Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 7, 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 25, 2025 we notified you a remedy was imposed. On July 11, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 23, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 10, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 25, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 6, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 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 25, 2025, we informed you of imposed enforcement remedies.

On June 18, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 10, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 10, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 10, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of June 25, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 6, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an"E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 6, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding

this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

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

July 3, 2025

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

Re: Event ID: HSWB11

Dear Administrator:

The above facility survey was completed on June 18, 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 06/18/2025

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) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/17/25 through 6/18/25, 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. The following complaint was reviewed H52227168C (MN00113854) with a deficiency cited at F600. As a result of the investigation, a deficiency was cited 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.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		6/20/25

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

Electronically Signed | 07/03/2025

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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to protect 1 of 3 residents (R1) from staff to resident verbal abuse. Findings include: R1's brief interview for mental status (BIMS) dated 6/5/25 indicated a score of 15/15, indicated no cognitive impairment. R1's care plan dated 5/30/25 indicated medical diagnoses of weakness, schizophrenia, anxiety disorder, depression, chronic pain syndrome. Facility camera footage reviewed on 6/18/25 at 9:44 a.m., revealed on 6/8/25 at approximately 5:04 p.m. R1 was at the kitchen door; R1 foot was holding door open, dietary aide (DA)-B was at door also holding the door open with her body and arm. Exchange of words between R1 and DA-B were visualized however there was no sound capabilities. R1 had sandwich in hand and there was no physical interaction between staff and R1. Facility camera footage failed to cover incident of R1 and DA-A verbal or physical interaction as footage was delayed. When interviewed on 6/17/25 at 1:11 p.m., R1 stated there was an altercation between DA-A due to requesting two sandwiches. R1 stated he and DA-A were yelling at each other and being "disrespectful" to each other. R1 stated they both	F 600	F600 – Free from Abuse and Neglect and F609 Reporting of Alleged Violations Immediate Corrective Action: R1 was discharged from the facility 6/9/2025. Dietary staff members were suspended pending investigation; an internal investigation was completed. Facility investigation was inconclusive regarding the allegation. Social Services completed interviews with residents; no other concerns noted. OHFC involving R1 was filed on 6.18.25. Corrective Action as it applies to others: The Abuse/Vulnerable Adult Policy was reviewed and remains current.¿ Full house audit regarding allegations of verbal abuse for the past 30 days. Staff educated on Abuse Policy which	

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F 600	Continued From page 2 called each other "bitches" in the altercation and he could not recall who said bitch first. R1 recalled DA-B coming to the door during the altercation and "defused" the situation and then he left. R1 added, he was surprised how escalated it got over a request for two sandwiches. When interviewed on 6/17/25 at 5:01 p.m., DA-A confirmed there was an altercation with R1 at the kitchen door when he requested two chicken sandwiches and was told there was only one chicken sandwich. DA-A recalled calling each other "bitches" could have happened, "we exchange some words and may have cussed at each other". DA-A stated DA-B came to the door and asked R1 to remove his foot from the door and to leave and R1 did as asked. DA-A stated the kitchen door was not supposed to be open for the residents, but we try to be "courteous and make sure they are fed", adding R1 was not happy with only have received one chicken sandwich. When interviewed on 6/18/25 at 9:49 a.m., administrator stated leadership was not aware of the allegation until survey but would initiate an investigation immediately. When interviewed on 6/18/25 at 10:49 a.m., DA-B stated she was working in the kitchen when the altercation between R1 and DA-A broke out. DA-B stated she was wearing earbuds but could still hear the conversation. She heard DA-A say, "come on man move your foot" and someone said "what ya gonna hit me" and that caught DA-B's attention. DA-B could not confirm she heard name calling but voices were loud and could be heard while wearing earbuds.	F 600	includes reporting guidelines. Customer Service education completed with Staff. Date of Compliance: 6.20.25 Recurrence will be prevented by: The Administrator or designee will review any concerns related to abuse, including verbal interactions between staff and residents, on a weekly basis for 4 weeks. 4 staff members per week will be quizzed x4 weeks on recognizing and reporting abuse, with questions specifically addressing verbal abuse and staff-to-resident interactions. Staff will receive facility-wide education on recognizing, preventing, and timely reporting of abuse at the next scheduled All-Staff Meeting. The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	

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F 600	Continued From page 3 Facility policy titled "Abuse Prohibition/Vulnerable Adult Policy" revised date 3/24, indicated the philosophy of Monarch healthcare management is to provide quality long-term care in a loving and caring atmosphere. Purpose was to protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse.	F 600		
F 609 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 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	F 609		6/20/25

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F 609	Continued From page 4 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, observation and record review the facility failed to report an allegation of staff to resident abuse to the State Agency (SA) and administrator for 1 of 3 resident (R1) who had a verbal altercation with a staff member, requiring another staff to intervene and no report was made. Findings include: R1's brief interview for mental status (BIMS) dated 6/5/25 indicated a score of 15/15, indicated no cognitive impairment. R1's care plan dated 5/30/25 indicated medical diagnoses of weakness, schizophrenia, anxiety disorder, depression, chronic pain syndrome. When interviewed on 6/17/25 at 1:11 p.m., R1 stated there was an altercation between DA-A due to requesting two sandwiches. R1 stated he and DA-A were yelling at each other and being "disrespectful" to each other. R1 stated they both called each other "bitches" in the altercation, and he could not recall who said bitch first. R1 recalled DA-B coming to the door during the altercation and "defused" the situation and then he left. R1 added, he was surprised how escalated it got over a request for two sandwiches.	F 609	F600 – Free from Abuse and Neglect and F609 Reporting of Alleged Violations Immediate Corrective Action: R1 was discharged from the facility 6/9/2025. Dietary staff members were suspended pending investigation; an internal investigation was completed. Facility investigation was inconclusive regarding the allegation. Social Services completed interviews with residents; no other concerns noted. OHFC involving R1 was filed on 6.18.25. Corrective Action as it applies to others: The Abuse/Vulnerable Adult Policy was reviewed and remains current.¿ Full house audit regarding allegations of verbal abuse for the past 30 days. Staff educated on Abuse Policy which	

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F 609	Continued From page 5 When interviewed on 6/17/25 at 3:43 p.m., administrator stated R1 never mentioned concerns with kitchen staff and being threatened with a knife or verbally threatened. When interviewed on 6/17/25 at 5:01 p.m., DA-A confirmed there was an altercation with R1 at the kitchen door when he requested two chicken sandwiches and was told there was only one chicken sandwich. DA-A recalled calling each other "bitches" could have happened, "we exchange some words and may have cussed at each other". DA-A stated DA-B came to the door and asked R1 to remove his foot from the door and to leave and R1 did as asked. DA-A stated the kitchen door was not supposed to be open for the residents, but we try to be "courteous and make sure they are fed", adding R1 was not happy with only have received one chicken sandwich. DA-A stated he had not contacted management related to the altercation with R1. When interviewed on 6/18/25 at 10:49 a.m., DA-B stated she was working in the kitchen when the altercation between R1 and DA-A broke out. DA-B stated she was wearing earbuds but could still hear the conversation. She heard DA-A say, "come on man move your foot" and someone said "what ya gonna hit me" and that caught her attention. DA-B could not confirm she heard name calling but voices were loud and could be heard while wearing earbuds.. DA-B stated she did not report to management as many residents come to the kitchen and get mad because staff cannot always give them what they want. DA-B stated DA-A did take a break after the incident because DA-A was upset. When interviewed on 6/18/25 at 9:49 a.m.,	F 609	includes reporting guidelines. Customer Service education completed with Staff. Date of Compliance: 6.20.25 Recurrence will be prevented by: The Administrator or designee will review any concerns related to abuse, including verbal interactions between staff and residents, on a weekly basis for 4 weeks. 4 staff members per week will be quizzed x4 weeks on recognizing and reporting abuse, with questions specifically addressing verbal abuse and staff-to-resident interactions. Staff will receive facility-wide education on recognizing, preventing, and timely reporting of abuse at the next scheduled All-Staff Meeting. The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	

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F 609	Continued From page 6 administrator stated when staff witnessed or suspected abuse toward a resident, they have been trained to report to management right away, also R1 never reported the incident to anyone in the facility. Administrator added the leadership was not aware of the allegation until survey, but would initiated an investigation immediately. Facility policy titled "Abuse Prohibition/Vulnerable Adult Policy" revised date 3/24, indicated all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin, misappropriation of resident property, or involuntary seclusion. A completed incident report will be routed per facility procedure. A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required.	F 609		

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 06/18/2025

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 *****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 6/17/25 through 6/18/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H52227168C (MN00113854). NO licensing	2 000		

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 06/18/2025

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2 000	Continued From page 1 orders were issued. Minnesota Department of Health is documenting the 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.	2 000		