DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATIO						N AND TRANSMITTAL ID: D1B2			
	PART	I - TO BE COM	PLETED BY TI	HE STAT	E SURVEY A	GENCY	I	Facility ID: 00494		
1. MEDICARE/MEDICAID PROVIDER N (L1) 245028 2.STATE VENDOR OR MEDICAID NO. (L2) 299242600	Ο.	 NAME AND ADI (L3) HIGHLAND (L4) 2319 WEST \$ (L5) SAINT PAUL 	CHATEAU HEA SEVENTH STRE	LTH CAR		6) 55116	 TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 	<u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2004		7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (I 13 PTIP	L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other		
6. DATE OF SURVEY 04/04 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	:	FISCAL YEAR ENDING 12/31	DATE: (L35)		
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN	64 (L18) 64 (L17)	B. Not in Com	nce With quirements	215:	2. To 3. 24 4. 7-	echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code A *	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room (L12)	ctor		
18 SNF 18/19 SNF 64	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		18. STATE SU	JRVEY AGENCY APP	PROVAL	Date:		
Susanne Reuss, Un	nit Superviso	or (04/04/2017	(L19)	Kate J	ohnsTon, Pr	ogram Speciali	<u>st</u> 03/31/2017 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA RE	· · /	OFFICE OF	R SINGLE STATI	EAGENCY	(120)		
 DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Para 2. Facility is not Eligible 			PLIANCE WITH CI ITS ACT:	VIL	2		al Solvency (HCFA-2572) tterest Disclosure Stmt (HCF/	A-1513)		
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMIN	ATION ACTION:	(L30)		
OF PARTICIPATION 01/01/1967	BEGINNING I	DATE	ENDING DATE		VOLUNTARY 01-Merger, Clo	osure	05-Fail to M	leet Health/Safety		
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVE A. Suspension of	of Admissions:	(L25) (L44)		03-Risk of Invo	tion W/ Reimbursemen oluntary Termination on for Withdrawal	OTHER	eet Agreement Status Change		
	B. Rescind Sus	pension Date:	(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARK	S				
	(1.28)	03001		(1.21)						
31. RO RECEIPT OF CMS-1539	(L28) 32	DETERMINATION C	OF APPROVAL DAT	(L31) E	Posted 0	5/12/2017 Co.				
	(L32)	04/04/2017		(L33)	DETERMI	NATION APPROV	VAL			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245028 May 5, 2017

Ms. Pat Voelker, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, MN 55116

Dear Ms. Voelker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective the above facility is certified for or recommended for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Highland Chateau Health Care Center May 5, 2017 Page 2

Sincerely,

Kato Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 5, 2017

Ms. Pat Voelker, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, MN 55116

RE: Project Number S5028027

Dear Ms. Voelker:

On March 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2017, effective March 28, 2017 and therefore remedies outlined in our letter to you dated March 7, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Highland Chateau Health Care Center May 5, 2017 Page 2

Sincerely,

X ate lon

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT				
	B. Wing	Y2	4/4/2017	Y3			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
HIGHLAND CHATEAU HEALTH CA	ARE CENTER	2319 WEST SEVENTH STREET					
		SAINT PAUL, MN 55116					

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEI	VI	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0205	Correction	ID Prefix	F0279		Correction	ID Prefix	F0280		Correction
Reg. #	483.15(d)(1)(i)-(iv)(2) Completed	Reg. #	483.20(d);483.21(b)(1)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v (3),483.21(b)(2))	Completed
LSC		03/28/2017	LSC			03/28/2017	LSC			03/28/2017
ID Prefix	F0282	Correction	ID Prefix	F0312		Correction	ID Prefix	F0314		Correction
Reg. #	483.21(b)(3)(ii)	Completed	Reg. #	483.24(a)(2)	Completed	Reg. #	483.25(b)(1)		Completed
LSC		03/28/2017	LSC			03/28/2017	LSC			03/28/2017
ID Prefix	F0315	Correction	ID Prefix	F0323		Correction	ID Prefix	F0329		Correction
Reg. #	483.25(e)(1)-(3)	Completed	Reg. #	483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. #	483.45(d)(e)(1)-(2)		Completed
LSC		03/28/2017	LSC			03/28/2017	LSC			03/28/2017
ID Prefix	F0334	Correction	ID Prefix	F0353		Correction	ID Prefix	F0356		Correction
Reg. #	483.80(d)(1)(2)	Completed	Reg. #	483.35(a)(1)-(4)	Completed	Reg. #	483.35(g)(1)-(4)		Completed
LSC		03/28/2017	LSC			03/28/2017	LSC			03/28/2017
ID Prefix	F0412	Correction	ID Prefix	F0431		Correction	ID Prefix	F0441		Correction
Reg. #	483.55(b)(1)(2)(5)	Completed	Reg. #	483.45(b)(2)(3)(g)(h)	Completed	Reg. #	483.80(a)(1)(2)(4)(e	e)(f)	Completed
LSC		03/28/2017	LSC			03/28/2017	LSC			03/28/2017
REVIEWE STATE AG		REVIEWED BY (INITIALS) SR/KJ	date 05/05/2	2017	SIGNATURE OF S		6022		date 04/04	4/207
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWI 2/16/2017	JP TO SURVEY CC	DMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						6 🗌 NO	

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT				
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01						
245028 _{Y1}	B. Wing	Y2	3/28/2017	Y3			
DENTIFICATION NUMBER 245028 NAME OF FACILITY HIGHLAND CHATEAU HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HIGHLAND CHATEAU HEALTH CA	ARE CENTER	2319 WEST SEVENTH STREET					
		SAINT PAUL, MN 55116					

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	М	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. #	 NFPA 101	Correction Completed	ID Prefix	Correction 01 Completed	ID Prefix	Correction Completed
LSC	K0211	03/28/2017	LSC <u>K0363</u>	03/28/2017	LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC		Completed	Reg. # 	Completed	Reg. # 	Completed
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
REVIEWE		REVIEWED BY (INITIALS) TL/KJ	date 05/05/2017	signature of surveyor 37	010	date 03/28/2017
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWL 2/14/2017	JP TO SURVEY CO 7	DMPLETED ON	CHECK FOR UNCORRECT			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COMI						D: D1B2 acility ID: 00494
1. MEDICARE/MEDICAID PROVIDER N (L1) 245028 2.STATE VENDOR OR MEDICAID NO. (L2) 299242600	ίΟ.	3. NAME AND ADE (L3) HIGHLAND (L4) 2319 WEST S (L5) SAINT PAUL	CHATEAU HEA EVENTH STRE	LTH CARI		55116	 TYPE OF ACTION: Initial Termination Validation 	<u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SUP	PLIER CATEGORY		<u>02</u> (L7)		7. On-Site Visit	9. Other
(L9) 04/01/2004		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After Con	mplaint
	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING	DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE		12/31	()
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY I	S CERTIFIED AS:				<u> </u>	
From (a):		X A. In Complian	ce With		And/Or Approv	ed Waivers Of The	Following Requirements:	
To (b):		Program Req Compliance			2. Tech 3. 24 H	nical Personnel our RN	6. Scope of Servi 7. Medical Direct	
12.Total Facility Beds	64 (L18)	<u>X</u> 1. A	cceptable POC		4. 7-Da	y RN (Rural SNF)	8. Patient Room S	Size
13.Total Certified Beds	64 (L17)	B Not in Comr	liance with Program		5. Life	Safety Code	9. Beds/Room	
15. Total Certified Deas	01 (217)	-	nd/or Applied Waive		* Code:	A1*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY M	IEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
64 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	. ,							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY API	PROVAL	Date:
Susan Miller, H	FE NE II		03/20/2017	(L19)	Kate Joh	nsTon, Pro	ogram Specialis	t 03/31/2017 (L20)
	PART II - TO	BE COMPLETEI) BY HCFA RE	GIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH CI TS ACT:	VIL	2. 0	Ownership/Control In	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	L-1513)
1. Facility is Eligible to Par 2. Facility is not Eligible	ticipate				3. E	Both of the Above :		
2. Facility is not Englote	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2-	4. LTC AGREEME	NT	26. TERMINAT	ION ACTION:	(1	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1967	23. LTC AGREEM BEGINNING		4. LTC AGREEME ENDING DATE		26. TERMINAT <u>VOLUNTARY</u> 01-Merger, Closu	00	INVOLUNT	
OF PARTICIPATION					<u>VOLUNTARY</u> 01-Merger, Closu	00		ARY
OF PARTICIPATION 01/01/1967	BEGINNING	DATE E SANCTIONS	ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Closu	 re h W/ Reimbursemen ntary Termination	<u>INVOLUNT</u> 05-Fail to Me 06-Fail to Me <u>OTHER</u>	ARY eet Health/Safety
OF PARTICIPATION 01/01/1967 (L24)	BEGINNING (L41) 27. ALTERNATIV	DATE E SANCTIONS of Admissions:	ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involur	 re h W/ Reimbursemen ntary Termination	<u>INVOLUNT</u> 05-Fail to Me 06-Fail to Me <u>OTHER</u>	ARY eet Health/Safety eet Agreement
OF PARTICIPATION 01/01/1967 (L24) 25. LTC EXTENSION DATE:	BEGINNING (L41) 27. ALTERNATIV A. Suspension	DATE E SANCTIONS of Admissions:	ENDING DATE (L25)		<u>VOLUNTARY</u> 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involur	 re h W/ Reimbursemen ntary Termination	<u>INVOLUNT</u> 05-Fail to Me ot 06-Fail to Me <u>OTHER</u> 07-Provider 1	ARY eet Health/Safety eet Agreement
OF PARTICIPATION 01/01/1967 (L24) 25. LTC EXTENSION DATE:	BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	DATE E SANCTIONS of Admissions:	ENDING DATE (L25) (L44) (L45)		<u>VOLUNTARY</u> 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involur	 re h W/ Reimbursemen ntary Termination	<u>INVOLUNT</u> 05-Fail to Me ot 06-Fail to Me <u>OTHER</u> 07-Provider 1	ARY eet Health/Safety eet Agreement
OF PARTICIPATION 01/01/1967 (L24) 25. LTC EXTENSION DATE: (L27)	BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	DATE E SANCTIONS of Admissions: pension Date:	ENDING DATE (L25) (L44) (L45)		VOLUNTARY 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involur 04-Other Reason f	 re h W/ Reimbursemen ntary Termination	<u>INVOLUNT</u> 05-Fail to Me ot 06-Fail to Me <u>OTHER</u> 07-Provider 1	ARY eet Health/Safety eet Agreement
OF PARTICIPATION 01/01/1967 (L24) 25. LTC EXTENSION DATE: (L27)	BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	DATE E SANCTIONS of Admissions: pension Date: 2. INTERMEDIARY/C/	ENDING DATE (L25) (L44) (L45)		VOLUNTARY 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involur 04-Other Reason f	 re h W/ Reimbursemen ntary Termination	<u>INVOLUNT</u> 05-Fail to Me ot 06-Fail to Me <u>OTHER</u> 07-Provider 1	ARY eet Health/Safety eet Agreement
OF PARTICIPATION 01/01/1967 (L24) 25. LTC EXTENSION DATE: (L27)	BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus 25 (L28)	DATE E SANCTIONS of Admissions: pension Date: 2. INTERMEDIARY/C/	ENDING DATE (L25) (L44) (L45) ARRIER NO.	(L31)	VOLUNTARY 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involur 04-Other Reason f	_00 re h W/ Reimbursemen ntary Termination for Withdrawal	<u>INVOLUNT</u> 05-Fail to Me ot 06-Fail to Me <u>OTHER</u> 07-Provider 1	ARY eet Health/Safety eet Agreement



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 7, 2017

Ms. Heather Welter, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, MN 55116

RE: Project Number S5028027

Dear Ms. Welter:

On February 16, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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. In addition, at the time of the February 16, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5028042.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793 Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 28, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 28, 2017 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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

Highland Chateau Health Care Center March 7, 2017 Page 4

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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 May 16, 2017 (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

Highland Chateau Health Care Center March 7, 2017 Page 5

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 August 16, 2017 (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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Highland Chateau Health Care Center March 7, 2017 Page 6

> 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Inston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			F		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	CON	E SURVEY IPLETED
		245028	B. WING				C 16/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER			2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	FC	000			
	A recertification su 13, 14, 15, and 16,	rvey was conducted February 2017.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
F 205 SS=D	completed at the tir complaint was subs issued at F329.	complaint H5028042 was also ne of the standard survey. The stantiated, with a deficiency 2) NOTICE OF BED-HOLD UPON TRANSFR	F 2	205			3/28/17
	(d) Notice of bed-he	old policy and return-					
	transfers a resident goes on therapeutic	ansfer. Before a nursing facility t to a hospital or the resident c leave, the nursing facility n information to the resident or tive that specifies-					
	any, during which th	he state bed-hold policy, if ne resident is permitted to residence in the nursing					
LABORATOR	L A DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURF		TITLE		(X6) DATE
	ically Signed				···· 		03/17/2017

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.

		AND HUMAN SERVICES			FORM	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245028	B. WING _		2/16/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 2319 WEST SEVENTH STREET	-	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 205	 (ii) The reserve becomplan, under § 447.4 (iii) The nursing fact bed-hold periods, we paragraph (c)(5) of resident to return; and it is section. (iv) The information of this section. (2) Bed-hold notice transfer of a resident therapeutic leave, at the resident and written notice which bed-hold policy dest this section. This REQUIREMENT by: Based on interviewed facility failed to ensure legal representative hold rights at the time Findings include: During a family interpresentation provided with inform would be held on each ospitalized. Record review and nurse (RN)-H on 2/ 	I payment policy in the state 0 of this chapter, if any; ility's policies regarding /hich must be consistent with this section, permitting a	F 20	All Residents or representative receive written notice of bed he upon transfer from the facility. All Residents may have been a none show any ill effects. Staff have been educated on th provide information on bed hol transfer from the facility. It is the responsibility of the Din Nursing/designee to ensure co Audits will be conducted week reviewed at QAPI for three mo ensure adherence to this polic	old rights affected, but he need to d upon rector of ompliance. ly and nths to	

Facility ID: 00494

		& MEDICAID SERVICES				0938-039
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
			A BOILDING	~		С
		245028	B. WING		02/	16/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 205	Review of R37's m with health informa 2/14/17, at 3:55 p.r information had not the two different ho licensed social wor time of admission, legal representative information and exp family member sign time of admission. and signed when a happened. Howeve R37 or legal repress bed hold information hospitalizations for On 2/14/17, at 3:55 unable to find the b thinned chart or bu the last 6 months th instructed staff to g however explained was no longer emp stated the new bus to the former emple On 2/15/17, at 8:51 missing bed hold n with the former bus worked at the corpor- notices were still no	edical record and interview tion manager (HIM)-A on n. revealed bed hold t been provided to R37 during ospitalizations. HIM-A and ker (LSW)-A, stated that at the residents and/or the resident's e are provided with bed hold plained that the resident or ned the bed hold policy at the The bed hold form was used n actual hospitalization er, there was no evidence that centative had been provided on for each of the two R37. 5 p.m. HIM-A stated being bed hold notices in R37's siness file. HIM-A stated for he business manager had give her the bed hold notices, that the business manager loyed at the facility. HIM-A iness manager had a call out oyee. a.m. HIM-A stated the otices had been discussed siness manager, who now orate offices, and the bed hold ot found.	F 20	5 Deficient practice to be corrected 3/28/2017	by	
	Policy revealed the hospitalization/ther for private pay, Mer Administration resid	lated form titled Bed Hold bed hold policy upon apeutic leave was spelled out dicare, Medicaid and Veteran's dents. The form had a he bottom, which when signed				

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		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED C
		245028	B. WING				0 16/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 205		ge 3 ent/responsible party had ng received the policy.	F 2	205			
F 279 SS=D	483.20(d);483.21(b COMPREHENSIVE		F 2	79			3/28/17
	assessments comp months in the resid results of the asses	nust maintain all resident bleted within the previous 15 ent's active record and use the ssments to develop, review dent's comprehensive care					
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass care plan must des (i) The services tha or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the	t develop and implement a son-centered care plan for sistent with the resident rights O(c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following - t are to be furnished to attain dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	TED: 03/20/2017 DRM APPROVED NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED C
		245028	B. WING	à		02/16/2017
NAME OF F	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	
HIGHLAN	ID CHATEAU HEALTI	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 279	rehabilitative servic provide as a result of recommendations. findings of the PAS, rationale in the resident (iv) In consultation we resident's represent (A) The resident's g desired outcomes. (B) The resident's p future discharge. Fa- whether the resident community was assist local contact agence entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observat review the facility fa for 1 of 3 residents Findings include: R37 was originally a 8/24/16, and readm 9/15 and 11/10/16. The care plan dated	services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document it's desire to return to the sessed and any referrals to ies and/or other appropriate pose. is in the comprehensive care e, in accordance with the rth in paragraph (c) of this NT is not met as evidenced ion, interview and document itled to develop the care plan (R37) with dental needs.	F	279	Resident #37 care plan has been reviewed and updated to reflect his individuals needs related to refusals to wear dentures at times. All Residents may be affected, but non show any ill effect. All other residents were interviewed to determine if there are dental care need	e Is.
	9/15 and 11/10/16. The care plan dated indicated R37 requi					

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		AND HUMAN SERVICES				FORM	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	
		245028	B. WING				_ 16/2017
	PROVIDER OR SUPPLIER	H CARE CENTER		23	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	developed to indica wear the lower den fitting. On 2/13/17, at 5:09 edentulous and a s soaking in a dentur 2/14/17, at 3:35 p.m the upper denture, denture was in a de 2/15/17, at 7:30 a.m cleansed R37's der offered the denture stated "these are th grabbed the lower of mouth and gagged removing the dentur denture, placed ad and placed the denture. At 8:08 a.m. R37 w the lower denture. If the lower denture of did not fit. R37 state chance and that he On 2/14/17, at 12:4 stated R37 told FM uncomfortable; and that the dentures of were worn more. F "difficult" and if R37 dentures. A 8/24/16, docume Comprehensive Ad	r, the care plan was not the R37 at times refused to ture due to concerns of it not p.m. R37 was observed to be et of dentures was noted to be e cup in R37's bathroom. On n. R37 was observed wearing but not the lower, as the lower enture cup in the bathroom. On n. nursing assistant (NA)-A nures; and at 8:03 a.m. s to R37 for placement. R37 he only one's I want" and denture, tried to put it in top of . NA-A assisted R37 with the R37 then took the correct hesive on the upper denture ture properly in mouth. ras asked about not wearing R37 stated had tried wearing on and off for a month and it ed people said to give it a is done giving it a chance. -6 p.m. family member (FM)-A -A the dentures are I FM-A stated R37 was told ould not be adjusted until they M-A stated R37 could be 7 did not want to put the 37 would not be wearing the	F 2	79	Nursing staff have been educated to ensure dental care needs are reflect the plan of care. Audits to be done weekly with schere care conferences to determine if the new or different dental care needs. The Director of Nursing/designee is responsible to ensure compliance. Audits will be reviewed at QAPI for months to ensure adherence to the Deficient practice to be corrected by 3/28/2017	duled ere are 3 policy.	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	03/20/2017 PPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION		(3) DATE COMPI	SURVEY LETED	
		245028	B. WING _			C 02/16/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S				
HIGHLAN	D CHATEAU HEALTH	H CARE CENTER		2319 WEST SEVENTH S SAINT PAUL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI/ FFICIENCY)	-	(X5) COMPLETION DATE	
F 280 SS=D	admission. A new N Admission Data Co completed at the time 9/15/18, indicated F present at the time another Nursing Co Collection and Asse completed at the time indicated R37 had f present at the time On 2/14/17, at 3:44 like to wear the lowe the denture did not On 2/15/17, at 10:2 (RN)-A stated some dentures and some On 2/16/17, at 8:55 stated at times, the 483.10(c)(2)(i-ii,iv,v PARTICIPATE PLA 483.10 (c)(2) The right to p and implementation plan of care, includi (i) The right to partie including the right to be included in the p request meetings a revisions to the perso	 and present at the time of the lursing Comprehensive llection and Assessment ine of a readmission on R37's dentures were not of the readmission; and omprehensive Admission Data essment dated 11/10/16, ine of another readmission, ull dentures which were of the admission. pm NA-B stated R37 did not er denture and R37 had stated fit. 8 a.m. registered nurse etimes R37 would wear the times not. a.m. RN-A stated R37 had lower denture did not fit.)(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP articipate in the development of his or her person-centered ng but not limited to: cipate in the planning process, the right to not the right to request son-centered plan of care. 	F 2	79	FIGENCY)	5	3/28/17	
		cipate in establishing the l outcomes of care, the type,						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES								APPROVED
		& MEDICAID SERVICES	. <u> </u>					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(E SURVEY PLETED
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		245028	B. WING					16/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLAN	ND CHATEAU HEALTI	H CARE CENTER			2319 WEST SEVENTH STREET			
					SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR	JLD E	BE	(X5) COMPLETION DATE
					DEFICIENCY)			
F 280	Continued From pa	ae 7	F 2	280				
	amount, frequency,	and duration of care, and any						
	other factors related plan of care.	d to the effectiveness of the						
	(iv) The right to reco included in the plan	eive the services and/or items of care.						
		the care plan, including the gnificant changes to the plan						
	right to participate in	nall inform the resident of the n his or her treatment and sident in this right. The nust						
	(i) Facilitate the incl resident representa	lusion of the resident and/or tive.						
	(ii) Include an asses strengths and need	ssment of the resident's ls.						
		resident's personal and s in developing goals of care.						
	483.21 (b) Comprehensive	Care Plans						
	(2) A comprehensiv	e care plan must be-						
	(i) Developed within the comprehensive	n 7 days after completion of assessment.						
	(ii) Prepared by an i includes but is not I	interdisciplinary team, that imited to						
	(A) The attending p	hysician.						

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		AND HUMAN SERVICES			FORM): 03/20/2017 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245028	B. WING	i	02	C 2/ 16/2017
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	 resident. (C) A nurse aide wirresident. (D) A member of fo (E) To the extent propriation must medical record if the and their resident and their resident resident's care plane. (F) Other appropriation disciplines as deterror as requested by (iii) Reviewed and rest residents. This REQUIREMENT 	th responsibility for the od and nutrition services staff. acticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n. tte staff or professionals in mined by the resident's needs the resident. revised by the interdisciplinary sessment, including both the	F	280		
	facility failed to revi	v and document review, the se the care plan for 2 of 4 26) reviewed for urinary			Resident #37 and Resident #126 urinary incontinence assessments and care plans have been reviewed and updated to reflect current assistance needs with toileting.	
	R37 was admitted t readmitted on 9/15/ readmission Minim 9/22/16, R37 was c	to the facility on 8/24/16, and (16. According to the um Data Set (MDS) dated continent of urine. A quarterly 6, indicated R37 was always			All Residents may be affected, but none show any ill effect. All other resident who are dependent for urinary continence have had their urinary incontinence assessments reviewed and care plan updated to reflect necessary care and treatment.	

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		AND HUMAN SERVICES				FORM	03/20/2017 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245028	B. WING			02/16/2017		
	PROVIDER OR SUPPLIER	H CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG			ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ge 9	F 2	80				
	Evaluation Tool-HD R37 was incontiner staff were to encou toileting every two h The care plan revis R37's urinary incon assist with toileting However, the care completion of the 1 assessment, which and assist R37 with as needed. On 2/14/17, at 12:4 (A) stated R37 user went from being co admitted to the faci On 2/15/17, at 7:53 stated R37 never to was too unsteady. R126 was admitted an indwelling Foley revised on 2/6/17, i removed and R126 program, which had and Bladder Functi assessment dated assessment verifier removed on 2/6/17, provide incontinent	and Bladder Functional GR dated 12/12/16, indicated at of bowel and bladder; and rage and assist R37 with hours and as needed. ed on 12/6/16, addressed tinence and staff were to needs "as determined." plan was not revised after 2/12/16, urinary incontinence directed staff to encourage toileting every two hours and 5 p.m. R37's family member- d incontinent products and ntinent of urine when first lity, to being incontinent. a.m. nursing assistant (NA)-A bok self to the toilet as R37 to the facility on 1/31/17, with catheter. The care plan was ndicating the catheter was was on a check and change the care plan was not revised uency of the check and change d been identified in a Bowel onal Evaluation Tool-HDGR 2/7/17. The 2/7/17, d the Foley catheter had been and indicated staff were to ac care every two hours and lowing each episode of			Education provided to nursing staff revision of care plans Audits of three resident per week w conducted to ensure urinary incont care plan is in place. It is the responsibility of the Directo Nursing or designee to ensure compliance. Audits will be reviewed at QAPI for months. Deficient practice to be corrected b 3/28/2017.	vill be inence or of three		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 03/20/2017 // APPROVED). 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED		
		245028	B. WING	i	02	C 02/16/2017		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLAN	ND CHATEAU HEALTI	H CARE CENTER			319 WEST SEVENTH STREET GAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 280	Continued From pa	ge 10	F 2	280				
F 282 SS=D	Plans-Comprehens was to be reviewed assessment. The facility's 11/16, Bladder Manageme who was incontiner appropriate treatme urinary tract infection the extent possible.	RVICES BY QUALIFIED	F 2	282		3/28/17		
	as outlined by the c must- (ii) Be provided by c accordance with ea care.	led or arranged by the facility, omprehensive care plan,						
	Based on observat review, the facility fa plan to ensure the r services were provi development and p	ion, interview, and document ailed to implement the care necessary treatment and ded to minimize the romote healing of pressure idents (R126) identified with a			Resident #126 has been repositioned pe plan of care. All Residents may be affected, but none show any ill effect. All other residents who are dependent for			
	Findings include:	itianad on Old Eld 7 for se			repositioning have had their care plan reviewed to ensure appropriate plan of care to minimize development and			
	10:12 a.m. to 1:50	sitioned on 2/15/17, from p.m. a total of 3 hours and 38 Initial Care plan directed			promote healing of pressure ulcers. Nursing staff educated on developing a			

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		AND HUMAN SERVICES			FORM	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	`́сом	E SURVEY IPLETED
		245028	B. WING _			C 16/2017
	PROVIDER OR SUPPLIER	H CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	staff to reposition F At 10:12 a.m. R126 mechanical lift and into a wheelchair. A lunch in room by N lunch tray was pick attempt or offer to r interaction. At 1:25 p.m. NA-C When informed R1 since being transfe wheelchair, NA-C v the wheelchair sinc morning cares. NA- every two hour repo p.m. R126 was trar mechanical lift and An 11/16, revised p Plan of Care-Comp were furnished to a highest practicable psychosocial well- b 483.24(a)(2) ADL C DEPENDENT RES (a)(2) A resident wh activities of daily liv services to maintain personal and oral h This REQUIREMEI by: Based on observati review, the facility f (R126) dependent of	A 126 every two hours. S was assisted out of bed via a three staff, and transferred At 12:42 p.m. R126 was served IA-C and at 1:25 p.m. the ed up. However, there was no reposition R126 during either stated shift ended at 2:00 p.m. 26 had not been repositioned rred from the bed to the rerified R126 had been up in the 10:12 a.m., which was after -A verified R126 was on an ositioning schedule. At 1:50 insferred back to bed via the two staff. policy titled Person-centered orehensive indicated services titain or maintain the resident's physical, mental and being. CARE PROVIDED FOR SIDENTS no is unable to carry out ing receives the necessary in good nutrition, grooming, and hygiene. NT is not met as evidenced tion, interview and document ailed to ensure 1 of 3 residents	F 28	 care plan to minimize risk of deve and promoting healing of pressure Audits will be conducted on three residents per week to ensure that plan of care is present for repositi- need. It is the responsibility of the Direct Nursing/designee to ensure comp Audits will be reviewed at QAPI fo months to ensure adherence to per being followed. Deficient practice to be corrected 3/28/2017 	by	3/28/17

Facility ID: 00494

If continuation sheet Page 12 of 52

		AND HUMAN SERVICES				FORM	03/20/201 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SUR COMPLETE C	
		245028	B. WING				16/2017
	PROVIDER OR SUPPLIER	H CARE CENTER		23	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 312	services to minimiz Findings include: R126 was not provievery two hours on 1:50 p.m. a total of On 2/15/17, at 9:30 during morning car incontinent product wet and R126 was condition of the pace assistant (NA)-A with care. At 9:51 a.m. I incontinence care f was assisted out of three staff, and tran 12:42 p.m. R126 w NA-C and at 1:25 p up. R126 remained being checked for the At 1:25 p.m. NA-C When informed R1 urinary incontinence R126 had been che was during morning on an every two ho change schedule. A	age 12 te urinary incontinence. ided with incontinence care 2/15/17, from 9:51 a.m. to 3 hours and 59 minutes. 0 a.m. R126 was observed es. At 9:37 a.m. R126's t was removed and noted to be also incontinent of bowel. The d was verified by nursing ho was providing incontinence NA-A had finished providing for R126. At 10:12 a.m. R126 f bed via a mechanical lift and nsferred into a wheelchair. At as served lunch in room by 0.m. the lunch tray was picked d up in the wheelchair without urinary or bowel incontinence. stated shift ended at 2:00 p.m. 26 had not been checked for e NA-C verified the last time ecked for urinary incontinence g cares. NA-A stated R126 was ur repositioning/check and At 1:50 p.m. R126 was bed via the mechanical lift incontinent pad was noted to	F 3	12	show any ill effect. Residents who have been identified dependent on staff for urinary incontinence have been reviewed ensure proper care plan in place to minimize urinary incontinence. Nursing staff have been educated providing residents care per their of plan to minimize urinary incontinent Audits conducted three times weet ensure that incontinent care plan in provided. It is the responsibility of the Direct Nursing/designee to ensure comp Audits will be reviewed at QAPI for months to ensure adherence to pot being followed. Deficient practice corrected by 3/28/3017	to o care nce. kly to s being or of liance. r three plicy is	
	be wet, and the corduring incontinence A Bowel and Bladd Tool-HDGR was co and identified an in	ndition of the pad was verified					

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		AND HUMAN SERVICES			FORM	: 03/20/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245028	B. WING		C 02/16/2017	
	PROVIDER OR SUPPLIER	H CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	• • • •	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	every two hours an each episode of inc The facility's 11/16, Bladder Manageme who was incontiner appropriate treatme	e to provide incontinence care d when necessary following continence. revised policy titled Bowel and ent-HDGR indicated a resident at of bladder was to receive the ent and services to prevent on and "restore continence to	F 31:	2		
F 314 SS=D	483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers	TMENT/SVCS TO RESSURE SORES	F 314	4		3/28/17
	facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that the (ii) A resident with p necessary treatmen professional standa healing, prevent inf from developing. This REQUIREMEN by: Based on observat review, the facility f (R126) with facility	e that- res care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and pressure ulcers receives and and services, consistent with ards of practice, to promote ection and prevent new ulcers NT is not met as evidenced tion, interview and document ailed to ensure 1 of 2 residents identified pressure ulcers priate treatment and services g and minimize the		Resident #126 care plan was revi and updated to reflect current care needed to promote healing of a pr ulcer. All residents may be affected, but	e essure	

Facility ID: 00494

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		AND HUMAN SERVICES			FORM	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COM	E SURVEY PLETED C
		245028	B. WING			_ 16/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 14	F 314			
	Findings include:			show any ill effect.		
	R126 was admitted according to a 2/1/7 Assessment there of time of admission. The revealed R126 developen area in the cro- A Pathway Health S Evaluation of Skin I 2/3/17, indicated the incontinent of bower staff and hoyer for the off loading/reposition Undated initial care reposition R126 eveloped wound on R126's c A Wound Care Spee document dated 2/7 crevice was a stage coccyx and now me Page two of the wo "Wound is occurrin significant moisture that reason will trial as it appears to be further indicated a sperformed and the x 0.4 x 0.1 cm. The wound speciali and the pressure up to measure 0.8 x 0.	were no pressure ulcers at the A nurses noted dated 2/2/17, eloped a 2 centimeter long evice of the buttocks. Services Comprehensive Risk Factors form dated e resident was bedfast, el; and was assisted by two transfers and bed mobility and oning. e plan directed staff to ery two hours and there was a		 Resident who are at risk for depressure ulcers where reviewed care plan is reflective of service to promote healing or prevent ulcers. Nursing staff has been educat providing the necessary treatmed services to prevent pressure upromote healing. Audits to be completed three to ensure appropriate care and are in place and care is being promote and or heal pressure. It is the responsibility of the Dim Nursing/designee to ensure conducts to be reviewed at QAPI months to ensure adherence to be correct 3/28/2017. 	ed to ensure es needed pressure ed on nent and lcers and imes weekly d services delivered to ulcers. rector of ompliance. for the o this policy	

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DEPART		FORM	APPROVED					
		& MEDICAID SERVICES				<u>DMB NO. 0938-0391</u>		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
			_			С		
		245028	B. WING			02/16/2017		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLA	ND CHATEAU HEALTI	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		COMPLETION DATE	
					DEFICIENCY)			
F 314	Continued From pa	ao 15	–	314				
1 014		e specialist indicated the area		514				
	was caused by she							
		g cares for R126 were						
		as a dry, non-draining scabbed eft buttock and an open area						
		crevice, on the coccyx. After						
		s, at 10:12 a.m., R126 was						
		hanical lift and three staff from chair. R126 remained in						
		from 10:12 a.m. and at 12:42						
	p.m., was served lu	nch. At 1:25 p.m. nursing						
		cked up the lunch tray, placed the cart to the kitchen.						
		e unit at 2:00 p.m. and when						
		ime verified R126 had not						
		since after morning cares. was to be an every two hour						
	repositioning.	,						
	R126 was transferr	ed back to bed, via a						
	mechanical lift and	two staff at 1:50 p.m.						
		incontinence care, R126's						
		at 2:10 p.m. and the areas						
		specialist documentation registered nurse (RN)-B and						
	observed by nurse	practitioner (NP)-B. RN-B						
	stated the area on t	he left buttock measured 1.2						
		here was no depth to the area. was no drainage from the						
		vas scabbed over and dry.						
	On 2/15/17, at 3:38	p.m. physical therapist (PT)-C						
	stated she had worl	ked with R126 after the						
		elchair. PT-C stated R126 did and some chair presses.						
		ted she couldn't say R126 had						

Facility ID: 00494

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		AND HUMAN SERVICES				FORM	03/20/2017 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED	
		245028	B. WING			C 02/16/2017		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314	Continued From pa	ge 16	F 3	14				
	When asked about least a minute, PT- motivation and dou wheelchair cushion	-						
F 315 SS=D			F 3	15			3/28/17	
	continent of bladde receives services a continence unless h	t ensure that resident who is r and bowel on admission nd assistance to maintain his or her clinical condition is hat continence is not possible						
		ith urinary incontinence, based omprehensive assessment, the that-						
	indwelling catheter	nters the facility without an is not catheterized unless the ondition demonstrates that necessary;						
	indwelling catheter is assessed for rem as possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary						
I	1		I		1		1	

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		AND HUMAN SERVICES				FORM	APPROVED	
						MB NO. 0938-0391 (X3) DATE SURVEY		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION			
			/			(2	
		245028	B. WING			02/16/2017		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLAN	ND CHATEAU HEALTH	H CARE CENTER			319 WEST SEVENTH STREET AINT PAUL, MN 55116			
		TEMENT OF DEFICIENCIES	15	3	PROVIDER'S PLAN OF CORRECTION	1	()(5)	
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE	DAIL	
			1					
F 315	Continued From pa	ge 17	F3	315				
	and							
	(iii) A resident who i	is incontinent of bladder						
		e treatment and services to						
	prevent urinary trac	t infections and to restore						
	continence to the ex	xtent possible.						
	(3) For a resident w	ith fecal incontinence, based						
		mprehensive assessment, the						
		that a resident who is I receives appropriate						
		ces to restore as much normal						
	bowel function as p							
	by:	NT is not met as evidenced						
	Based on observat	ion, interview, and record			Resident #37 bowel and bladder ca	are		
		ailed to ensure 1 of 4 residents			plan and assessment was reviewed	and		
		urinary incontinence was ecessary treatment and			updated.			
		e urinary incontinence and			All residents may be affected, but n	one		
	improve bladder fur	nction.			show an ill effect.			
	Findings include:				All residents at risk for incontinence reviewed to ensure they are received			
					necessary treatment/services to pre-	0		
		49 a.m. to 10:38 a.m., a total			incontinence.			
		ninutes, R37 was not observed the toilet or checked for			Nursing staff has been educated or	ı		
	urinary incontinence				providing the appropriate care to re			
	At 7.41 am D27 w	as in bed and nursing			the risk for incontinence.			
		ked R37 about changing the			Audits will be conducted three times	s		
	incontinent pad, wh	ich NA-A stated was wet. R37			weekly to ensure care is provided to	o those		
		ericare a new incontinent pad a.m. R37 requested of NA-A			at risk for incontinence.			
		A-A assisted R37 to the toilet			It is the responsibility of the Directo	r of		
	and R37 voided. B	efore being weighed, at 10:38			Nursing/designee to ensure complia	ance.		
	a.m., NA-A asked F however R37 declir	R37 about using the toilet,			Audit to be reviewed at QAPI for the			
		ICU.			months to ensure adherence to pol being followed.	icy is		

Facility ID: 00494

		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED : 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
245028			B. WING			02/16/2017			
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 315	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	315	Deficient practice to be corrected by 3/28/2017	y			
	was requested and	at 11:58 a.m. was provided by							

Facility ID: 00494

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				PLE CONSTRUCTION		. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	(X3) DATE SURVEY COMPLETED			
				С		
		B. WING _		02/16/2017		
				STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET		
HIGHLA				SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315 F 323 SS=E	 2/7 to 2/9/17, howe were blank with no pointed out, RN-B s not having time to a The facility's 11/16, Bladder Manageme who was incontiner appropriate treatme urinary tract infection the extent possible. The policy also indibladder tracking too incontinent resident in incontinence and was to be updated resident's bowel an preferences. 483.25(d)(1)(2)(n)(THAZARDS/SUPER (d) Accidents. The facility must enform accident haza (2) Each resident readent and assistance dev (n) - Bed Rails. The appropriate alternatibed rail. If a bed or must ensure correct. 	ealed data was collected from ver, many sections of the form data collection. When this was stated "Correct" and explained analyze the data. revised policy titled Bowel and ent-HDGR indicated a resident and services to prevent on and services to prevent on and "restore continence to " cated the three-day bowel and of was to be completed for ts with any significant change a person centered care plan and revised to include the d bladder needs, goals and 1)-(3) FREE OF ACCIDENT VISION/DEVICES usure that - vironment remains as free rds as is possible; and eceives adequate supervision ices to prevent accidents. e facility must attempt to use tives prior to installing a side or side rail is used, the facility et installation, use, and d rails, including but not limited	F 31			3/28/17

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP							APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03										
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,			(X3) DATE SURVEY COMPLETED					
245028		B. WING _			C 02/16/2017					
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE					
HIGHLAN	ND CHATEAU HEALTH	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 323	Continued From pa	ge 20	F 32	23						
	(1) Assess the resid from bed rails prior	lent for risk of entrapment to installation.								
		and benefits of bed rails with dent representative and obtain rior to installation.								
	(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced									
	by: Based on observation, interview and document review, the facility failed to ensure water temperatures in resident bathrooms and/or bathing rooms were maintained at a comfortable range. This had the potential to affect 16 residents identified by the facility on 2/16/17, at 12:10 p.m. as having diagnoses that included Alzheimer's, dementia or other related diagnoses of the 57 residents who resided in the facility.				Immediately upon recognition of th on 2/13/2017 ED/DON alert staff to any showers/tub baths until further	halt				
					All Residents maybe affected, but r show any ill effect.	none				
					Water lines were bled by turning all water on in each resident bathroom shower room to bleed out existing h	and				
	Findings include:				water from lines on 2/13/2017.					
	bathroom of room 1 warm to the touch b this time, water tem	p.m. the water in the 11 was noted to feel overly by two different surveyors. At peratures were tested with the			Called placed to plumber to service regulator by 2-14-2017, which was replaced evening of 2/14/2017.					
	utilizing a thermome the ED.	ED) and two surveyors eter provided and operated by			Written education given to mainten on acceptable water temperatures what to do when these are out of acceptable range.					
	areas on 2/13/17, to Fahrenheit (F).	s were noted in the following be greater than 120 degrees			Updated Log form to include accep ranges and actions needed if the w temperatures are out of range.					
	registered 132° (de	ter in room 104-west (W) grees) (F) using a laser heat d the water felt hot to the			Audit of water temperatures will be three times per week in alternating					

Facility ID: 00494

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		AND HUMAN SERVICES				FORM	03/20/2017 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SURVEY COMPLETED C	
245028			B. WING			02/16/2017	
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 21	F 3	23			
	touch. At 6:01 p.m. water in room 111-W registered at 110° F using the laser thermometer. The ED, who was testing the water, touched the water and stated "That's hotter than 110, I know my temperatures." The ED stated he was going to get a different thermometer, which he personally used when testing water temperatures, and compared the two thermometers. When the water in room 111-W was retested using the ED's thermometer, the water temperature registered at 125° F.				ensure appropriate temperatures a maintained.	re	
					It is the responsibility of the Director of Environment Services/designee to ensure compliance. Audits to be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice was corrected by 3/28/2017.		
	at 123.4°F with the	01 p.m. the water in room 105-W registered 3.4° F with the ED's thermometer and 107° h the laser thermometer.					
		p.m. the water in room 112-E registered 8° F. The ED stated "the gun needs ing"					
	at 126.4° F with the resident in the room fine. At this time the gun thermometer n	ter in room 114-E registered ED's thermometer. The In stated the water temp felt ED again stated the laser eeded to be recalibrated. All after this, were taken using ter.					
	at 124.2° F. The reshad not used the ba 239-E did, as it was	ter in room 240-E registered sident in room 240-E stated athroom, but the resident in a shared bathroom. The as not available for interview.					
		ter in room 228-E registered p.m. the water in the 2 East at 126.7°F.					

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		AND HUMAN SERVICES			FORM	APPROVED	
		& MEDICAID SERVICES				MB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
			/			(C
		245028	B. WING _			02/	16/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALTI	H CARE CENTER			19 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	0,	PROVIDER'S PLAN OF CORRECTION	<u></u>	(X5)
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
TAG	NEGOLATORT ON E		TAG		DEFICIENCY)		
			1				
F 323	Continued From pa	ge 22	F 32	23			
	At 6.25 n m the re	sident in room 221-CE stated					
		o quickly, but liked hot water.					
		ater in the bathroom of 221-CE					
	registered 125.3° F						
		ter in room 207-W registered					
		ed if the water temperature ED said it was still slowly					
		agine that if we left it running					
	it would continue to	slowly rise."					
	A review of water te	emperature logs from 1/17 and					
	2/17, revealed wate	er temperatures ranged from					
		F. The log indicated water taken once a day in different					
	areas of the facility.						
	At 7:04 mm the FD) stated the meintenence staff					
) stated the maintenance staff d there was a mixing valve					
	problem.						
	On 2/15/17 at 7:56	a.m. R37 was observed to					
		and cold water valves in the					
		e the nursing assistant was in					
		n asked how the water e stated it was "warmer than					
	average".						
F 329		DRUG REGIMEN IS FREE	F 32	29			3/28/17
SS=D	FROM UNNECESS	DART DRUGS					
		sary Drugs-General.					
		g regimen must be free from . An unnecessary drug is any					
	drug when used	. An annoocoodry aray is ally					
		oo (including duraliasta dura					
	(1) In excessive dos therapy); or	se (including duplicate drug					
	·						

Facility ID: 00494

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				MB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(-)	E SURVEY PLETED
				-		(C
		245028	B. WING			02/16/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ID CHATEAU HEALTH	H CARE CENTER		-	319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	,	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	< C	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
E 000		20					
F 329	Continued From pa	ge 23	F 3	29			
	(2) For excessive d	uration; or					
	(3) Without adequa	te monitoring; or					
	(4) Without adequa	te indications for its use; or					
		of adverse consequences lose should be reduced or					
		ns of the reasons stated in nrough (5) of this section.					
	483.45(e) Psychotro Based on a compre resident, the facility	hensive assessment of a					
	drugs are not given medication is neces	have not used psychotropic these drugs unless the ssary to treat a specific sed and documented in the					
	gradual dose reduc interventions, unles an effort to discontin This REQUIREMEN by: Based on documen facility failed to ensu	NT is not met as evidenced nt review and interview, the ure appropriate monitoring for 03, R129) reviewed for			Resident #103 behavior monitoring was implemented as soon as recog on 2/16/2017.	inized	
	Findings include:				Resident #129 has discharged from facility.	i the	

Event ID:D1B211

Facility ID: 00494

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		& MEDICAID SERVICES				OMB NO.	APPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONS		СОМ	E SURVEY PLETED
		245028	B. WING _				C 16/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER			ST SEVENTH STREET PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	-	F 32		logidante may be offected	hut nono	
	behaviors for R103	tor and document target			lesidents may be affected, v any ill effect.	but none	
	of the undated Med	ne facility on 9/25/16. Review lical Data Sheet in R103's noses of Alzheimer's and depression.		have and	esidents behavior monitorin been reviewed to ensure i appropriate target behavior	n place s listed.	
	and Paxil. The phys (milligrams) of Ativa	ed current orders for Ativan sician ordered 0.5 mg an to be given twice daily for her 0.5 mg Ativan to be given		there	esident's MAR reviewed to are no medications that a able from the pharmacy on	re3 not	
		ily. The physician ordered 20 r anxiety and depression.		proc	ing staff educated on prope edure for when medication able as prescribed.		
	Review of R103's c revealed a focus or medications Ativan disorder. Intervention required staff to mo- of target behavior s		be co that	ts of behavior monitoring sl onducted two times weekly they are in place with targe aviors.	to ensure		
	per facility protocol. Review of the Unne	the Unnecessary Drugs - Antipsychotic		times	ts of MAR will be complete s per week to ensure all me available per MD orders.		
	following requirements be quantitatively and the resident's media medication adminis	Drugs policy, last revised 4/09, revealed the ollowing requirement: "All target behaviors must be quantitatively and objectively documented in he resident's medical record and/or on the nedication administrative record, to monitor the effectiveness or the side effects of the antipsychotic."		Nurs Audi mon is be	the responsibility of the Dire sing/designee to ensure cor ts to be reviewed at QAPI f ths to ensure adherence to sing followed.	compliance. I for three	
	In an interview on 2/16/17, at 12:50 p.m., when asked where staff documented target behaviors, registered nurse (RN)-G said staff should document all behaviors on the Flow Record in the medication administrative record (MAR). RN-G continued that staff should always monitor behaviors, whether the medication was				cient practice to be correcte /2017	ed by	

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		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245028	B. WING			02/16/2017	
NAME OF	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER			2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	scheduled to be giv be given only as ne the MAR to find the saying "they have t through the records 1:05 p.m. RN-G sta one." RN-G created and Paxil, to monito behaviors for the Reco Review of the Reco Review revealed th reviewed R103's m The pharmacist wr staff to monitor for In an interview on 2 pharmacist confirm 2/14/17, and said s staff monitoring tar pharmacist confirm Medication Regime monitor target beha R129 did not recei orders. Review of R129's r was admitted to the diagnosis including intractable epilepsy spastic hemiparesi depression, obsess R129's medications armodafinil (Nuvigi mouth once daily.	ven at regular intervals, or to be ded. RN-G looked through a Flow Records for February, o be here." After looking s for R103's Flow Record, at ated, "I can't find the February d a new Flow Sheet for Ativan or and document target est of February. ord of Medication Regimen he pharmacist most recently redication regimen on 2/14/17. ote a short-hand comment for the Ativan. 2/16/17, at 4:28 p.m. the ned visiting the facility on the did not see evidence of get behaviors in February. The ned noting on the Record of an Review that staff needed to	F	329	9		

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		AND HUMAN SERVICES			F	NTED: 03/20/2017 ORM APPROVED 3 NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		245028	B. WING			C 02/16/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIA		
F 329 F 334 SS=D	given in the AM. The record had nurses 1/7/16 through 2/4/ letters NA written ut the back side of the record had nothing the director of nurs p.m., indicated the regarding what the medication was not expectation would the resident did not get explainednot being would call the phar information regardi staff. DON indicate was not delivered to should notify the fa- verified there was not R129 did not receive the physician, and the patient. The Do not notified in a tim receiving the medic Interview with regiss at 1:50 p.m., stated was not delivered to call the pharmacy. delivered she would physician. If the ph the request, she would physician. If the ph	edication was scheduled to be he medication administration initials circled every day from 16. Six of the days had the nderneath the signatures, and e medication administration written on it. Interview with ing (DON) on 2/15/17 at 12:51 facility did not have a policy procedure was for when a t available. DON indicated the be for the nurse to circle his or fy the physician of why the the medication. DON familiar with R129's case and macist to see if there was ng this and would also ask the d if a resident's medication by the pharmacy, the pharmacy cility. On 2/16/17 the DON no further information on why we the medications ordered by the current staff did not recall ON verified the physician was ely manner of the resident not cation. tered nurse (RN)-A on 2/15/17 I that if a resident's medication by the pharmacy, she would If the medication still wasn't d contact the resident's nysician was not responsive to puld contact the medical not know if there was a policy being available. ELUENZA AND	F 3			3/28/17	
	67(02-99) Previous Versions	Obsolete Event ID:D1B211		Facility ID: 00494		sheet Page 27 of 5	

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	E CONSTRUCTION	0MB NO. 0938-0391 (X3) DATE SURVEY	
-	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		045000	B. WING			С	
	PROVIDER OR SUPPLIER	245028	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	16/2017
NAME OF F	ROVIDER OR SUPPLIER				319 WEST SEVENTH STREET		
HIGHLAN	ND CHATEAU HEALTH	H CARE CENTER			SAINT PAUL, MN 55116		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLÉTION DATE
					DEFICIENCY)		
F 334	Continued From no	~~ 07	- -	~ 1			
Г 334	Continued From pa	ge 27	F 3	34			
	(d) Influenza and pr	neumococcal immunizations					
		acility must develop policies					
	and procedures to e	ensure that-					
		ne influenza immunization,					
		e resident's representative regarding the benefits and					
		is of the immunization;					
	(ii) Each resident is	offered an influenza					
	immunization Octob	per 1 through March 31					
		e immunization is medically he resident has already been					
	immunized during t						
		the resident's representative to refuse immunization; and					
	has the opportunity						
		nedical record includes					
	following:	indicates, at a minimum, the					
	(A) That the resider	nt or resident's representative					
	was provided educa	ation regarding the benefits					
	and potential side e immunization; and	ffects of influenza					
	(B) That the resider	nt either received the influenza					
	immunization or did	I not receive the influenza					
	immunization due to refusal.	o medical contraindications or					
	(2) Pneumococcal (disease. The facility must					
		d procedures to ensure that-					
	(i) Deferse offering the						
	(i) Before offering th	ie pheumococcal					

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		AND HUMAN SERVICES			RINTED: 03/20/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		245028	B. WING		02/16/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 334	 immunization, each representative received benefits and potent immunization; (ii) Each resident is immunization, unlear medically contrained already been immunity (iii) The resident or has the opportunity (iv) The resident's redocumentation that following: (A) That the resident was provided education and potential side eximmunization; and (B) That the resident or This REQUIREMET by: Based on interview facility failed to ensireviewed for immunity for the Prevner Findings include: The Center for Dise (CDC) identified, "Awho have not previous provided in the previous of the previo	 a resident or the resident's sives education regarding the ial side effects of the offered a pneumococcal so the immunization is licated or the resident has nized; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the and or resident's representative ation regarding the benefits effects of pneumococcal ant either received the nunization or did not receive immunization due to medical refusal. NT is not met as evidenced <i>v</i> and document review, the ure 1 of 5 residents (R89) nizations was offered and 	F 334	Resident #89 has received the Pre 13 vaccine as previously requested All residents may be affected, but n show any ill effect. All other resident's immunization re were reviewed to determine if resid received the Prevnar 13 vaccine. Residents who request Prevnar 13	ione cords ent

Facility ID: 00494

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY PLETED
		245028	B. WING			C 16/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334 F 353 SS=F	Valent Vaccine] sho The dose of PCV13 year after receipt of dose." R89's Consent for R89 on 10/18/1, ide to receive a Prevna had no documenter been offered or add R89's medical reco any evidence of R8 provided the PCV- CDC. Review of R8 admitted to the faci the consent on 10/ On 2/16/17, at 11:1 (DON) verified R89 Prevnar 13 immuni the immunization. 483.35(a)(1)-(4) SU STAFF PER CARE 483.35 Nursing Set The facility must has the appropriate cor provide nursing and resident safety and practicable physica well-being of each resident assessme and considering the	coccal polysaccharide 23 puld receive a dose of PCV13. 3 should be given at least 1 f the most recent PPV23 Immunizations form, signed by entified R89 as giving consent ar 13 immunization, however d evidence the PCV13 had ministered. Ind was reviewed and lacked 9 having been offered or 13 as recommended by the 39's face sheet indicated R89 lity on 7/15/16, and completed 18/16 0 a.m., the director of nursing had given consent for the zation, and had not received UFFICIENT 24-HR NURSING PLANS	F 334	received the vaccine. Audits of staff offering Prevnar 13 w done with each admission. The Director of Nursing/designee is responsible for compliance. Audits to be reviewed at QAPI for th months to ensure adherence to this is being followed. Deficient practice to be corrected by 3/28/2017	nree s policy y	3/28/17

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		AND HUMAN SERVICES			RINTED: 03/20/201 FORM APPROVED MB NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		245028	B. WING		02/16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
HIGHLAN	ID CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 353	 be implemented be (Phase 2)] (a) Sufficient Staff. (a) (1) The facility m sufficient numbers of personnel on a 2 nursing care to all r resident care plans (i) Except when was this section, licensed (ii) Other nursing performed by the section, licensed (iii) Other nursing performed by the section, the face nurse to serve as a duty. (a) (2) Except when this section, the face nurse to serve as a duty. (a) (3) The facility m nurses have the sp sets necessary to c identified through redescribed in the plate (a) (4) Providing car assessing, evaluation resident care plans needs. This REQUIREMENT by: Based on observation review, the facility for were available to measure to measure to measure to measure to measure to measure the second the se	y Assessment, §483.70(e), will ginning November 28, 2017 hust provide services by of each of the following types 4-hour basis to provide esidents in accordance with : ived under paragraph (e) of ed nurses; and ersonnel, including but not es. waived under paragraph (e) of ility must designate a licensed charge nurse on each tour of nust ensure that licensed ecific competencies and skill are for residents' needs, as esident assessments, and an of care. re includes but is not limited to ng, planning and implementing and responding to resident's NT is not met as evidenced tion, interview and document ailed to ensure enough staff eet the needs of residents	F 353	DON will monitor daily nursing statensure sufficient staff is provided.	
	residing in the facili	ty. This affected 9 of 9		All Residents may be affected, but	none

Facility ID: 00494

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		TIDI	O	FORM MB NO.	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245028	B. WING				, 16/2017
	PROVIDER OR SUPPLIER	H CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	residents (R3, R96 R130, R19) and har residents in the fac Findings include: During stage one re following complaint insufficient staffing: On 2/13/17, at 7:00 with a smell of urine admission Minimur 8/25/16, indicated F stated "Since I have floor, it is almost im indicated wanting to about a month or tw completely full, they nurse and one nurs are too busy, we ca wanna get up too!" button for assistant around 9:00 a.m. th to assist with cares assistant came into yelled, stating there not just you! R3 stated explained just want stated the director about it and the DC but there had been stated the physicial independently trans assist of two, and st time. On 2/13/17, at 7:04	, R51, R81, R37, R126, R73, ad the potential to affect all 57 illity. esident interviews, the ts were made regarding facility	F	353	show any ill effect. Education provided to staffing depa on proper staffing levels; problem s calling in; and hours reduction when needed. Interviews with residents will be dor days per week to ensure care need being met to their specifications. Audits of call lights will be done 3 da week. It is the responsibility of the Director Nursing/designee to ensure complia Audits will be completed and review QAPI for three months to ensure su staff is provided. Deficient practice to be corrected by 3/28/2017	olving n s are ays per r of ance. ved at ufficient	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245028	B. WING				C 16/2017
NAME OF I	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	"not nearly." R96's 12/9/16, indicated F stated there was on nurse working both further indicated sta 10:00 p.m. and bus afternoons. On 2/13/17, at 7:04 light response, R51 should respond to the R51's quarterly MD R51 was cognitively come into the room leave, stating they Sometimes it took of light assistance. R5 change or during m any assistance, wh In an interview on 2 stated should have a.m. but nursing as 10:45 a.m. R81's q indicated R81 was they were short stathad not been fully s During an interview licensed practical m unable to get every when some duties previous shift. LPN	hout waiting a long time stated admission MDS dated R96 was cognitively intact. R96 he nursing assistant and one east and west units. R96 affing was the worst after siest in the mornings and 4 p.m. when asked about call 1 stated nursing assistants the call light within 10 minutes. 9S dated 12/22/16, indicated y intact. R51 stated staff would h, turn off the call light and would return or were busy. one-half to one hour for call 51 further stated during shift heal service R51 could not get ich happened frequently. 2/13/17, at 7:06 p.m. R81 received a shower at 9:15 ssistant did not come until uarterly MDS dated 12/29/16, cognitively intact. R81 stated ffed at least once a week and staffed the past day or two. 4 on 2/14/17, at 3:08 p.m. hurse (LPN)-C stated was thing done during the shift had been carried over from the -C stated was often asked to nee or twice a week and was	F 3	53			
	During an interview	v on 2/15/17, at 12:12 p.m. NA)-D stated sometimes was					

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		AND HUMAN SERVICES				FORM	03/20/2017 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245028	B. WING				16/2017	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET			
				3	AINT PAUL, MN 55116 PROVIDER'S PLAN OF CORRECTIC	NI.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 353	Continued From pa	age 33	F 3	53				
	•	k done during shift and passed						
	it on to the next shi	ift. NA-D further stated they						
		now, had been for about eight o adjust the work load to						
	complete duties. N	A-D stated was burned out,						
		looking for jobs elsewhere.						
		d when new nursing assistants y don't like the heavy workload,						
	so there is huge sta							
	During on intonviou	v on 2/15/17, at 12:30 p.m.						
		n they were short staffed, the						
	work load was cha	llenging, and would fall behind						
		and work extra hours. LPN-D ve a full-time health unit						
		ess physician orders. LPN-D						
		ere was a facility nursing						
	During an interview	v on 2/15/17, at 12:39 p.m.						
		vere short staffed and were						
		neavy care workload was time 20 to 30 minutes per resident						
		were experienced could you						
	get work done with	in the allotted timeframe.						
	During an interview	v on 2/16/17, at 9:03 a.m. NA-F						
	stated every week	they were short staffed, most						
		ee nursing assistants or t should have four. NA-F						
	· · · · · · · · · · · · · · · · · · ·	en happening for about three						
	years and year end	was the worst. When new						
		taff starts, they will see the						
		d work load and leave. NA-F day last week lunch trays sat						
		staff could distribute them and						
	they had to heat the	em up to serve the meal. NA-F						
		taff schedule listed four						
	nursing assistants	but only three were working.						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL		OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:				`́сом	PLETED
		245028	B. WING _				C 16/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HIGHLA	ND CHATEAU HEALTI	H CARE CENTER			319 WEST SEVENTH STREET		
		TEMENT OF DEFICIENCIES		3	AINT PAUL, MN 55116 PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 34	F 3	53			
	NA-G felt they need the first floor, was in budget, but we have here. NA-G indicate duties during the sh every two hour chee Residents were left time for cares. NA-0 to complete duties, may leave other dur During an interview (DON) on 2/16/17, a call light report may sometimes staff wo when they were in a they had the call lig would talk to them a nurse managers an pagers to assist wit stated they had call ago, pulled call light pagers. DON indicat tool, had not audited basis, but would do During an interview 2:03 p.m. DON stat long-term care units transitional care units	with the director of nursing at 1:57 p.m. DON stated the					

Facility ID: 00494

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		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		PLE CONSTRUCTION G	CON	E SURVEY IPLETED
		245028	B. WING	ì			/16/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER			2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 353	1/14/2017 to 2/15/2 times. Included bellights remained on 2/10/17, for 78 min 2/9/17, for 71m, 25 2/3/17, for 70m, 46 2/12/17, for 70m, 11 2/1/17, for 69m, 11 2/8/17, for 69m, 11 2/8/17, for 67m, 44 2/8/17, for 62m, 36 2/5/17, for 62m, 36 2/5/17, for 62m, 38 2/10/17, for 59m, 3 2/10/17, for 59m, 3 2/10/17, for 57m, 8s 2/10/17, for 55m, 46 2/14/17, for 55m, 12 2/9/17, for 55m, 2s 2/9/17, for 55m, 2s 2/9/17, for 55m, 2s 2/9/17, for 55m, 2s 2/9/17, for 50m, 12 2/2/17, for 49m, 57 2/9/17, for 49m, 47 2/2/17, for 49m, 47 2/2/17, for 49m, 47 2/2/17, for 49m, 16 The call light policy requested, but not 10 On 2/15/17, from 7 of 2 hours and 49 r to be asked to use urinary incontinenc	ty's device activity report from 2017 p.m. listed call light reset ow are 23 times when call over 49 minutes. utes (m), 19 seconds (s) s s 6s s s s s s s s s s s s s s s s	F	353	3		
		as in bed and nursing sked R37 about changing the					

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				DMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
			A. BOILD	iii d		(С	
		245028	B. WING			02 / ⁻	16/2017	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHLA	ND CHATEAU HEALTI	H CARE CENTER			2319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION DATE	
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)			
			1					
F 353	Continued From pa	-	F 3	353				
		ich NA-A stated was wet. R37						
		ericare a new incontinent pad a.m. R37 requested of NA-A						
	to use the toilet. NA	-A assisted R37 to the toilet						
		efore being weighed, at 10:38 R37 about using the toilet,						
	however R37 declir							
		ne worked on the first floor, was not often, he could get his						
		his breaks. However, he						
		econd floor and it was hard to						
	get the work done a	and take breaks.						
		ded with incontinence care						
		2/15/17, from 9:51 a.m. to 3 hours and 59 minutes.						
	1.50 p.m. a total of	S hours and 59 minutes.						
		a.m. R126 was observed						
		es. At 9:37 a.m. R126's was removed and noted to be						
		also incontinent of bowel. The						
		was verified by nursing						
		no was providing incontinence						
		or R126. At 10:12 a.m. R126						
	was gotten out of be	ed via a mechanical lift and						
		sferred into a wheelchair. At						
		as served lunch in their room 5 p.m. the lunch tray was						
	picked up. R126 rei	mained up in the wheelchair						
	without being check incontinence.	ked for urinary or bowel						
	incontinence.							
		stated her shift ended at 2:00						
		d R126 had not been checked ence and repositioned for over						
		verified the last time R126 had						
		ladder and bowel incontinence						

If continuation sheet Page 37 of 52

		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED : 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		245028	B. WING			C 02/16/2017		
NAME OF	PROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER			2319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 353	and repositioned w stated R126 was or repositioning scheo not get all their wor did not get to take b transferred back to and two staff. The i be wet, and the cor during incontinence over area was note small open area wa near the coccyx. A review of 12/8/16 minutes revealed re about facility staffin On 2/16/17, at 11:1 attended resident c staffing issues were as were bedtime sr puts snacks out on every night and who people working on four, snacks were r able to go to the nu snack, as could sev were some who we nursing desk indep R73 stated at 11:19 discussed and the acknowledged the i "fairly" often when t the second floor. On 2/16/17, at 2:41 and FM-C stated R	as during morning cares. NA-A n an every two hour dule, but sometimes staff could k done and sometimes staff preaks. At 1:50 p.m. R126 was bed via the mechanical lift ncontinent pad was noted to ndition of the pad was verified e care by NA-A. A dry scabbed d on R126's left buttock and a as noted in the buttock crevice, d, resident council meeting esidents were concerned g. 0 a.m. R73 who frequently council meetings, stated e brought up at every meeting, nacks. R73 stated the kitchen the nursing desk counter en there were only three the second floor instead of not passed. R73 stated being mising desk and get their veral other residents, but there ere not able to get to the	F3	353				

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		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245028	B. WING				/16/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353 F 356 SS=C	FM-B and FM-C sta facility on 2/12/17, a shower every day. It told R130 would ge did not happen. The the shower would h did not receive a sh FM-C stated they w not had a shower. If there was one night on all night. The director of nurse R130 had received speaking with the s registered nurse (R incident report to in received a shower of Interview with R19's p.m., indicated R19's receive assistance R19's family explain the need to use the being incontinent of come to assist R19 help. R19's family in in the building more the residents. 483.35(g)(1)-(4) PC INFORMATION 483.35 (g) Nurse Staffing II (1) Data requirem	eding to use the restroom. ated R130 was admitted to the and had for R130 to have a FM-B and FM-C stated being t a shower on 2/14/17, but that en FM-B and FM-C were told happen on 2/15/17, but R130 hower on that date. FM-B and rere never told why R130 had FM-B and FM-C also stated t when staff left R130's clothes ess (DON) stated at 3:30 p.m. a shower when the family was urveyor. The DON stated N)-B had completed an vestigate why R130 had not on either 2/14 or 2/15/17. Is family on 2/13/17 at 5:15 has waited 20 - 30 minutes to to go to the bathroom lately. hed that R19 could tell staff of toilet and that R19 reported f urine because staff did not when family was not there to ndicated when the State was e staff were available to assist DSTED NURSE STAFFING	F 3				3/28/17
	67(02-99) Previous Versions	Obsolete Event ID: D1B211	<u> </u>	_	bility ID: 00494		Page 20 of 52

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED C	
		245028	B. WING				16/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HIGHLAN	ND CHATEAU HEALTI	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE	
F 356	Continued From pa	ae 30	F 3	56				
1 000	(i) Facility name.	ge oo	ГJ	000				
	(ii) The current date).						
	(iii) The total numbe	er and the actual hours worked						
	by the following cate	egories of licensed and						
	resident care per sh	staff directly responsible for hift:						
	(A) Registered nurs	es.						
		cal nurses or licensed as defined under State law)						
	(C) Certified nurse	aides.						
	(iv) Resident censu	S.						
	(2) Posting requirer	nents.						
	specified in paragra	post the nurse staffing data uph (g)(1) of this section on a eginning of each shift.						
	(ii) Data must be po	osted as follows:						
	(A) Clear and reada	able format.						
	(B) In a prominent presidents and visito	blace readily accessible to rs.						
	The facility must, up make nurse staffing	o posted nurse staffing data. Son oral or written request, data available to the public not to exceed the community						
	(4) Facility data rete	ention requirements. The						

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		AND HUMAN SERVICES			FORM	03/20/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245028	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 356	facility must mainta staffing data for a n required by State la This REQUIREMEN by: Based on observati interview, the facilit nurse staffing inform hours worked by lic 2 of 2 days reviewe potential to affect fa residents residing a Findings include: Observations of the 2/11/17, and 2/12/1 the actual number of licensed and unlice During the initial fac approximately 11:55 staffing posting date posted on the lobby receptionist desk. T facility, the date, ce unlicensed staff, sh shifts as day, eveni During an interview Human Resources pattern was determ staffing schedule and daily staff posting. Review of Punch D 2017/01/11-2017/02	in the posted daily nurse hinimum of 18 months, or as w, whichever is greater. NT is not met as evidenced tion, document review, and y failed to post the required mation to include the actual ensed and unlicensed staff for id. This practice had the amily, staff, visitors and all 57 at the facility. e posted staffing forms dated 7, lacked documentation for of staff shift hours worked by nsed staff at the facility. cility tour on 2/13/17, at 5 a.m., the facility nurse ed 2/13/17, was observed y wall near the first floor The form identified the name of nsus, number of licensed and ift hours, and identified the ng and night. f on 2/16/17, at 1:20 p.m. the Director (HRD) stated staffing ined by looking at daily and matching it to the posted etail - Report Nursing dated 2/12 revealed staff shift hours osted shift hours dated 7.		 Posting during survey were up reflect the actual hours worked licensed and unlicensed person All resident may be affected, bu show any ill effect. Education provided to staffing of on the expectations that the por reflect actual hours worked by and unlicensed personnel, incluchanges that may occur during Audits of postings will be done per week to ensure accuracy of hours worked. The Director of Nursing/Staffing Coordinator is responsible to as compliance. Audits to be reviewed at QAPI fmonths to ensure adherence to is being followed. Deficient practice to be corrected 3/28/2017 	by nnel. ut none department sting licensed uding any that day. three times f posting of g ssure for three o this policy	

		AND HUMAN SERVICES			FORM): 03/20/2017 1 APPROVEE 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	CON	TE SURVEY MPLETED C
		245028	B. WING			/16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE		
HIGHLAN	ID CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 356	Continued From pa	age 41	F 356	5		
	indicated: Staff worked: 2 RN, 2 LPN, 5 CN 6:00 - 10:00 pm. Actual staff worked 1 RN, 3 LPN and 4 CNA 6:00 - 10:00 p This indicated 1 CN Posted nurse staffi indicated: Staff worked: 2 RN, 2 LPN, 5 CN 4:00 - 10:00 p.m. a Actual staff worked 2 RN, 2 LPN, 4 CN 4:00 - 10:00 p.m. a This indicated 1 CN During an interview HRD verified the ac nursing staff at the lacking. HRD state hours worked shou staff on the posted further stated going	CNA 2:00 - 10:00 p.m. and 1 o.m. NA was lacking 2/11/17. ng form dated 2/12/17, IA 2:00 - 10:00 p.m., 1 CNA and 1 CNA 2:00 - 8:00 p.m.				
F 412 SS=D	requested, but not	ROUTINE/EMERGENCY	F 412	2		3/28/17
	(b) Nursing Facilitie					

Facility ID: 00494

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CENTEF STATEMENT	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		FORM MB NO. (X3) DATE	03/20/2017 APPROVED 0938-0391 E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		245028	B. WING				6/2017
	PROVIDER OR SUPPLIER	H CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	Continued From pa The facility-	ge 42	F 4	12			
	resource, in accord	or obtain from an outside ance with §483.70(g) of this lental services to meet the dent:					
	(i) Routine dental so under the State pla	ervices (to the extent covered n); and					
	(ii) Emergency dent	tal services;					
	(b)(2) Must, if neces the resident-	ssary or if requested, assist					
	(i) In making appoi	ntments; and					
	(ii) By arranging for dental services loca	transportation to and from the ations;					
	wish to participate t dental services as a under the State pla	esidents who are eligible and o apply for reimbursement of an incurred medical expense n. NT is not met as evidenced					
	Based on observat review, the facility f	tion, interview and document ailed to ensure 1 of 3 residents appropriate dental services to g dentures.			Resident #37 has an appointment dentist for services on dentures. All Residents maybe affected, but r		
	Findings include:				show any ill effect. All residents were assessed for pre of dental problems and need for de		
	edentulous (without was noted to be so bathroom. On 2/14/ observed wearing t	p.m. R37 was observed to be t teeth) and a set of dentures aking in a denture cup in R37's (17, at 3:35 p.m. R37 was he upper denture, but not the denture was in a denture cup			Staff have been educated on communicating the need for dental for residents who present with dent problems.	care	

Facility ID: 00494

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED	
		245028	B. WING					
	PROVIDER OR SUPPLIER	243020	D. 11110 _		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	16/2017	
	ND CHATEAU HEALT	H CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 412	assistant (NA)-A cle 8:03 a.m. offered th placement. R37 sta want" and grabbed atteempted to put if gagged. NA-A assis denture. R37 then to placed adhesive on the denture in mour At 8:08 a.m. R37 w to wear the lower of and it did not fit. R3 a chance and he is On 2/14/17, at 12:4 stated R37 tells FM uncomfortable; and could not be adjust FM-A stated R37 co not want to put the not be wearing the R37 BIMS (brief int score from the mos set) dated 12/11/16 indicating some cos On 2/14/17, at 3:44 like to wear the low the dentures did not On 2/15/17, at 10:2 (RN)-A stated some dentures and some	n 2/15/17, at 7:30 a.m. nursing eansed R37's dentures; and at he dentures to R37 for ated "these are the only one's I the lower denture and t in the top of his mouth and sted R37 with removing the took the correct denture, in the upper denture and placed th. vas asked why he did not want enture and stated having tried denture on and off for a month 87 stated people said to give it done giving it a chance. 46 p.m. family member (FM)-A 1-A the dentures are 4 FM-A told R37 the dentures ed until they are worn more. ould be "difficult" and if R37 did dentures in, then R37 would dentures. erview for mental status) st recent MDS (minimum data 5, was recorded as "10" gnitive impairment. 4 p.m. NA-B stated R37 did not ver denture and R37 had stated ot fit. 28 a.m. registered nurse etimes R37 would wear the etimes not.	F 4	12	Audits will be conducted weekly wit conferences. It is the responsibility of the Directo Nursing/designee to assure compli Audits will be reviewed at QAPI for months to ensure adherence to pol followed. Deficient practice to be corrected b 3/28/2017	or of ance. three licy is		
	On 2/16/17, at 8:55	a.m. RN-A said R37 had						

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		AND HUMAN SERVICES			FORM	: 03/20/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245028	B. WING			0 16/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 412		ge 44 lower denture did not fit.	F 412	2		
F 431 SS=E	On 2/16/17, at 8:50 manager (HIM)-A s medical record and the dentist since firs 8/24/16. HIM-A stat documentation that prior to admission. HIM-A provided doo clinic which indicate dentures for the firs documentation obta revealed R37 had b dentures, especially well and causing dia notes revealed den done on 7/26, 7/28 returned to the dem adjustments despite staff members the I The facility's 11/16, Service (General) in provide or obtain fro routine and emerge the needs of each r 483.45(b)(2)(3)(g)(h LABEL/STORE DR The facility must pro drugs and biological them under an agre §483.70(g) of this p unlicensed personn	a.m. the health information tated she had reviewed the found R37 had not been to st admitted to the facility on ed she had been able to find R37 had dental appointments cumentation from a dental ed R37 had received new st time on 7/26/16. Additional ained from the dental clinic been complaining of the y the lower denture, not fitting scomfort. The dental progress ture adjustments had been and 8/2/16. R37 had not tal clinic for additional denture e telling FM-A and other facility ower denture did not fit. revised policy titled Dental ndicated the facility was to om an outside resource, ency dental services to meet resident. n) DRUG RECORDS, UGS & BIOLOGICALS ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit hel to administer drugs if State by under the general	F 431			3/28/17

Facility ID: 00494

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		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			PLETED
		245028	B. WING				5 16/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET		
HIGHLAN	HIGHLAND CHATEAU HEALTH CARE CENTER				AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 45	F 4	31			
	pharmaceutical ser that assure the acc dispensing, and adu	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident.					
		ation. The facility must e services of a licensed					
	disposition of all co	vstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and					
	that an account of a	drug records are in order and all controlled drugs is iodically reconciled.					
	labeled in accordan professional princip appropriate access	als used in the facility must be ice with currently accepted iles, and include the					
	the facility must sto locked compartmer	with State and Federal laws, re all drugs and biologicals in hts under proper temperature t only authorized personnel to					
	permanently affixed controlled drugs list	t provide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and					

					OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED
		245028	B. WING _			C 16/2017
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 431	Continued From pa	age 46	F 43	1		
	abuse, except whe package drug distri quantity stored is m be readily detected This REQUIREMEN by: Based on observar review, the facility f medications were m given to residents. (R53) and had the residents on 2 wes stock medications. Findings include: During medication for 7:10 p.m. in the 2 w following expired st observed. Licensed confirmed expiratio medications from the	storage review on 2/13/17, at who may have been given storage review on 2/13/17, at west medications were d practical nurse (LPN)-B on dates and removed tables to cart for destruction.		Identified expired medication wa removed from circulation and de according to procedure. All Residents may be affected, b show any ill effect. All medications were audited to a more expired medication were in circulation. Staff educated on looking for exp dates and discarding medication are expired. Audits will be conducted three tin week. it is the responsibility of the Direct	stroyed ut none ensure no piration s if they nes per	
	with pharmacy labe and manufacturer I - Bottle of ½ full ma with pharmacy labe manufacturer label - Bottle of ¾ full cal 600/200mg tablets date of 8/17/16, an expiration date. - Full bottle of mine expiration date of 6 expiration date of 1 - Bottle of loperami	el expiration date of 3/25/15, abel expiration date of 2/17. agnesium oxide 400mg tablets el expiration date of 3/7/15, and expiration date of 10/16. licium with vitamin D with pharmacy label expiration d illegible manufacturer eral oil with pharmacy label i/10/16, and manufacturer label		Nursing or designee to ensure compliance. Audits will be reviewed at QAPI t months to ensure adherence to followed. Deficient practice to be corrected 3/28/2017	or three policy is	

Facility ID: 00494

If continuation sheet Page 47 of 52

		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED C
		245028	B. WING				16/2017
NAME OF	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	date. One box of ipratrop sulfate was observe unopened vials with date of 10/3/16, and of 1/17. F53's signed physic 1/16/17, included "i vial per neb 4 times verified expiration of the medication cart Review of R53's Fe administration reco received the medic 2/6/17, 2/9/17 and t During interview wit (DON) on 2/14/17, expired medication medication cart. DO pharmacist stated r should be used, no date. Review of the facilit Pharmacy Disposit policy revealed: "10 deteriorated medica that are cracked, so secure closures are stock, disposed of a procedures for medication	anufacturer label expiration bium bromide and albuterol ed which contained 16 in a pharmacy label expiration d manufacturer expiration date cian medication orders dated pratropium/sol albuter inhale 1 is daily as needed". LPN-B date and removed the box from the director of the box from the director of nursing at 3:41 p.m. DON stated is should not be stored in the DN further indicated the manufacturer expiration dates t the pharmacy label expiration ty's undated Merwin LTC ion of Unused Medications 0. Outdated, contaminated or ations and those in containers piled, unlabeled or without e immediately removed from	F 4	31			

Facility ID: 00494

If continuation sheet Page 48 of 52

		AND HUMAN SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED C
		245028	B. WING				16/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 48	F4	41			
F 441 SS=D	483.80(a)(1)(2)(4)(e PREVENT SPREA	e)(f) INFECTION CONTROL, D, LINENS	F4	41			3/28/17
	(a) Infection preven	tion and control program.					
		tablish an infection prevention n (IPCP) that must include, at owing elements:					
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	l upon the facility assessment ng to §483.70(e) and following tandards (facility assessment					
		ds, policies, and procedures hich must include, but are not					
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the					
		om possible incidents of ase or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including I	isolation should be used for a out not limited to:					

If continuation sheet Page 49 of 52

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/20/2017 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED C
		245028	B. WING				16/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstan- must prohibit emplo- disease or infected contact with resider contact with resider contact will transmit (vi) The hand hygie by staff involved in (4) A system for required under the facility's actions taken by th (e) Linens. Person process, and trans- spread of infection. (f) Annual review. annual review of its program, as necess This REQUIREMED by: Based on observar review, the facility f handwashing durin (R37, R126) review who were observed Findings include: On 2/15/17, at 7:35	uration of the isolation, e infectious agent or organism that the isolation should be the ssible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct its or their food, if direct it the disease; and ene procedures to be followed direct resident contact. cording incidents identified IPCP and the corrective e facility. unel must handle, store, port linens so as to prevent the sary. NT is not met as evidenced tion, interview, and document failed to ensure proper g cares for 2 of 4 residents ved for urinary incontinence,	F 4	141	NA-A was educated on proper hand-washing techniques. All residents may be affected, but r show any ill effect. Staff have been educated on proper hand-washing technique to provide safe and sanitary environment. It is the responsibility of the Director	er ed a	

Facility ID: 00494

If continuation sheet Page 50 of 52

			()(0) 1411			0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	`´CON	E SURVEY IPLETED
		245028	B. WING		C 02/16/2017	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 441	gloves. Perineal ca had been incontine incontinent product completion of perin gloves, and without new pair of gloves a and sit up in bed. A need to use the toil and without washin gloves and assisted voiding on the toilet the wheelchair by N gloves. Without wa new pair of gloves a with putting denture On 2/15/17, during R126 was observed amount of stool. W cleansed R126's sk cleansing R126, NA donned a new pair handwashing, and R126's buttocks. At removed the gloves handwashing and a R126. At 9:45 a.m. while k again incontinent or removed R126's so R126's lower extrent data and a set of R126's lower extrent at 9:49 a.m. NA-C	hands and then don a pair of re was provided to R37, who nt of urine and who wore s. NA-A verified R37's had been wet with urine. After eal care NA-A removed the twashing hands, donned a and helped R37 put on shoes t 7:49 a.m. R37 indicated the et. NA-A removed the gloves g hands donned a new pair of d R37 to the toilet. After t R37 was assisted back into JA-A and then NA-A removed shing hands, NA-A donned a and proceeded to assist R37 es in. morning cares at 9:37 a.m. d to be incontinent of a small hile wearing gloves NA-A kin with disposable wipes. After A-A removed the gloves,	F 44	1 Nursing/designee to ensure comp Audits will be conducted three tim week and results reviewed at QA three months to ensure adherence policy. Deficient practice to be corrected 3/28/2017	nes per PI for ce to this	

If continuation sheet Page 51 of 52

		AND HUMAN SERVICES			FORM	03/20/2017 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COM	E SURVEY PLETED
		245028	B. WING			C 16/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
HIGHLA	ND CHATEAU HEALTI	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	having helped NA-C lower extremities, N and without handwa gloves and began of bowel incontinence gloves after cleansi hands before puttin assisting NA-C with At 9:56 a.m. NA-A t trash can, tied the b on R126's wheelchait the gloves, perform NA-C with transferr wheelchair. On 2/15/17, at 1:50 to bed and was not and stool. The inco Prior to incontinent perform handwashi clean gloves. After removed the soiled handwashing donne placing a new and of beneath R126. The facility's 4/1/08 and Gloves, Non-Si wash their hands at contact for which ha accepted profession that were contamin standard precaution	of gloves. At 9:51 a.m. after C put R126's pants on the IA-A removed a pair of gloves ashing donned a new pair of cleansing R126's skin after the . NA-A removed the soiled ing R126, but did not wash g on a new pair of gloves and a the rest of R126's dressing. ook the trash bag out of the bag and placed the trash bag air seat. NA-A then removed ed handwashing and assisted ing R126 from the bed to p.m. R126 was assisted back ed to be incontinent of urine ntinence was verified by NA-A. care NA-A was observed to ng prior to donning a pair of cleansing R126's skin NA-A gloves and without ed a new pair of gloves before clean incontinent product , policy titled Hand Washing terile indicated staff were to fter each direct resident and-washing was indicated by nal practices; and that gloves ated with body fluids for which ns applies, were to be s possible and hands were to	F 441			

Facility ID: 00494

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		AND HUMAN SERVICES	F	5028027	PRINTED: 03/21/2017 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245028	B. WING		02/14/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET	
				SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMPLETION
к 000	INITIAL COMMEN	rs	K 00	0	
	FIRE SAFETY				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.			
12	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departn time of this survey, Center was found r requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC),			
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	R THE FIRE SAFETY		EPOC	
	HEALTHCARE FIR STATE FIRE MAR 445 MINNESOTA ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145			
	Or by email to:				
	y DIRECTOR'S OR PROVII	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE 03/17/2017

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.

	OF DEFICIENCIES	& MEDICAID SERVICES			AB NO: 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	· /	01 - MAIN BUILDING 01	COMPLETED
		245028	B. WING		02/14/2017
	PROVIDER OR SUPPLIER	H CARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
K 000	Marian. Whitney@s Angela.Kappenman THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the deficient 2. The actual, or pr 3. The name and/or responsible for corresponsible for cor	A state.mn.us and m@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. If title of the person rection and monitoring to ence of the deficiency. Healthcare Center is a 2-story ial basement. The building was ferent times. The original ructed in 1963 and was f Type II(222) construction. In was constructed to the south that was determined to be of uction. Because the original ditions meet the construction isting buildings, the facility was uilding. sprinkler protected throughout. omplete fire alarm system with the corridors and spaces r and resident rooms, that is matic fire department cility has a licensed capacity of census of 57 at the time of the	K 000		
	The requirement at NOT MET as evide	t 42 CFR Subpart 483.70(a) is enced by:			

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				. 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		MPLETED
		245028	B. WING		02	/14/2017
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IIGHLAN	ND CHATEAU HEALT	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 211 SS=F	NFPA 101 Means o Means of Egress -	-	K 21 [,]	1		3/28/17
K 363 SS=D	exit locations, and a with Chapter 7, and continuously mainta full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1. ⁻ This STANDARD is Based on observat has failed to provide This deficient pract rapid evacuation of staff in the event of require quick evacu- section 7.1. 19.2.1 Findings include: On facility tour betwo on 02/14/2017, it w 1st floor exit door to open and took seve open. This deficient pract staff (I), at the time NFPA 101 Corridor Corridor - Doors 2012 EXISTING	10.1 s not met as evidenced by: ion and interview, the facility e a proper exit to the outside. ice could affect the safe and all residents, visitors, and f an emergency that may lation in accordance with ween 08:00 AM and 11:30 AM as observed that the east stair o the outside was difficult to eral attempts to force the door ice was verified by the facility of discovery.	K 36:	The first floor exit door to the o the facility was fixed 2/14/2017. Audits will be completed 3 time to assure that doors remains we properly. Director of Environmental servi- responsible to assure that audit completed and that the door is properly. Audits will be reviewed at QAPI three months to assure door is properly.	s a week orking ces is s are working for next	3/28/17
	hazardous areas sh as those constructe core wood, or capa 20 minutes. Doors compartments are	s of vertical openings, exits, or nall be substantial doors, such ed of 1-3/4 inch solid-bonded ble of resisting fire for at least in fully sprinklered smoke only required to resist the Doors shall be provided with a				

Facility ID: 00494

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE	
		245028	B. WING		02/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALTI	H CARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 363	There is no impedir doors. Clearance be floor covering is not latches are prohibite corridor doors and it or combustible mat complying with 7.2. devices that release pulled are permitted of unlimited height a meeting 19.3.6.3.6 Door frames shall be or other materials in the smoke compart window assemblies sprinklered compart restrictions in area frames in window a 19.3.6.3, 42 CFR P and 485 Show in REMARKS protection ratings, a etc. This STANDARD is Based on observat has failed to mainta accordance with LS practice could affect Findings include: On facility tour betwo on 01/06/2016, obs The doors between not close all of the v	keeping the door closed. nent to the closing of the etween bottom of door and exceeding 1 inch. Roller ed by CMS regulations on rooms containing flammable erials. Powered doors 1.9 are permissible. Hold open e when the door is pushed or d. Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors are permitted. Dutch doors ment is sprinklered. Fixed fire are allowed per 8.3. In tments there are no or fire resistance of glass or ssemblies. arts 403, 418, 460, 482, 483, 6 details of doors such as fire automatics closing devices, s not met as evidenced by: ions and interview, the facility in smoke/fire barrier doors in GC 19.3.7.5. This deficient t all patients.	K 3	 A special ordered door will be inst May 15th. Audits will be completed on fire do assure that they are closing prope weekly for the next 3 months. Mo there after. The Director of Environmental Ser will be responsible to review audit report to QAPI for review of finding audits. 	oors to rly nthly vices s and to	

Facility ID: 00494

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES			FORM): 03/21/2017 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DA COI	TE SURVEY MPLETED
		245028	B. WING		02	/14/2017
NAME OF	PROVIDER OR SUPPLIER		1 1	STREET ADDRESS, CITY, STAT		
	ND CHATEAU HEALT			2319 WEST SEVENTH STRE	ET	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER		SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICII	ACTION SHOULD BE	(X5) COMPLETION DATE
K 363	Continued From pa	age 4	K 3(63		
	This deficient pract staff (I), at the time	ice was verified by the facility of discovery.				
ORM CMS-28	67(02-99) Previous Versions	Obsolete Event ID: D1B22	?1	Facility ID: 00494	If continuation sh	eet Page 5 of {



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted March 7, 2017

Ms. Heather Welter, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, MN 55116

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5028027

Dear Ms. Welter:

The above facility was surveyed on February 13, 2017 through February 16, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5028042. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Highland Chateau Health Care Center March 7, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE COMP	SURVEY LETED
		00494	B. WING		02/1	; 6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH NUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depu- Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

6899

If continuation sheet 1 of 47

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00494				C 02/16/2017
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	ND CHATEAU HEALTI	2319 WE	ST SEVENTH S			
IIGIILA		SAINT P	AUL, MN 55110	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. <i>J</i> is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm On February 13, 14 of this Department's provider and the fol issued. In addition, H5028042 was also licensing survey. Th substantiated. Corr Licensing 1535, Ch indicate in your elec you have reviewed date when they will Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement, evidence by." Follow	4, 15, and 16, 2017, surveyors s staff, visited the above lowing correction orders are investigation of complaint o completed at the time of the ne complaint was ection order issued at State apter 4658.1315. Please etronic plan of correction that these orders, and identify the be completed. nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the int of Deficiencies" column o Comply" portion of the nis column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00494	B. WING			C 02/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HIGHLAI	ND CHATEAU HEALT		ST SEVENTH				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	ige 2	2 000				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC	IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A					
2 302	MINNESOTA STAT	CTION FOR VIOLATIONS OF E STATUTES/RULES. 44.6503 Alzheimer's disease	2 302			3/28/17	
2 002	or related disorder		2 002			0/20/17	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related o segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	ı				
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;					

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00494	B. WING		02/1	; 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	This MN Requireme by: Based on interview facility failed to ens in a written or electri facility staff training dementia/Alzheime frequency of trainin training. Findings Include: On 2/16/17 the adm admissions was rev description of facilit residents with demo of staff trained, frect covered in the train On 2/16/17, at 11:1 (DON) confirmed th consumer educatio dementia/Alzheime indicated she was g administrator about administrator verifie the admission pack any other way. SUGGESTED MET administrator or des information describ categories of emplo frequency of the trained	ent is not met as evidenced and document review, the ure consumers were provided ronic form, a description of for the care of residents with r's, categories of staff trained, g and topics covered in the hission packet given to all new viewed. The packet lacked a y staff training for the care of entia/Alzheimer's, categories juency of training and topics ing. 0 a.m., the Director of Nursing he facility did not have any n or information related to r's training. The DON going to talk to the it. At 12:30 p.m., the ed the statement was not in et nor given to new admits in CHOD OF CORRECTION: The signee could provide the ing the staff training program, oyees trained and the ining, as required. The signee could develop an		corrected		

Minnesc	ota Department of He	alth			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION ()	X3) DATE SURVEY COMPLETED
		00494	B. WING		C 02/16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	ND CHATEAU HEALT	H CARE CENTER 2319 WES	ST SEVENTI	ISTREET	
manea		SAINT PA	UL, MN 551	16	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 302	Continued From pa	ige 4	2 302		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-One			
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555		3/28/17
	must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	elopment. A nursing home nprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the , a registered nurse with e resident, and other disciplines as determined by s, and, to the extent e participation of the resident, guardian or chosen			
	by: Based on interview facility failed to revi	ent is not met as evidenced and document review, the se the care plan for 2 of 4 26) reviewed for urinary		corrected	
	Findings include:				
	readmitted on 9/15, readmission Minim 9/22/16, R37 was o	to the facility on 8/24/16, and /16. According to the um Data Set (MDS) dated continent of urine. A quarterly 6, indicated R37 was always			
	A form titled Bowel	and Bladder Functional			
Minnesota D STATE FOR	epartment of Health M		6899	D1B211 If	continuation sheet 5 of 47
			'		

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IDENTITION TON NOMBER.	A. BUILDING: _		-	
		00494	B. WING		C 02/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IGHI AN	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
		SAINT P	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 5	2 555			
	Evaluation Tool-HDGR dated 12/12/16, indicated R37 was incontinent of bowel and bladder; and staff were to encourage and assist R37 with toileting every two hours and as needed.					
	R37's urinary incor assist with toileting However, the care completion of the 1 assessment, which	sed on 12/6/16, addressed ntinence and staff were to needs "as determined." plan was not revised after 2/12/16, urinary incontinence directed staff to encourage n toileting every two hours and				
	(A) stated R37 use went from being co	45 p.m. R37's family member- d incontinent products and ontinent of urine when first ility, to being incontinent.				
		3 a.m. nursing assistant (NA)-A ook self to the toilet as R37				
	an indwelling Foley revised on 2/6/17, i removed and R126 program. However to indicate the freq program, which had and Bladder Functi assessment dated assessment verifie removed on 2/6/17 provide incontinent	d to the facility on 1/31/17, with catheter. The care plan was indicating the catheter was was on a check and change , the care plan was not revised uency of the check and change d been identified in a Bowel ional Evaluation Tool-HDGR 2/7/17. The 2/7/17, d the Foley catheter had been , and indicated staff were to ce care every two hours and llowing each episode of	9			
		6, revised policy titled Care sive indicated the care plan				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00494	B. WING	B. WING		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 5511	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 6	2 555			
	was to be reviewed assessment.	and revised after each				
	Bladder Manageme who was incontine appropriate treatme	, revised policy titled Bowel and ent-HDGR indicated a resident nt of bladder was to receive the ent and services to prevent on and "restore continence to ."	t			
	The Director of Nu develop a system t developed to reflec needs. The DON o	THOD OF CORRECTION: rsing (DON) or designee could to ensure a care plan is at each residents' current care r designee could educate all in the system, and monitor to mpliance.				
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty On	e			
2 560	MN Rule 4658.040 Plan of Care; Cont	5 Subp. 2 Comprehensive ents	2 560			3/28/17
	comprehensive pla objectives and time long- and short-tern and mental and ps identified in the cor assessment. The must include the in	of plan of care. The in of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are mprehensive resident comprehensive plan of care dividual abuse prevention plan sota Statutes, section 626.557, agraph (b).	n			
	by: Based on observat	ent is not met as evidenced ion, interview and document ailed to develop the care plan		corrected		

Minnesc	ta Department of He	ealth			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.		- c	
		00494	B. WING			0 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
		SAIN I P/	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pa	age 7	2 560			
	for 1 of 3 residents (R37) with dental needs.					
	Findings include:					
		admitted to the facility on hitted after hospitalizations on				
	indicated R37 requ and if R37 refused later time. Howeve developed to indica	d as being initiated on 12/6/16, ired assistance with grooming cares, to re-approach at a r, the care plan was not ate R37 at times refused to ture due to concerns of it not				
	edentulous and a s soaking in a dentur 2/14/17, at 3:35 p.r the upper denture, denture was in a de 2/15/17, at 7:30 a.r cleansed R37's der offered the denture stated "these are th grabbed the lower mouth and gagged removing the dentu- denture, placed ad	p.m. R37 was observed to be et of dentures was noted to be re cup in R37's bathroom. On n. R37 was observed wearing but not the lower, as the lower enture cup in the bathroom. Or n. nursing assistant (NA)-A ntures; and at 8:03 a.m. s to R37 for placement. R37 he only one's I want" and denture, tried to put it in top of . NA-A assisted R37 with tre. R37 then took the correct hesive on the upper denture ture properly in mouth.				
	the lower denture. the lower denture of did not fit. R37 stat chance and that he	ras asked about not wearing R37 stated had tried wearing on and off for a month and it ed people said to give it a s is done giving it a chance.				
	stated R37 told FM	6 p.m. family member (FM)-A -A the dentures are				
nesota D	epartment of Health M		6899 D		lf continua	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION		E SURVEY PLETED
		BERTH TO THOMBET.	A. BUILDING: _		0	
		00494	B. WING		C 02/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH	-		
		SAINT P	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 8	2 560			
	that the dentures c were worn more. F "difficult" and if R37 dentures in, then R dentures. A 8/24/16, docume Comprehensive Ad Assessment indica the dentures were admission. A new N Admission Data Co	Imission Data Collection and ted R37 had full dentures, but not present at the time of the Nursing Comprehensive Illection and Assessment				
	9/15/18, indicated I present at the time another Nursing Co Collection and Asso completed at the time	me of a readmission on R37's dentures were not of the readmission; and omprehensive Admission Data essment dated 11/10/16, me of another readmission, full dentures which were of the admission.				
		pm NA-B stated R37 did not ver denture and R37 had stated fit.	Ł			
		28 a.m. registered nurse etimes R37 would wear the etimes not.				
		a.m. RN-A stated R37 had lower denture did not fit.				
	director of nursing policy and procedu needed, staff traine	THOD OF CORRECTION: The or designee could assure the res are reviewed, revised as ad and systems assessed, luated to assure the	,			

Minneso	ta Department of He	ealth			FORM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00494	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
(X4) ID		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
2 560	Continued From pa	age 9	2 560			
		n of care is developed and ojectives and timetables to ts individual needs.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/28/17
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review, the facility f plan to ensure the services were provi development and p	ent is not met as evidenced ion, interview, and document ailed to implement the care necessary treatment and ided to minimize the promote healing of pressure sidents (R126) identified with a		corrected		
	Findings include:					
	10:12 a.m. to 1:50 minutes. An undate	sitioned on 2/15/17, from p.m. a total of 3 hours and 38 ed Initial Care plan directed 126 every two hours.				
	mechanical lift and into a wheelchair. <i>A</i> lunch in room by N	6 was assisted out of bed via a three staff, and transferred At 12:42 p.m. R126 was served IA-C and at 1:25 p.m. the ed up. However, there was no				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00494	B. WING	B. WING		C 02/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HIGHLAI	ND CHATEAU HEALT		ST SEVENTH SAUL, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 10	2 565				
	attempt or offer to r interaction.	reposition R126 during either					
	When informed R1 since being transfe wheelchair, NA-C v the wheelchair sinc morning cares. NA every two hour repo p.m. R126 was tran mechanical lift and An 11/16, revised p Plan of Care-Comp	stated shift ended at 2:00 p.m. 26 had not been repositioned rred from the bed to the verified R126 had been up in the 10:12 a.m., which was after -A verified R126 was on an ositioning schedule. At 1:50 nsferred back to bed via the two staff.					
		physical, mental and					
	director of nursing review and revise p to ensuring the care resident is followed designee could dev and develop a mon	THOD OF CORRECTION: The (DON) or designee could policies and procedures related e plan for each individual I. The director of nursing or velop a system to educate staff itoring system to ensure staff as directed by the written plan	1				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 800	MN Rule 4658.051 Staffing requiremen	0 Subp. 1 Nursing Personnel; nts	2 800			3/28/17	
	home must have of	requirements. A nursing n duty at all times a sufficient I nursing personnel, including					

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IDEITH IOMINITY MIDEN.	A. BUILDING	:		
		00494	B. WING		C 02/16/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	ND CHATEAU HEALT		ST SEVENT			
		SAINT P	AUL, MN 55	116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 11	2 800			
	nursing assistants residents at all nur in all buildings if m	licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.				
	by: Based on observat review, the facility t were available to m residing in the facil residents (R3, R96	tion, interview and document failed to ensure enough staff neet the needs of residents lity. This affected 9 of 9 5, R51, R81, R37, R126, R73, ad the potential to affect all 57 cility.		corrected		
	Findings include:					
		esident interviews, the ts were made regarding facility :				
	with a smell of urin admission Minimur 8/25/16, indicated stated "Since I hav floor, it is almost in indicated wanting t about a month or th completely full, the nurse and one nurs are too busy, we ca wanna get up too!" button for assistan- around 9:00 a.m. th	D p.m. R3's room was observed the closer to the bed. R3's m Data Set (MDS) dated R3 was cognitively intact. R3 re moved up here to second inpossible to get up at all", and o get up after lunch. It began wo ago, if rooms were not y only staff the unit with one sing assistant. R3 was told "we an't help you" and R3 stated "I ' R3 indicated pushing the call ce sometime after breakfast hinking staff should have time s and explained that a nursing				

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 12	2 800			
	not just you! R3 sta explained just wan stated the director about it and the D0 but there had been stated the physicia independently trans	e were lots of other residents, ated, answering "ok", and ting to get out of bed. R3 of nursing (DON) was told DN said it would be looked into n or response. R3 further n did not want R3 to sfer, but to use a Hoyer lift with staff told R3 they don't have				
	there were enough and assistance wit "not nearly." R96's 12/9/16, indicated stated there was o nurse working both further indicated st	4 p.m. when asked if R96 felt staff available to provide care hout waiting a long time stated admission MDS dated R96 was cognitively intact. R96 ne nursing assistant and one n east and west units. R96 affing was the worst after siest in the mornings and				
	light response, R5 should respond to R51's quarterly ME R51 was cognitivel come into the room leave, stating they Sometimes it took light assistance. R change or during n	4 p.m. when asked about call 1 stated nursing assistants the call light within 10 minutes. OS dated 12/22/16, indicated ly intact. R51 stated staff would n, turn off the call light and would return or were busy. one-half to one hour for call 51 further stated during shift neal service R51 could not get hich happened frequently.	I.			
	stated should have a.m. but nursing as 10:45 a.m. R81's q indicated R81 was	2/13/17, at 7:06 p.m. R81 e received a shower at 9:15 ssistant did not come until juarterly MDS dated 12/29/16, cognitively intact. R81 stated affed at least once a week and				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00494	- B. WING	B. WING		C 02/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
		2319 WF	ST SEVENTH				
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER SAINT P	AUL, MN 5511	6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 13	2 800				
	had not been fully s	staffed the past day or two.					
	licensed practical r unable to get every when some duties previous shift. LPN	v on 2/14/17, at 3:08 p.m. hurse (LPN)-C stated was thing done during the shift had been carried over from the I-C stated was often asked to nce or twice a week and was a double shift.	9				
	nursing assistant (I not able to get work it on to the next shi were short staffed months, and tried t complete duties. N and felt staff were I NA-D further stated	v on 2/15/17, at 12:12 p.m. NA)-D stated sometimes was k done during shift and passed ift. NA-D further stated they now, had been for about eight o adjust the work load to A-D stated was burned out, looking for jobs elsewhere. d when new nursing assistants y don't like the heavy workload aff turnover.					
	LPN-D stated wher work load was chal completing duties a felt they should hav coordinator to proc	v on 2/15/17, at 12:30 p.m. n they were short staffed, the llenging, and would fall behind and work extra hours. LPN-D ve a full-time health unit ress physician orders. LPN-D ere was a facility nursing					
	NA-E stated they w always short. The f consuming taking 2 and only when you	y on 2/15/17, at 12:39 p.m. vere short staffed and were neavy care workload was time 20 to 30 minutes per resident were experienced could you in the allotted timeframe.					
		v on 2/16/17, at 9:03 a.m. NA-F they were short staffed, most	-				

If continuation sheet 14 of 47

AME OF F	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		0.011	PLETED
						_
		00494	B. WING		C 02/16/2017	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		2319 WF	ST SEVENTH			
IGHLAN	ND CHATEAU HEALT	H CARE CENTER SAINT P	AUL, MN 5511	6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
RÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 800	Continued From pa	age 14	2 800		,	
		-				
		ee nursing assistants or the should have four. NA-F				
		n happening for about three				
		I was the worst. When new				
		taff starts, they will see the				
		d work load and leave. NA-F				
		day last week lunch trays sat staff could distribute them and				
		em up to serve the meal. NA-F				
		taff schedule listed four				
		but only three were working.				
	During an interview	<i>ı</i> on 2/16/17, at 9:07 a.m.				
		ded a float nursing assistant or	ı			
		nformed it was not in the				
		e extra help when State is				
		ed being unable to complete				
		hift and could not complete ocks or resident repositioning.				
		t wet because there was no				
		G further indicated would rush				
		prioritize important duties, and				
	may leave other du	ities to complete.				
		v with the director of nursing				
		at 1:57 p.m. DON stated the				
		y not be accurate as				
		ould forget to turn off the light a room. If a resident stated				
		th on for a long time, DON				
		about it. DON stated she,				
		nd nursing assistants have				
	pagers to assist wit	th answering call lights. DON				
		I light concerns a few months				
		It reports to view, and then got				
		ated used call light report as a ed call lights lately on a regular				
		that on an individual basis.				
	During an interview	v with the DON on 2/16/17, at				
esota De	epartment of Health					

If continuation sheet 15 of 47

PRINTED: 03/20/2017 FORM APPROVED

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		DENTITION TON NOMBER.	A. BUILDING: _			
		00494	B. WING		C 02/16/2017	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ID CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
		SAINT P	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 15	2 800			
	long-term care unit transitional care un adjust long-term ca down, would trim he end of day shift tim times. DON further managers, could he included they also s Review of the facilit 1/14/2017 to 2/15/2 times. Included bel lights remained on	utes (m), 19 seconds (s) s 6s s s s s s s 0s 1s s 0s s 0s s 0s				
	2/14/17, for 51m, 2 2/5/17, for 50m, 12 2/2/17, for 49m, 57 2/9/17, for 49m, 47 2/2/17, for 49m, 16	s s s				
	The call light policy	and procedure was				
	epartment of Health					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		00494	B. WING		C 02/16/2017	
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
IGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 5511	-		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	COBRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 16	2 800			
	requested, but not	requested, but not provided.				
	of 2 hours and 49 r	:49 a.m. to 10:38 a.m., a total ninutes, R37 was not observed the toilet or checked for e.	ł			
	At 7:41 a.m. R37 was in bed and nursing assistant (NA)-A asked R37 about changing the incontinent pad, which NA-A stated was wet. R37 agreed and after pericare a new incontinent pad was placed. At 7:49 a.m. R37 requested of NA-A to use the toilet. NA-A assisted R37 to the toilet and R37 voided. Before being weighed, at 10:38 a.m., NA-A asked R37 about using the toilet, however R37 declined.					
	which NA-A stated work done and take	he worked on the first floor, was not often, he could get his e his breaks. However, he econd floor and it was hard to and take breaks.				
	every two hours on	ided with incontinence care 2/15/17, from 9:51 a.m. to 3 hours and 59 minutes.				
	during morning car incontinent product wet and R126 was condition of the pac assistant (NA)-A will care. At 9:51 a.m. I	a.m. R126 was observed es. At 9:37 a.m. R126's was removed and noted to be also incontinent of bowel. The d was verified by nursing ho was providing incontinence NA-A had finished providing for R126. At 10:12 a.m. R126				
	three staff, and trar 12:42 p.m. R126 w	ed via a mechanical lift and nsferred into a wheelchair. At as served lunch in their room 25 p.m. the lunch tray was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			С	
		00494	B. WING			02/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IGHLAN	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH	-			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	age 17	2 800				
	At 1:25 p.m. NA-C stated her shift ended at 2:00 p.m. When informed R126 had not been checked for urinary incontinence and repositioned for over three hours, NA-C verified the last time R126 had been checked for bladder and bowel incontinence and repositioned was during morning cares. NA-A stated R126 was on an every two hour repositioning schedule, but sometimes staff could not get all their work done and sometimes staff did not get to take breaks. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. The incontinent pad was noted to be wet, and the condition of the pad was verified during incontinence care by NA-A. A dry scabbed over area was noted on R126's left buttock and a small open area was noted in the buttock crevice, near the coccyx.						
		6, resident council meeting esidents were concerned ng.					
	attended resident of staffing issues wer as were bedtime su puts snacks out on every night and wh people working on four, snacks were able to go to the nu snack, as could se	10 a.m. R73 who frequently council meetings, stated e brought up at every meeting, nacks. R73 stated the kitchen of the nursing desk counter the nursing desk counter the second floor instead of not passed. R73 stated being ursing desk and get their veral other residents, but there ere not able to get to the bendently.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		00494	B. WING		C 02/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	acknowledged the i "fairly" often when t the second floor. On 2/16/17, at 2:41 and FM-C stated R taken over 20 minu answered when ne FM-B and FM-C stat facility on 2/12/17, a shower every day. I told R130 would ge did not happen. The the shower would h did not receive a sh FM-C stated they w not had a shower. If there was one nigh on all night. The director of nurs R130 had received speaking with the s registered nurse (R incident report to in	ige 18 executive director had issue. R73 stated it happened there were only three staff on p.m. family member (FM)-B 130 had mentioned it has tes to have the call light eding to use the restroom. ated R130 was admitted to the and had for R130 to have a FM-B and FM-C stated being it a shower on 2/14/17, but that en FM-B and FM-C were told happen on 2/15/17, but R130 hower on that date. FM-B and vere never told why R130 had FM-B and FM-C also stated t when staff left R130's clothes ses (DON) stated at 3:30 p.m. a shower when the family was surveyor. The DON stated tN)-B had completed an vestigate why R130 had not on either 2/14 or 2/15/17.				
	p.m., indicated R19 receive assistance R19's family explain the need to use the being incontinent of come to assist R19 help. R19's family in	s family on 2/13/17 at 5:15 has waited 20 - 30 minutes to to go to the bathroom lately. ned that R19 could tell staff of toilet and that R19 reported f urine because staff did not when family was not there to ndicated when the State was e staff were available to assist				

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00494	B. WING		C 02/16/2017	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S			
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH NUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 800	Continued From pa	ge 19	2 800			
	director of nursing a assess and evaluat	THOD OF CORRECTION: The and/or designee could monitor, te to assure necessary staffing re the needs of residents are				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin		2 840			3/28/17
		or determining adequate and criteria for determining er care include:				
	odors. A bathing pl resident's plan of ca condition requires t must be given a co other day and more incontinent resident every two hours, an	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least ad must receive perineal care ode of incontinence.				
	Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident	I. Incontinent residents. nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00494	B. WING		C 02/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 551	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	age 20	2 840			
		erval, and this waiver is resident's care plan.]				
	promptly each time Perineal care inclue the perineal area. to keep the bed dry comfort. Special a skin to prevent irrita types of protectors completely covered contact with the res	thing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and emoved immediately from revent odors.				
	by: Based on observat review, the facility f (R126) dependent incontinence care,	ent is not met as evidenced ion, interview and document failed to ensure 1 of 3 residents on staff for urinary received the appropriate are urinary incontinence.	5	corrected		
	every two hours on	ided with incontinence care 2/15/17, from 9:51 a.m. to 3 hours and 59 minutes.				
	On 2/15/17, at 9:30 during morning car incontinent product wet and R126 was condition of the pad assistant (NA)-A wi care. At 9:51 a.m.	a.m. R126 was observed es. At 9:37 a.m. R126's t was removed and noted to be also incontinent of bowel. The d was verified by nursing ho was providing incontinence NA-A had finished providing for R126. At 10:12 a.m. R126				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING		- C		
		00494	B. WING			02/16/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH				
		TEMENT OF DEFICIENCIES	AUL, MN 5511	PROVIDER'S PLAN OF	CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 840	Continued From pa	ge 21	2 840				
	three staff, and trar 12:42 p.m. R126 with NA-C and at 1:25 p up. R126 remained being checked for u At 1:25 p.m. NA-C When informed R11 urinary incontinence R126 had been che was during morning on an every two hol change schedule. A transferred back to and two staff. The i be wet, and the cor during incontinence A Bowel and Bladde Tool-HDGR was co and identified an inte been removed on 2 indicated staff were	er Functional Evaluation mpleted for R126 on 2/7/17, dwelling Foley catheter had 2/6/17. The assessment to provide incontinence care d when necessary following					
	Bladder Manageme who was incontiner appropriate treatme	revised policy titled Bowel and ent-HDGR indicated a resident at of bladder was to receive the ent and services to prevent on and "restore continence to "					
	director of nursing a policies and proced staff, assess the sy	THOD OF CORRECTION: The and/or designee could review lures, revise as needed, train stem, monitor, evaluate to ho are incontinent of urine,					

	ta Department of He	alth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D	ATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		OMPLETED	
		00494	B. WING C	C 02/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH STREET		
(X4) ID	SUMMARY STA	SAIN I P.	AUL, MN 55116	(X5)	
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE	
2 840	Continued From pa	ge 22	2 840		
	receive the necess to incontinence.	ary services and care related			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900	3/28/17	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which			
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and			
	receives necessar	ho has pressure sores y treatment and services to event infection, and prevent veloping.			
	by: Based on observati review, the facility f (R126) with facility		s		
	Findings include:				
	R126 was admitted	to the facility on 1/31/17, and			

STATE FORM

D1B211

If continuation sheet 23 of 47

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00494	B. WING		C 02/16/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH SAUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 23	2 900			
	Assessment there time of admission. revealed R126 dev open area in the cr A Pathway Health & Evaluation of Skin 2/3/17, indicated th incontinent of bowe staff and hoyer for off loading/repositio	17, Admission Skin were no pressure ulcers at the A nurses noted dated 2/2/17, reloped a 2 centimeter long revice of the buttocks. Services Comprehensive Risk Factors form dated he resident was bedfast, el; and was assisted by two transfers and bed mobility and oning.				
	reposition R126 ev wound on R126's c	ery two hours and there was a coccyx.				
	document dated 2/ crevice was a stage coccyx and now me Page two of the wo "Wound is occurrin significant moisture that reason will tria as it appears to be further indicated a	ecialist Initial Evaluation 7/17, revealed the area in the e III pressure ulcer on the easured 1 x 0.4 x 0.1 cm. bund care sheet revealed og amidst background of fairly e associated dermatitis. For I barrier cream for wound care the causative event." The note surgical debridement was coccyx area then measured 3	9			
	and the pressure u to measure 0.8 x 0 smaller. However, which measured 1	ist saw R126 again on $2/14/17$ lcer on the coccyx was noted .2 x 0.1 cm, having gotten a new area on the left buttock, x 0.6 x 0.1 cm had developed e specialist indicated the area earing.				
		ng cares for R126 were as a dry, non-draining scabbed	Ł			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		СОМ	E SURVEY PLETED
		00494	B. WING			C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALTI		ST SEVENTH S AUL, MN 55116	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	noted in the buttock completion of cares transferred via mec the bed to the whee room watching TV f p.m., was served lu assistant (NA)-C pid it on a cart and took NA-C returned to the interviewed at this t been repositioned s NA-C stated R126 v repositioning. R126 was transferred mechanical lift and After completion of skin was observed noted on the wound were measured by observed by nurse stated the area on t x 1 cm and stated t RN-B verified there area and the area v On 2/15/17, at 3:38 stated she had work transfer to the wheelch When asked about least a minute, PT-C	ge 24 eft buttock and an open area c crevice, on the coccyx. After s, at 10:12 a.m., R126 was chanical lift and three staff from elchair. R126 remained in from 10:12 a.m. and at 12:42 unch. At 1:25 p.m. nursing cked up the lunch tray, placed c the cart to the kitchen. The unit at 2:00 p.m. and when ime verified R126 had not since after morning cares. was to be an every two hour ed back to bed, via a two staff at 1:50 p.m. incontinence care, R126's at 2:10 p.m. and the areas d specialist documentation registered nurse (RN)-B and practitioner (NP)-B. RN-B the left buttock measured 1.2 here was no depth to the area was no drainage from the vas scabbed over and dry. p.m. physical therapist (PT)-C ked with R126 after the elchair. PT-C stated R126 did and some chair presses. ted she couldn't say R126 had hair cushion to totally off- load. being able to off-load for at C stated R126 had low bted R126 could clear the				

If continuation sheet 25 of 47

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00494	B. WING		– C – 02/16/201 7	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH SAUL, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Injury/Skin Integrity indicated residents loss of skin integrity appropriate treatme include: repositionin resident assessme SUGGESTED MET The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. The designee, could could delivery of care; to services are impler pressure ulcer developing	revised policy titled Pressure /Wound Management-HDGR who were at risk or who had a y were to receive the ent/services which might ng or "off-loading" as per nt and care plan. THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure he necessary to prevent pressure ulcers id to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
2 910	Incontinence Subp. 5. Incontine have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and no is incontinent of bladder re treatment and services to	2 910			3/28/17

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				·	С	
		00494	B. WING		02/16/2017	
AME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTI AUL, MN 55 [.]	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	
2 910	Continued From pa	age 26	2 910			
		t infections and to restore as ler function as possible.				
	by: Based on observat review, the facility f (R37) reviewed for provided with the n	ent is not met as evidenced ion, interview, and record ailed to ensure 1 of 4 residents urinary incontinence was ecessary treatment and te urinary incontinence and nction.	5	corrected		
	Findings include:					
	of 2 hours and 49 r	:49 a.m. to 10:38 a.m., a total ninutes, R37 was not observed the toilet or checked for e.	8			
	assistant (NA)-A as incontinent pad, wh agreed and after pe was placed. At 7:49 to use the toilet. NA and R37 voided. B	vas in bed and nursing sked R37 about changing the nich NA-A stated was wet. R37 ericare a new incontinent pad 9 a.m. R37 requested of NA-A A-A assisted R37 to the toilet before being weighed, at 10:38 R37 about using the toilet, ned.				
	Evaluation Tool-HD R37 was incontiner staff were to encou	and Bladder Functional OGR dated 12/12/16, identified nt of bowel and bladder; and grage and assist R37 with hours and as needed.				
nacoto D		ealed R37 had a urology 20/17. According to the urology				
TE FOR	-		6899	D1B211	If continuation sheet 27	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	of connection	BERTH TOATTON NOMBER.	A. BUILDING: _			
		00494	B. WING		C 02/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
		SAINT P	AUL, MN 55110	6		
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pa	age 27	2 910			
	antibiotic Cipro 250 The referral form d urologist after com was no improveme incontinence. The indicated that after urologist with a pro	referral summary also the facility contacted the gress report, the urologist ttomical evaluation with				
	1/31/17, revealed the regarding R37's unit referenced on 1/31 incontinent of urine to determine if R37 improved or if the ut to lack of urinary in Medication Administ had a check mark in had been updated,	notes dated 1/20/17 to he only documentation inary incontinence was /17, indicating R37 was e. There was no documentation ''s urinary incontinence had urologist had been notified due continence improvement. The stration Record dated 1/31/17, in a box indicating the urologis but there was no indication as the urologist or what the entailed.	t			
	three-day voiding of voiding patterns wa 2/15/17, at 10:18 a was requested and registered nurse (F collection form reve 2/7 to 2/9/17, howe were blank with no	sed on 1/31/17, indicated a lata collection to evaluate as to be completed. On .m. the three-day voiding data I at 11:58 a.m. was provided by RN)-B. Review of the data ealed data was collected from ever, many sections of the form data collection. When this was stated "Correct" and explained analyze the data.	1			
	Bladder Manageme	, revised policy titled Bowel and ent-HDGR indicated a resident nt or bladder was to receive the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00494	B. WING			C 2/ 16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH SAUL, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 910	Continued From pa	ige 28	2 910				
		ent and services to prevent on and "restore continence to ."					
	bladder tracking too incontinent residen in incontinence and was to be updated	cated the three-day bowel and ol was to be completed for ts with any significant change a person centered care plan and revised to include the d bladder needs, goals and					
	The director of nurs all residents at risk they are receiving t treatment/services director of nursing random audits of t	to prevent incontinence. The or designee, could conduct he delivery of care; to ensure ad services are implemented;					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325			3/28/17	
	home must provide resource, routine d needs of each resid include dental exan fillings and crowns, oral surgery, bridge orthodontic proced	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00494	B. WING		C 02/16/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTI			
		SAINT P/	AUL, MN 55 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLE	
21325	Continued From pa	ge 29	21325			
	community at large reimbursement poli	, as limited by third party cies.				
		ent is not met as evidenced				
	by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R37) received the appropriate dental services to ensure proper fitting dentures.		3	correct		
	Findings include:					
	edentulous (withour was noted to be so bathroom. On 2/14, observed wearing t lower, as the lower in the bathroom. On assistant (NA)-A cle 8:03 a.m. offered th placement. R37 sta want" and grabbed atteempted to put it gagged. NA-A assis denture. R37 then t	p.m. R37 was observed to be t teeth) and a set of dentures aking in a denture cup in R37's (17, at 3:35 p.m. R37 was he upper denture, but not the denture was in a denture cup in 2/15/17, at 7:30 a.m. nursing eansed R37's dentures; and at he dentures to R37 for atted "these are the only one's I the lower denture and the top of his mouth and sted R37 with removing the took the correct denture, in the upper denture and placed th.				
	to wear the lower d wearing the lower of and it did not fit. R3	as asked why he did not want enture and stated having tried lenture on and off for a month 7 stated people said to give it done giving it a chance.				
	stated R37 tells FM uncomfortable; and could not be adjust	6 p.m. family member (FM)-A I-A the dentures are I FM-A told R37 the dentures ed until they are worn more. puld be "difficult" and if R37 did	4			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00494	B. WING			C 16/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21325	Continued From pa not want to put the not be wearing the	dentures in, then R37 would	21325			
	score from the mos	erview for mental status) t recent MDS (minimum data , was recorded as "10" gnitive impairment.				
		p.m. NA-B stated R37 did not er denture and R37 had stated t fit.				
		8 a.m. registered nurse etimes R37 would wear the times not.				
	-	a.m. RN-A said R37 had lower denture did not fit.				
	manager (HIM)-A s medical record and the dentist since firs 8/24/16. HIM-A stat	a.m. the health information tated she had reviewed the found R37 had not been to st admitted to the facility on ed she had been able to find R37 had dental appointments				
	clinic which indicate dentures for the firs documentation obta revealed R37 had b dentures, especially well and causing dia notes revealed den done on 7/26, 7/28 returned to the den adjustments despite	cumentation from a dental ed R37 had received new at time on 7/26/16. Additional ained from the dental clinic been complaining of the y the lower denture, not fitting scomfort. The dental progress ture adjustments had been and 8/2/16. R37 had not tal clinic for additional denture e telling FM-A and other facility ower denture did not fit.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED C
		00494	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 551	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	age 31 , revised policy titled Dental	21325			
	Service (General) i provide or obtain fr	ndicated the facility was to om an outside resource, ency dental services to meet				
	The director of nurs develop and impler to ensure appropria residents who pres Monitoring systems	THOD OF CORRECTION: sing (DON) or designee could ment policies and procedures ate dental care is sought for tent with dental problems. s could be developed to ensure e and report the findings to the				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			3/28/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and ent.				
	by: Based on observat review, the facility f handwashing durin	ent is not met as evidenced ion, interview, and document ailed to ensure proper g cares for 2 of 4 residents ved for urinary incontinence, d during cares.		corrected		
	Findings include:					

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STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00494	B. WING			C 16/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH SAUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	On 2/15/17, at 7:35 cares for R37, nurs observed to wash gloves. Perineal ca had been incontine incontinent product completion of perin gloves, and without new pair of gloves and sit up in bed. A need to use the toil and without washin gloves and assisted voiding on the toile the wheelchair by N gloves. Without wa new pair of gloves with putting denture On 2/15/17, during R126 was observe amount of stool. W cleansed R126's st cleansing R126, N/ donned a new pair handwashing, and R126's buttocks. A removed the gloves handwashing and a R126. At 9:45 a.m. while R again incontinent o removed R126's so R126's soiled pants gloves and handwa pants for R126 and	 a.m. prior to starting morning sing assistant (NA)-A was hands and then don a pair of re was provided to R37, who nt of urine and who wore is. NA-A verified R37's is had been wet with urine. After eal care NA-A removed the twashing hands, donned a and helped R37 put on shoes at 7:49 a.m. R37 indicated the et. NA-A removed the gloves g hands donned a new pair of d R37 to the toilet. After t R37 was assisted back into NA-A and then NA-A removed shing hands, NA-A donned a and proceeded to assist R37 es in. morning cares at 9:37 a.m. d to be incontinent of a small hile wearing gloves NA-A kin with disposable wipes. Afte A-A removed the gloves, of gloves without applied a barrier skin cream to fter applying the cream, NA-A s, donned new gloves without assisted NA-C with dressing being dressed, R126 was f stool. At 9:47 a.m. NA-A poiled pants and NA-C placed is in a bag. Without removing ashing, NA-C got a new pair of I began putting the pants on mities with NA-A's assistance. 	r			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE	SURVEY
	or connection	A. BUI	A. BUILDING:	<u></u>		
		00494	B. WING		C 02/16/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		2319 WF	ST SEVENTH			
IIGHLAI	ND CHATEAU HEALT	A CARE CENTER SAINT P	AUL, MN 5511	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 33	21375			
	and don a new pair having helped NA- lower extremities, I and without handw gloves and began bowel incontinence gloves after cleans hands before puttir assisting NA-C with At 9:56 a.m. NA-A trash can, tied the on R126's wheelch the gloves, perform	s for less than five seconds r of gloves. At 9:51 a.m. after C put R126's pants on the NA-A removed a pair of gloves vashing donned a new pair of cleansing R126's skin after the e. NA-A removed the soiled sing R126, but did not wash ng on a new pair of gloves and h the rest of R126's dressing. took the trash bag out of the bag and placed the trash bag nair seat. NA-A then removed ned handwashing and assisted ring R126 from the bed to				
	to bed and was not and stool. The inco Prior to incontinent perform handwash clean gloves. After removed the soiled handwashing donn	D p.m. R126 was assisted back ted to be incontinent of urine ontinence was verified by NA-A t care NA-A was observed to ing prior to donning a pair of cleansing R126's skin NA-A d gloves and without hed a new pair of gloves before clean incontinent product				
	and Gloves, Non-S wash their hands a contact for which h accepted profession that were contamin standard precaution	B, policy titled Hand Washing Sterile indicated staff were to after each direct resident and-washing was indicated by onal practices; and that gloves nated with body fluids for which ons applies, were to be as possible and hands were to emoval of gloves.				
	SUGGESTED ME	THOD OF CORRECTION: The				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY IPLETED
	of connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
		00494	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
		SAINTP	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21375	Continued From pa	age 34	21375			
	policies and proceed control, specific to techniques, train st proper techiniques of nursing or desig audits of the delive appropriate care at TIME PERIOD FO	or designee, could review dures related to infection proper hand washing taff and monitor to assure are being utilized. The director nee, could conduct random ery of care; to ensure nd services are implemented. R CORRECTIONS: Twenty	r			
21426	one (21) days MN St. Statute 144 Prevention And Co	IA.04 Subd. 3 Tuberculosis ntrol	21426			3/28/17
	maintain a compre- infection control pro- current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provid regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and , contractors, students, inteers. The Department of e technical assistance entation of the guidelines.				
	(b) Written compli be maintained by t	ance with this subdivision mus he nursing home.	t			
	This MN Requirem	ent is not met as evidenced				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00494	B. WING	B. WING		C 16/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
21426	Continued From pa	ge 35	21426			
	facility failed to ens R103, and R124) a	nt review and interview, the ure 3 of 5 residents (R96, and 1 of 5 employees (RN-B) ning for tuberculosis.		corrected		
	Findings include:					
	Minnesota Health C directed all resident tuberculosis (TB) se admission or within and baseline TB sc Health Care Worke must include an ass employee's current disease, risk factors symptoms, and tes infection with Mycol administering either	Tuberculosis Control in Care Settings, July 2013, ts must receive a baseline creening within 72 hours of 3 months prior to admission, reening is required for all ers (HCWs). The screening sessment of the resident's or symptoms of active TB s for TB, and any current TB ting for the presence of bacterium tuberculosis by r a two step tuberculin T), or a single Interferon Assay (IGRA).				
	R96's "Baseline TB Template", indicate	to the facility on 12/2/16. Screening Tool of Residents d R96 received a TST - First leven days after admission.				
	R103's medical rec the date and time the the Tuberculin man	to the facility on 9/25/16. ord lacked documentation of ne TST-first step was read, ufacturer, the date the s completed, and the e second step.				
		to the facility on 1/25/17. ord lacked documentation of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00494	B. WING			16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH S AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ige 36	21426			
		ed nurse (RN) -B's Baseline TB HCW's Template dated TST-second step.				
	(DON) verified the R103 and R124, th	0 a.m., the Director of Nursing lack of documentation for e timing of R 96's baseline ck of a two step TST.				
	director of nursing review policies and components of the monitoring program educated on the TE Mantoux process. designee could dev	THOD OF CORRECTION: The (DON) and/or designee could procedures related to the infection control and TB n. Facility staff could be regulations and the two step The director of nursing and/or velop a monitoring system to mpliance with TB screening.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one-				
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535			3/28/17
	must be free from unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, th with provisions in th	al. A resident's drug regimen unnecessary drugs. An s any drug when used: e dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
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21535	Continued From pa	age 37	21535			
	Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th	Appendix P of the State I, Guidance to Surveyors for acilities, published by the lith and Human Services, cing Administration, April 1992 corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on documer facility failed to ens	ent is not met as evidenced nt review and interview, the sure appropriate monitoring for 103, R129) reviewed for cations.		corrected		
	Findings include:					
	Staff failed to moni behaviors for R103	tor and document target				
	of the undated Med	he facility on 9/25/16. Review dical Data Sheet in R103's proses of Alzheimer's and depression.				
	and Paxil. The physical (milligrams) of Ativa agitation, and anothes a needed twice data and the second sec	led current orders for Ativan sician ordered 0.5 mg an to be given twice daily for her 0.5 mg Ativan to be given aily. The physician ordered 20 r anxiety and depression.				
	revealed a focus or medications Ativan disorder. Interventi	care plan, dated 10/7/16, n R103's use of antianxiety and Paxil, related to anxiety ons listed in the care plan ponitor and record occurrences				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00494	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 38	21535			
	of target behavior s per facility protocol	symptoms, and document them				
	Drugs policy, last re following requirement be quantitatively ar the resident's medi medication adminis	eccessary Drugs - Antipsychotic evised 4/09, revealed the ent: "All target behaviors must ad objectively documented in cal record and/or on the strative record, to monitor the e side effects of the				
	asked where staff of registered nurse (F document all behave medication adminis continued that staff behaviors, whether scheduled to be giv be given only as net the MAR to find the saying "they have t through the records 1:05 p.m. RN-G state one." RN-G created	2/16/17, at 12:50 p.m., when documented target behaviors, RN)-G said staff should viors on the Flow Record in the strative record (MAR). RN-G should always monitor the medication was ven at regular intervals, or to eeded. RN-G looked through Flow Records for February, o be here." After looking for R103's Flow Record, at ated, "I can't find the February d a new Flow Sheet for Ativan or and document target est of February.				
	Review revealed th reviewed R103's m	ord of Medication Regimen e pharmacist most recently edication regimen on 2/14/17. ote a short-hand comment for the Ativan.				
	pharmacist confirm 2/14/17, and said s staff monitoring tar	2/16/17, at 4:28 p.m. the led visiting the facility on he did not see evidence of get behaviors in February. The led noting on the Record of				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	00494		B. WING			C 16/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		2319 WE	ST SEVENTH			
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER	AUL, MN 5511			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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iAd		,	IAG	DEFICIENC		
21535	Continued From pa	ide 39	21535			
	-	-				
		en Review that staff needed to				
	monitor target beha	aviors for RT03.				
	R129 did not receive medications per physician					
	orders.					
		nedical record indicated R129				
		e facility on 1/6/16 with				
		status post epilepsy surgery, , Cerebral Palsy with right				
		s, mental retardation,				
		sive behavior and somnolence.				
		s ordered on admit included:				
	armodafinil (Nuvigil) 150 mg tab Take 1 tablet by				
		Review of R129's Medication				
		ord for January/February 2016				
		or Nuvigil tab 150 mg. 1 tablet				
		edication was scheduled to be				
		ne medication administration initials circled every day from				
		16. Six of the days had the				
	0	nderneath the signatures, and				
		e medication administration				
	record had nothing	written on it. Interview with				
		ing (DON) on 2/15/17 at 12:51				
		facility did not have a policy				
		procedure was for when a				
		t available. DON indicated the				
	•	be for the nurse to circle his or				
		fy the physician of why the the medication. DON				
		familiar with R129's case and				
		macist to see if there was				
		ng this and would also ask the				
		d if a resident's medication				
		by the pharmacy, the pharmacy	,			
		cility. On 2/16/17 the DON				
		no further information on why				

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TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:				
		00494	B. WING			C 16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IGHLAN	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21535	Continued From pa	age 40	21535				
	the physician, and the patient. The Denot notified in a time receiving the medic Interview with regist at 1:50 p.m., stated was not delivered to call the pharmacy. delivered she would physician. If the physician was not well the request, she we	stered nurse (RN)-A on 2/15/17 d that if a resident's medication by the pharmacy, she would If the medication still wasn't d contact the resident's hysician was not responsive to build contact the medical not know if there was a policy	,				
	director of nursing conjunction with the develop policies an monitoring behavior prescribed antipsyc ensuring residents ordered. The DON these changes in p resident records to implemented. Res to the quality assur	THOD OF CORRECTION: The (DON) could work in e consultant pharmacist to ad procedures related to ors of residents who are chotic medications, and receive medications as could educate staff related to policy and procedure, and audit ensure process changes are ults of audits could be reported ance committee for further to ensure ongoing compliance	t				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			3/28/17	
	Drugs used in the r	nursing home must be labeled					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
				A. BUILDING:		С
		00494	B. WING			16/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH SAUL, MN 5511			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
21620	Continued From pa	lge 41	21620			
	in accordance with	part 6800.6300.				
	This MN Requirem	ent is not met as evidenced				
	by: Based on observati review, the facility f medications were r given to residents. (R53) and had the	ion, interview, and document ailed to ensure expired emoved from storage and not This affected one resident potential to affect all other t who may have been given		corrected		
	stock medications.					
	Findings include:					
	7:10 p.m. in the 2 w following expired st observed. Licensec confirmed expiratio	storage review on 2/13/17, at vest medication cart, the ock medications were d practical nurse (LPN)-B n dates and removed ne cart for destruction.				
	with pharmacy labe and manufacturer la- Bottle of ½ full ma with pharmacy labe manufacturer label - Bottle of ¾ full cal 600/200mg tablets date of 8/17/16, and expiration date. - Full bottle of mine expiration date of 6 expiration date of 1					
	remained) with pha	de 2mg capsules (46 capsules rmacy label expiration date of anufacturer label expiration				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	of connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		00494	B. WING		C 02/16/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	TH CARE CENTER	ST SEVENTH	-		
		SAINT P	AUL, MN 5511		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	age 42	21620			
	sulfate was observ unopened vials wit	pium bromide and albuterol red which contained 16 h a pharmacy label expiration nd manufacturer expiration date)			
	1/16/17, included " vial per neb 4 time	cian medication orders dated ipratropium/sol albuter inhale 1 s daily as needed". LPN-B date and removed the box fron t.				
	administration reco received the medic	ebruary 2017 medication ord (MAR) indicated R53 cation once on 2/4/17, 2/5/17, twice on 2/7/17, 2/8/17.				
	(DON) on 2/14/17, expired medication medication cart. Do pharmacist stated	ith the director of nursing at 3:41 p.m. DON stated as should not be stored in the ON further indicated the manufacturer expiration dates of the pharmacy label expiration	1			
	Pharmacy Dispositi policy revealed: "10 deteriorated medic that are cracked, s secure closures ar stock, disposed of procedures for me	ity's undated Merwin LTC tion of Unused Medications 0. Outdated, contaminated or cations and those in containers coiled, unlabeled or without e immediately removed from according to facility dication destruction and e pharmacy if a current order				
	administrator, direc	THOD OF CORRECTION: The ctor of nursing (DON) and cist could review and revise				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	or connection	IDENTITION TON NOMBER.	A. BUILDING	:		
		00494	B. WING		C 02/16/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IIGHLAI	ND CHATEAU HEALT	H CARE CENTER	EST SEVENTI			
		SAINTP	AUL, MN 55		DEATION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	age 43	21620			
	medications. Nursi necessary to the in medications proper medications. The D the pharmacist, con regular basis to en	dures for proper storage of ng staff could be educated as nportance of labeling dy and discarding expired DON or designee, along with uld audit medications on a sure compliance. R CORRECTION: Twenty-one	9			
21710	Subp. 7. Hot water	5 Subp. 7 Plant eration, & Maintenance r temperature. Hot water nd bathing fixtures must be	21710			3/28/17
	maintained within a	t to115 degrees Fahrenheit at	t			
	by: Based on observat review, the facility f temperatures in res bathing rooms were range. This had the residents identified 12:10 p.m. as havin Alzheimer's, demen	ent is not met as evidenced ion, interview and document ailed to ensure water sident bathrooms and/or e maintained at a comfortable e potential to affect 16 by the facility on 2/16/17, at ng diagnoses that included ntia or other related diagnoses who resided in the facility.		corrected		
		p.m. the water in the 111 was noted to feel overly				
	warm to the touch this time, water ten	by two different surveyors. At aperatures were tested with the ED) and two surveyors	e			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00494		B. WING	B. WING		C 16/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HIGHLAN	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21710	Continued From pa	age 44	21710			
	utilizing a thermometer provided and operated by the ED.					
		s were noted in the following o be greater than 120 degrees				
	registered 132° (de	ater in room 104-west (W) grees) (F) using a laser heat d the water felt hot to the				
	110°F using the las was testing the wat stated "That's hotte temperatures." The get a different therr used when testing compared the two t in room 111-W was	in room 111-W registered at ser thermometer. The ED, who er, touched the water and er than 110, I know my e ED stated he was going to nometer, which he personally water temperatures, and thermometers. When the wate a retested using the ED's vater temperature registered at	r			
		ater in room 105-W registered ED's thermometer and 107° rmometer.				
		ater in room 112-E registered D stated "the gun needs				
	at 126.4° F with the resident in the room fine. At this time the gun thermometer n	ater in room 114-E registered E ED's thermometer. The In stated the water temp felt E ED again stated the laser leeded to be recalibrated. All after this, were taken using eter.				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				A. BUILDING.		С
		00494	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IGHLAN	ID CHATEAU HEALT	H CARE CENTER	ST SEVENTH AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21710	Continued From pa	age 45	21710			
	at 124.2° F. The re had not used the ba 239-E did, as it was resident in 239-E w At 6:20 p.m. the wa at 127.5° F; at 6:22 shower registered a At 6:25 p.m. the re the water heated up When tested the w	esident in room 221-CE stated p quickly, but liked hot water. ater in the bathroom of 221-CE	Ξ			
	at 118.5. When ask was still rising, the	ater in room 207-W registered ked if the water temperature ED said it was still slowly nagine that if we left it running				
	2/17, revealed wate temps 100° to 123°	emperature logs from 1/17 and er temperatures ranged from ° F. The log indicated water taken once a day in different				
		D stated the maintenance staff d there was a mixing valve				
	turn on both the ho bathroom sink, whi the bedroom. Whe	a.m. R37 was observed to t and cold water valves in the le the nursing assistant was in n asked how the water e stated it was "warmer than				
		THOD OF CORRECTION: supervisor, administrator or				

PRINTED: 03/20/2017 FORM APPROVED

ND PLAN OF CORF		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AME OF PROVIDE				· · · · · · · · · · · · · · · · · · ·	C	
AME OF PROVIDE		00494	B. WING		02/16/2017	
	R OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IGHLAND CHA	TEAU HEALT	H CARE CENTER	ST SEVENTH			
		SAINT P	AUL, MN 5511			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMF	
21710 Contin	ued From pa	age 46	21710			
proceed to sink a temp to 115 mainted design and de water mainta degree the fix	dures related s and bathin berature rang degrees Fal enance supe nee could develop a mor supplied to s ained within a es Fahrenhei tures.	view and revise policies and to ensuring hot water supplied or fixtures is maintained within ge of 105 degrees Fahrenheit hrenheit at the fixtures. The rvisor, administrator or velop a system to educate staff hitoring system to ensure hot sinks and bathing fixtures is a temperature range of 105 it to 115 degrees Fahrenheit a R CORRECTION: Twenty-one	t			
esota Departmer	t of Ucolth					