrator and Social Services educated on abuse policy and stolen items being reported to the state agency.<br><br>Corrective Action as it applies to others:<br><br>The Vulnerable Adult Policy was reviewed and remains current.<br><br>Full house audit regarding stolen/missing items for the past 30 days.<br><br>IDT educated that a police report is to be | |

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| F 609 | Continued From page 2 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.<br><br>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.<br><br>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."<br><br>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.<br><br>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.<br><br>On 5/14/25 at 11:00 a.m., the director of nursing (DON) stated taking a resident's money could be | F 609 | filed within 24 hours when a resident states something is stolen.<br><br>Date of Compliance:<br><br>5/30/25<br><br>Recurrence will be prevented by:<br><br>All missing items/stolen items to be reviewed weekly x4 weeks by the Regional Director of Operations/Designee<br><br>Quiz 4 staff members weekly x4 weeks regarding abuse policy and timely reporting.<br><br>All staff will be educated on timely reporting per MDH guidelines and facility policies at the next all-staff meeting.<br><br>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 | |

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| F 609 | Continued From page 3<br>considered financial abuse. R2 reported her money was taken, and the incident should have been reported to the SA.<br><br>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.<br><br>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."<br><br>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. | F 609 | | |
| F 658 SS=D | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- | F 658 | | 5/30/25 |

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| F 658 | Continued From page 4<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>R1's quarterly Minimum Data Set (MDS) dated 2/11/25, indicated R1 was cognitively intact, had no behaviors, and diagnoses that included diabetes and heart disease.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 658 | F658 Services to meet professional standards<br>What did we do to the resident affected :<br>The Prior Authorization for the medication was completed, and the medication was provided.<br><br>What did we do other residents affected :<br>Reviewed the Pharmacy Portal to find other prior auths in process and ensured those are completed<br><br>Process change : Typed up a new prior authorization process: Pharmacy sends Clinical Leaders notifications regarding Prior Authorizations needed.<br>DON/designee will check the pharmacy Portal on business days to identify Prior Authorizations needed as well .Clinical Leader will forward the prior authorization information to Integra. Integra is the company that works with Monarch to ensure proper medication billing and to assist with Prior Authorization. The Clinical leader will also notify provider that medication is not available due to awaiting prior authorization. The clinical Leader will reach out to Integra daily until the Prior Authorization and continue to update the provider until the medication is available .<br><br>Education : Clinical Leaders will be educated to the prior auth process<br><br>Audits: Will Audit 3 x a week for 4 weeks | |

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| F 658 | Continued From page 5<br>MAR indicated missed doses continuously from May 5, 2025, through May 9, 2025.<br><br>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 3/13/25, 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.<br><br>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.<br><br>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 | F 658 | to ensure prior authorizations are obtained and the medication is available. This will be done by reviewing PA auth report on Pharmacy portal. Then checking to ensure medications were delivered. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.<br><br>Corrections will be monitored by: DON/designee<br><br>Date of Compliance: 5/30/25 | |

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| F 658 | Continued From page 6 | F 658 | | |

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.

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.

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.

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.

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| F 658 | Continued From page 7 | F 658 | | |

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.

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.

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.

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00937 | A. BUILDING: ______ B. WING ______ | C 05/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE ESTATES AT CHATEAU LLC** | **2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 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) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 5/13/25 through 5/14/25, 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.<br><br>The following complaint was reviewed during the | 2 000 | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00937 | A. BUILDING: ______<br>B. WING ______ | C<br>**05/14/2025** |

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|---|---|---|---|---|
| 2 000 | Continued From page 1<br>survey:<br>H52223889C (MN00112720). No licensing orders were issued.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br>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. | 2 000 | | |