#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KU29 Facility ID: 00494

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1. MEDICARE/MEDICAID PROVIDER NO.       3. NAME AND A.         (L1) 245028       (L3) HIGHLANI         2.STATE VENDOR OR MEDICAID NO.       (L4) 2319 WEST         (L2) 299242600       (L5) SAINT PAU			CHATEAU I SEVENTH S	HEALTH (	CARE CENTER (L6) 55116	4. TYPE OF AC  1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9) <b>04/01/2004</b>		7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey A		
6. DATE OF SURVEY 01/3 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	30/2015 (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 EN	NDING DATE: (L35)	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Or		rements:	
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of 7. Medical	f Services Limit	
12.Total Facility Beds	<b>64</b> (L18)	•	cceptable POC		4. 7-Day RN (Rural Sl		Room Size	
13.Total Certified Beds	<b>64</b> (L17)		npliance with Pro- ents and/or Appl		* Code: <b>A</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
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 REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Suesanne Reuss, Supervi	sor	0	01/30/2015	(L19)	Anne Kleppe, Enforce	ement Specialist	02/17/2015 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	7	
19. DETERMINATION OF ELIGIBIDATE  1. Facility is Eligible to 1	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :			
22. ORIGINAL DATE	23. LTC AGREEI	MENT 2/	4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)	
OF PARTICIPATION	BEGINNING		ENDING DA		VOLUNTARY 0		LUNTARY	
01/01/1967	DD OIL (III)	, , , , , , , , , , , , , , , , , , , ,	ENDING BIL		01-Merger, Closure	<del></del>	l to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	00141	l to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHE		
	A. Suspension	n of Admissions:	7.10		04-Other Reason for Withdrawal	07-Pro 00-Act	ovider Status Change	
(L27)	B. Rescind St	uspension Date:	(L44)			00-Act	live	
20 TERMINATION DATE.	20	) INTERMEDIARY	(L45)		20 DEMARKS			
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	L DATE				
	(L32)	01/22/2015		(L33)	DETERMINATION APP	ROVAL		



CMS Certification Number (CCN): 24-5028

March 4, 2015

Ms. Erin Shvetzoff Hennessey, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, Minnesota 55116

Dear Ms. Shvetzoff Hennessey:

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 January 13, 2015 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.

Sincerely,

Dre Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Health Regulations Division Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697



February 17, 2015

Ms. Erin Shvetzoff Hennessey, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, Minnesota 55116

RE: Project Number S5028025

Dear Ms. Shvetzoff Hennessey,

Enclosed please find updated CMS forms 2567B for Health and Life Safety Code post-certification revisit findings for Highland Chateau Health Care Center. The forms reflect a correction date of 1/13/2015 (vs 1/15/2015, previously mailed to you). If you have any questions, please let me know.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4124 Fax: (651) 215-9697

Email: anne.kleppe@state.mn.us



January 30, 2015

Ms. Erin Shvetzoff Hennessey, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, Minnesota 55116

RE: Project Number S5028025

Dear Ms. Shvetzoff Hennessey:

On December 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 26, 2015 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 December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective January 15, 2015 and therefore remedies outlined in our letter to you dated December 18, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Dre Kleese

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Health Regulations Division Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

# Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245028	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/30/2015
Name of Facility		Street Address, City, State, Zip Code	
HIGHLAND CHATEAU HEALTH CAR	E CENTER	2319 WEST SEVENTH STREET	Г

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).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5) Date	(Y4	) Item	(	Y5)	Date
	F0241 483.15(a)		Correction Completed 01/13/2015	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483.	Correctic Complet 01/13/20 10(k)(2)	ed		F0282 483.20(k)(3)(ii)		Correction Completed 01/13/2015
ID Prefix Reg. # LSC	483.25		Correction Completed 01/13/2015	ID Prefix Reg. # LSC	F0311 483.25(a)(2)	Correction Complet 01/13/20	ed	ID Prefix Reg. # LSC	F0431 483.60(b), (d),	(e)	Correction Completed 01/13/2015
	F0441 483.65		Correction Completed 01/13/2015			Correction Complet					Correction Completed
ID Prefix Reg. # LSC											
Reg. #											
Reviewed I	Зу	Reviewed	Ву	Date:	Signature	of Surveyor:		-		Date:	
State Agen	су	SR/AK		02/17/2	015			16022		01/30	0/2015
Reviewed E	Зу	Reviewed	Ву	Date:	Signature	of Surveyor:				Date:	
Followup t	o Survey Co 12/4	ompleted or 1/2014	1:		Check for any Uncorrected	Uncorrected D Deficiencies	eficien CMS-2	cies. Was a 567) Sent to	a Summary of the Facility?	YES	NO

# Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245028	(Y2) Multiple Con: A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 1/26/2015	
Name of Facility			Street Address, City, State, Zip Code		
HIGHLAND CHATEAU HEALTH CARE CENTER			2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	Г	

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).

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5	5) [	Date
ID Prefix	NEDA 404	Correction Completed 01/13/2015	D "		Correction Completed		ID Prefix			Correction Completed
_	NFPA 101 K0050		Reg. # LSC				Reg. # LSC			=
Reg. #			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
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ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			
Reviewed B	By Re	viewed By	Date:	Signature of Sur	veyor:	1		D	ate:	
State Agen	cy P	S/AK	01/30/2015				12424	(	01/26	5/2015
Reviewed B	Ву Re	viewed By	Date:	Signature of Sur	veyor:			D	ate:	
Followup t	o Survey Compl 12/4/20		c	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?			.::	/ES	NO	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

		ARE/MEDICAL TO BE COMPI							: KU29
1. MEDICARE/MEDICAID PROVII (L1) 245028 2.STATE VENDOR OR MEDICAID (L2) 299242600	DER NO.	3. NAME AND AI (L3) HIGHLAND (L4) 2319 WEST (L5) SAINT PAU	DDRESS OF FAC CHATEAU I SEVENTH ST	CILITY HEALTH (	CARE CENTER (L6) 5		4. TYPE C  1. Initial 3. Termin 5. Valida 7. On-Sit	OF ACTION: nation tion	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9) 04/01/2004 6. DATE OF SURVEY 12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	04/2014 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 14 CORF 0 15 ASC 16 HOSPICE	22 CLIA	FISCAL YEA	AR ENDING	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	64 (L18) 64 (L17)	Complianc1. A  X B. Not in Con	nce With equirements to Based On: cceptable POC	gram	3. 24 Ho 4. 7-Day 5. Life S	ical Personnel our RN RN (Rural SN afety Code	6. Sc 7. M F) 8. Pa	Requirement ope of Servi edical Direct tient Room S eds/Room	ces Limit tor
14. LTC CERTIFIED BED BREAKD  18 SNF 18/19 SNF 64 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY ME		(I	L15)	
STATE SURVEY AGENCY REN     SURVEYOR SIGNATURE     Vidya Tomar, HFE NE I		Date :	01/08/2015	(L19)	18. STATE SURV			list	Date:01/16/2015(L20
PA	ART II - TO BE	COMPLETED I	BY HCFA RI	` /	L OFFICE OR	SINGLE S	FATE AGE	NCY	(LZU)
DETERMINATION OF ELIGIBLE     1. Facility is Eligible to     2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. Ov	atement of Finan vnership/Contro th of the Above	l Interest Disclo		CFA-1513)
22. ORIGINAL DATE  OF PARTICIPATION  01/01/1967  (L24)	23. LTC AGREEI BEGINNING (L41)		4. LTC AGREEM ENDING DA		26. TERMINAT  VOLUNTARY  01-Merger, Closur  02-Dissatisfaction	 re a W/ Reimburse	ment (		
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS  n of Admissions:  uspension Date:	(L44) (L45)		03-Risk of Involun 04-Other Reason f	-	<u>(</u>	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	L DATE					

(L33)

DETERMINATION APPROVAL

(L32)



Certified Mail # 7010 1670 0000 8044 4547

December 18, 2014

Ms. Erin Shvetzoff Hennessey, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, Minnesota 55116

RE: Project Number S5028025

Dear Ms. Shvetzoff Hennessey:

On December 4, 2014, 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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the 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>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;

Highland Chateau Health Care Center December 18, 2014 Page 2

<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 P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: <a href="mailto:susanne.reuss@state.mn.us">susanne.reuss@state.mn.us</a>

Telephone: (651) 201-3793

Fax: (651) 201-3790

#### 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 January 13, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

#### PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC 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 PoC 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 PoC 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 PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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

Highland Chateau Health Care Center December 18, 2014 Page 4 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

#### 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 March 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). 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 June 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

Highland Chateau Health Care Center December 18, 2014 Page 5

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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: <u>pat.sheehan@state.mn.us</u> Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Are Klegge.

Anne Kleppe, Enforcement Specialist

Highland Chateau Health Care Center December 18, 2014 Page 6

Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: <a href="mailto:anne.kleppe@state.mn.us">anne.kleppe@state.mn.us</a>

Telephone: (651) 201-4124 Fax: (651) 215-9697

#### Enclosure

cc: Licensing and Certification File

PRINTED: 12/18/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245028	B, WING		12/04/2014	
	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)	NTEMENT 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 APPROPI DEFICIENCY)	BE COMPLÉTIC	ИС
F 000	as your allegation of Department's acce bottom of the first poe used as verifica. Upon receipt of an revisit of your facilitivalidate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an enhances each restull recognition of horizontal transfer in the province of	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will	F 24	Preparation, submission and implementation of this Plan of Correction do not constitute a admission of or agreement with facts and conclusions set for the survey report. Our Plan of Correction is prepared and exast a means to continuously in the quality of care and to comwith all applicable state and foregulatory requirements.	an ith the th on of secuted mprove nply ederal  een ect sident aints  eatment s an n care nt in a ect and all light and s and vill be s.	(4)
L	V DIDECTORIC OF BOOM	DESCRIPTION OF THE PERSON NATIVE SIG	NIATHOE	TITLE	(X6) DATE	

Any deficiency statement ending with an asterist (\*) 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.

	LDIO/ UD GETTING					
	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	' '		CONSTRUCTION		SURVEY PLETED
	245028	B. WING		anglessen og grenne seg en en seg en	12/0	04/2014
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH CA	RE CENTER		231	REET ADDRESS, CITY, STATE, ZIP CODE 9 WEST SEVENTH STREET INT PAUL, MN 55116		
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
staff treated her with dig of having to wait so long having to wait a half ho get off the toilet. R27 and time for help in being tradressed and undressed made her feel, R27 resphere, like their playing gbeing. I'm human but I chuman. I just get treated something."  R27's care plan for impressed sand Parkinson directed staff to provide for transfers and ambul care plan, last revised 1 have two staff assist with morning. The self care revised 9/25/11, directe assistance of one staff.  On 12/2/14 at 3:25 p.m. R27's unit, (NA)-E, reporting time for call lights three nursing assistants. NA-E explained if resic 2 or 3 staff for cares, the assistant to help answers sometimes residents or wait for help.  On 12/2/14 at 3:25 p.m. (NA)-D, on R27's unit for help.	ur to get help from staff to Ided she waited a long ansferred into bed, . When asked how that bonded "Like I'm not even ames with a human don't get treated like d like a wall flower or asired mobility related to on's, last revised 6/9/14, assistance of one staff ation. The fall prevention 1/19/14 directed staff to th getting up in the deficit care plan, last d staff to provide for dressing.  . a nursing assistant on orted residents waited a to get answered when only swere on second floor. Ident required assistance of at did not leave a nursing er call lights. NA-E reported omplained about having to a nursing assistant,		241			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	H CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	DE		
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F 241		-D added residents had many all issues and required timely	F 24	11			
	working on R27's uresidents have to vusing the toilet. R2 toilet alone after trashe has not been a NA-A reported R27	p.m. a nursing assistant unit, (NA)-A, reported regularly vait a long time for help with 7 used to be able to sit on the ansfer assistance, but recently allowed to be left in there alone. You usually would yell when she but has also needed to wait in cares.					
	working on R27's u often needed to wa assistants worked explained if nursing onto the toilet and unit needed help, t need to wait for en	p.m. a nursing assistant unit, (NA)-B, reported residents ait for help if only three nursing on second floor. NA-B g aides helped one resident then another resident on the hen the one on the toilet might ough staff to be available for finish helping them with					
F 280 SS=D	through 12/4/14 re activated for over 1 arrived to help on occasions indicate from the bathroom was activated from 483.20(d)(3), 483.	call light log for 11/4/14 vealed the call light was wenty minutes before staff iive occasions. Three of those d the call light was activated . Two indicated the call light to bedroom. 10(k)(2) RIGHT TO ANNING CARE-REVISE CP	F 2	80			
	incompetent or oth	he right, unless adjudged nerwise found to be er the laws of the State, to					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245028				/04/2014
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F 280	participate in plann changes in care ar A comprehensive of within 7 days after comprehensive as interdisciplinary tea physician, a registe for the resident, ar disciplines as dete and, to the extent the resident, the relegal representative	aing care and treatment or and treatment.  care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility and other appropriate staff in rmined by the resident's needs, practicable, the participation of esident's family or the resident's e; and periodically reviewed eam of qualified persons after	F 2	Resident #42 has had care integrated to incl monitoring for infection bleeding of CVC dialyst graft care removed from care plan.  All residents receiving services have the potential fected by this praction Nurse managers and local coordinator have been need for integrated playereflect dialysis site even monitoring.  Nurse managers have residents receiving dialysis of consure the plan of consumers the consumers the plan of consumers the plan of consumers the consumers the consum	ude on and sis site and om dialysis quialysis ential to be ce. MDS an educated or ans of care to aluation and reviewed all alysis service care reflects	
	by: Based on observative review, the facility plan of care relate (CVC) hemodialystare plan reviewed Findings include: R42's care plan rewas not revised to potential infection site.  During observation R42 was sitting in was watching tele a dialysis clinic the	ation, interview and document failed to review and revise the d to central venous catheter is site for 1 of 1 resident (R42) d.  Alated to hemodialysis treatment include the monitoring for and bleeding of current CVC ons on 12/03/14, at 2:00 p.m. her wheelchair in her room and vision. R42 stated she went to ree times per week to receive timent. When asked regarding		site management and Audit by DON/designed dialysis patients charplan of care reflects somanagement and morongoing.  Audits will be reviewed three months to ensure of dialysis services.  Deficient practice to 1/13/2015.	ee of all is to assure ite initoring will be at QAA for re coordinati	on

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		E SURVEY PLETED
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(X4) ID PREFIX TAG	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETIO DATE
F 280	her dialysis site, R2 chest stating, "here a dressing on it. W staff monitored her R24 stated, "the nuanything to it."  During record revie plan of care, dated to dialysis three tim Renal Disease (ES included monitor la pressure dressing bleeding occurs frobleeding of the subclavian dialysis site, there the nursing staff m CVC site integrity of infections, bleeding dislodging of CVC On 12/04/12, at 10 (RN)-C indicated F graft and the only subclavian site for current dialysis plan of car graft care and add	24 pointed to her right upper is the catheter". The site had then asked how frequently the site for infection and bleeding, urses don't look at it or do asked how frequently the site for infection and bleeding, urses don't look at it or do asked how on 12/03/14, the dialysis 10/19/14, revealed R24 went nes per week due to End Stage (SRD). The interventions to, check vital signs, remove after dialysis per order and if the site apply pressure, if a transport R24 to the check for bruit/thrill (to monitor patency) every shift, do not blood pressure in the arm with and written undated note under splan of care indicated R24's genanges occurred at the was no documentation whether conitored and recorded R42's during each shift to limit/prevent gencerns and potential of catheters.  2000 a.m. Registered Nurse R42 did not have a fistula or site R42 had was the dialysis. After reviewing R42's an of care, RN-C stated, the re needed revision to remove CVC care and monitoring.		80		
	On 12/04/12, at 10 (RN)-C indicated F graft and the only subclavian site for current dialysis pladialysis plan of car graft care and add RN-C reviewed the records to see if the documenting CVC	catheters.  2:00 a.m. Registered Nurse R42 did not have a fistula or site R42 had was the dialysis. After reviewing R42's an of care, RN-C stated, the re needed revision to remove				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245028	B, WING	Name and Address of the	to the state of th	12/0	04/2014
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	,		9 WEST SEVENTH STREET INT PAUL, MN 55116		
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F 282 SS=D	add the CVC site in records for nurses medical care team her CVC site.  483.20(k)(3)(ii) SEI PERSONS/PER C.  The services provide must be provided by accordance with eacordance activities of dail bathed according the Findings include:  R80's most recent 9/18/14, collection memory/recall ability decision making.  R80's care plan refervised 9/23/14, dand supervision with treatment record donce a week with servirity."  Interview with R80 was asked a questing a contract the contract	nonitoring to the treatment to document and update R42's if there were any changes in RVICES BY QUALIFIED		282	• F282 Resident #80 and Resident #2 received showers per their preferences. All residents are at risk of not receiving showers per prefere or schedule. Nursing staff educated on giv showers per resident preferer schedule or PRN need. Nursing staff educated on documenting on showers rour as well as documenting refuse care and offering a shower ag refused. Audits weekly by DON/design assure that showers are being completed per the resident's preference or in accordance w schedule. Audits will be reviewed at QA/ three months to ensure adher to policy. Deficient practice to be correct 1/13/2015	ences ing ince, tinely als of ain if ee to  vith A for eence	

AND PLAN OF CORRECTION IDENTIFICATION NOWIGER. A, BUILDING	
245028 B. WING	12/04/2014
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F 282 It for that week, even if I really want it." R80 explained that he had not been bathed last week and was supposed to be bathed one time a week.  A review of the November and December 2014 resident body audit forms, untitled bathing forms and November treatment record revealed R80 received showers on 11/3/14, 11/17/14 and 12/1/14 for the time period of 11/1/14 through 12/3/14.  A review of Interdisciplinary Notes for 11/1/14 through 12/3/14 did not reflect R80 declined bathing at any point.  On 12/3/14 at 8:00 a.m. the nurse manager for second floor, [RN]-B reported a body audit sheet should be completed to reflect if resident was bathed or refused. At 9:25 a.m. RN-B reported staff should offer a shower weekly on the scheduled day. If a resident chose not to have a shower at that time, the resident should be re-approached and offered different choices. RN-B confirmed there was no evidence of showers being given, outside of 11/3/14,11/17/14 and 12/1/14. RN-B could not explain the circumstances surrounding R80 not receiving a shower each week.  Although, on 12/4/14 at 8:15 a.m., the director of nursing [DON] reported an aide [NA]-C had been called and reported she showered R80 on 11/10/14, the DON confirmed this was not reflected in R80's medical record.	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTR ING	(X3) DATE SURVEY COMPLETED		
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, ,, ,,,,,,	PROVIDER OR SUPPLIER	H CARE CENTER		2319 WEST	ORESS, CITY, STATE, ZIP CODE SEVENTH STREET UL, MN 55116		
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F 282	R27's care plan title weakness, Parkins revised 9/25/11, dir bathing" A review of December medicated directed staff to enshampoo (Seleniur showers once wee  During interview or was asked about the R27 responded that shower every night just once a week be waiting.  During interview or reported that some showered weekly a shower recently. Reference the shower would restrict the sho	ed "Self Care Deficit related to: on's and dementia", last ected staff "Assist with f R27's November and ion administration record sure R27 used a prescription in Sulfate Lotion 2.5%) with	F	282			
	On 12/4/14 at 9:41 [DON] confirmed s	a.m. the director of nursing he had provided all records of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMF	SURVEY PLETED
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	PROVIDER OR SUPPLIER ND CHATEAU HEALT			STREET ADDRESS, CITY, STATE, ZIP CO 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	DDE	
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F 282	R27's bathing for I 12:09 p.m. the DC assistant should k the shower schedd the shower was completed due to attempt an interve showered and if u The nursing staff or made aware of mi alternate time. The aware of missed substantial time and plan of care.  Each resident mu provide the necessor maintain the himmental, and psychaccordance with the and plan of care.  This REQUIREMI by: Based on observed the necessor maintain the himmental of care.  This REQUIREMI by: Based on observed the necessor findings include: R42's care plan revised to revised the necessor findings include:	November and December. At an investment of the nursing and the nursing and the nurse should ensure completed. If the shower was not a refusal the nurse should antion to ensure the resident ansuccessful offer alternatives. On the next shift should be a ssed showers in order to try and an enurse manager should be showers.  CARE/SERVICES FOR BEING  st receive and the facility must sary care and services to attain a ghest practicable physical, ansocial well-being, in the comprehensive assessment as a service to the edition, interview and document of failed to review and revise the edition to the same and services.		F309 Resident #42 has had he CVC site assessed for in bleeding and has had ne effects from this practice. All residents receiving a services have the potent affected by this practice. Nursing staff have been need for CVC dialysis somonitoring and notificate medical team with chan not not not not not not not not not no	rection and o negative i.e. dialysis tial to be e.e. educated on ite tion to ages. eviewed all ysis services record and plete weekly e reviewed at o ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245028	B. WING		ANN	12/	04/2014	
	NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH CARE CENTER			2319	ET ADDRESS, CITY, STATE, ZIP CODE WEST SEVENTH STREET T PAUL, MN 55116	TH STREET		
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F 309	Continued From p	_	F3	809			A Private in Article i	
	R42 was sitting in was watching tele a dialysis clinic thr life sustaining treather dialysis site, Fohest and said, "had a dressing on the staff monitore."	hes on 12/03/14, at 2:00 p.m. her wheelchair in her room and vision. R42 stated she went to receive atment. When asked regarding 124 pointed to her right upper ere is the catheter". The site it. When asked how frequently d her site for infection and ted, "the nurses don't look at it t."				<i>;</i>		
	plan of care, date to dialysis three til Renal Disease (E included monitor I pressure dressing bleeding occurs fi bleeding continue emergency room. a graft or fistula's draw blood or tak graft. Although a the social service sublcavian dressi dialysis site, there the nursing staff r CVC site integrity	lew on 12/03/14, the dialysis of 10/19/14, revealed R24 went mes per week due to End Stage SRD). The interventions ab, check vital signs, remove after dialysis per order and if om the site apply pressure, if is transport R24 to the check for bruit/thrill (to monitor patency) every shift, do not e blood pressure in the arm with hand written undated note under is plan of care indicated R24's ing changes occurred at the e was no documentation whether monitored and recorded R42's during each shift to limit/prevent	`					
	On 12/04/12, at 1 (RN)-C indicated graft and the only subclavian site fo current dialysis pl	ng concerns and potential of C catheters.  0:00 a.m. Registered Nurse R42 did not have a fistula or site R42 had was the r dialysis. After reviewing R42's an of care, RN-C stated, the are needed revision to remove						

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
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F 309	RN-C reviewed the records to see if the documenting CVC and found there was the CVC site monits add the CVC site more records for nurses medical care team her CVC site.  483.25(a)(2) TREA IMPROVE/MAINTA A resident is given services to maintain specified in paragram This REQUIREME by:  Based on interview facility failed to prove residents (R80, R2 daily living that require with bathing.  Findings include:  R80's most recent 9/18/14, collection memory/recall ability decision making.  R80's care area as set [MDS], dated 9 supervision by stat requires assist with	CVC care and monitoring.  medication and treatment e nursing staff was monitoring on these records as no documentation regarding oring. RN-C stated he would nonitoring to the treatment to document and update R42's if there were any changes in	F3	• F311 Resident #80 and resident been provided assistance to participate with bathing	provide or shower meeding pripation. participate giving erences, flucation showers menting nurse and prior signee to eing y given for therence	-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245028	B. WING			12/	04/2014
	PROVIDER OR SUPPLIER			23	TREET ADDRESS, CITY, STATE, ZIP CODE B19 WEST SEVENTH STREET AINT PAUL, MN 55116		
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F 311	was asked how m bath or shower?" I on Monday, I don' really want it. I got bitched." R80 add last week at all. Ridue to staffing issue R80's care plan rerelated to: dx [diag weakness", last re"Provide assist an R80's November to "Bath/Shower ond nurse. Nurse to ve A review of the Noresident body aud and November trereceived showers 12/1/14 for the tim 12/3/14.  A review of Interdit through 12/3/14 at 8:0 second floor, [RN] should be comple bathed or refused staff should offer scheduled day. If shower at that tim	on 12/1/14 at 3:38 p.m. R80 any times a week R80 took a R80 responded, "If I don't get in t get it for that week, even if I one today because I really ed that he had not been bathed 80 reported he was told it was ues.  Plated to "Self Care Deficit gnosis] of progressive exised on 9/23/14, directed staff d supervision with shower." creatment record directed staff e a week with skin check by erify."  Every progressive exists and December 2014 it forms, untitled bathing forms extend trecord revealed R80 on 11/3/14, 11/17/14 and the period of 11/1/14 through	F	311			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			231	REET ADDRESS, CITY, STATE, ZIP CODE 9 WEST SEVENTH STREET INT PAUL, MN 55116		
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F 311	RN-B confirmed the showers being give and 12/1/14. RN-I circumstances sure shower each week Although on 12/4/inursing [DON] repicalled and reporte	nere was no evidence of en, outside of 11/3/14,11/17/14 B could not explain the rounding R80 not receiving a could at 8:15 a.m. the director of orted an aide [NA]-C had been d she showered R80 on I confirmed this was not	F	311			
	was asked how of shower?" R27 res shower every nigh just one because  A review of R27's Minimum Data Se revealed R27 requipart of bathing. The noted "Triggered with cares. She do Parkinson's and stimes. She is aler communicate her no change in the with cares though possible that she in the amount of a progresses." The R27 was cognitive A review of R27's	red on 12/1/14 at 6:09 p.m. and ten R27 took a bath or ponded that ideally she would at but decided to go along with the waiting is "horrible".  care area assessment and it (MDS), dated 8/14/14, uired physical help by staff in the care area assessment further because she required assist the does become more stiff at and oriented and able to needs to the staff. She has had amount of assistance needed based on her diagnosis it is will have a change/deterioration assistance need as her disease MDS, dated 8/14/14, revealed ely intact.  care plan titled "Self Care weakness, Parkinson's and	5				

	TO F OTT WILD TO THE	<u> </u>	r			1	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 311	dementia", last revi "Assist with bathing and December medirected staff to enshampoo (Seleniur showers once wee!  A review of the Nov treatment and med body audits and un through 12/3/14 rev on 11/7/14, 11/14/1 provided that reflect A review of interdis through 12/3/14 rev shower.  During interview or reported sometime least once each we shower recently. R skip the shower du her.  On 12/4/14 at 9:41 (DON) confirmed so of R27's bathing fo 12:09 p.m. the DO assistant should kr the shower was co completed due to attempt an interver showered and if ur The nursing staff of made aware of mis	ised 9/25/11 directed staff g" A review of R27's November dication administration record sure R27 used a prescription in Sulfate Lotion 2.5%) with kly.  Identify a subject of the subject		311			

OLITTE:	10 / OII MED 10: 11:12		1		T	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245028	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER ND CHATEAU HEALT	H CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 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	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE
F 431 SS=D	The facility must er a licensed pharmar of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled.  Drugs and biologic labeled in accordar professional princip appropriate access instructions, and thapplicable.  In accordance with facility must store a locked compartme controls, and perm have access to the The facility must propermanently affixe controlled drugs list Comprehensive Drugs abuse, except whe package drug distripuntity stored is readily detected.	anploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug ir and that an account of all maintained and periodically als used in the facility must be not existed in the facility must be not existed and include the cory and cautionary are expiration date when the state and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys.  Tovide separately locked, docompartments for storage of the drug Abuse Prevention and and other drugs subject to the facility uses single unit ibution systems in which the ninimal and a missing dose car	F	Residents #79, #124, # medications replaced a surveyor notified facility. All residents are at risk medication that has not with date opened and edate.  Nurses have been educt proper dating and expidence and insulin.  DON/designee to audit ensure proper dating a of eye drops and insuling policy.  Audits will be reviewed three months to ensure to this policy.  Deficient practice to be 1/13/2015.	at the time ty. c for receiving t been dated expiration cated on iration of eye weekly to and expiration in as per d at QAA for e adherence	
	by:	in is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		245028	B. WING	mand distribution and resident and self-state at six matter of the form and the self-state of the self	1	2/04/2014		
	PROVIDER OR SUPPLIER	H CARE CENTER		STREET ADDRESS, CITY, STAT 2319 WEST SEVENTH STRE SAINT PAUL, MN 55116	E, ZIP CODE			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 431	review, the facility were stored and la residents (R79, R1 were observed for Findings include:  During observation storage areas thro for R79, R124 and and eye drops, lac they were opened, expired.  The medication stowas reviewed on 1 licensed practical R79's insulin vial, diabetes) was ope expired. At 8:08 a. medication was ope stated the insulin would give it to the destroyed.  During the medica at 8:16 a.m. with dirst floor east, mu vials were observed R124's Novolog in (medication for dia and had been use R141's Travatan (hypertension) eye undated and used Review of R124's administration recommends.	failed to ensure medications beled properly for 3 of 5 24, R141) whose medications medication storage.  In sof multiple medication ughout the facility, medications R141, which included insulin ked dates to indicate when or when the medications were crage area of first floor east 2/3/14, at 8:05 p.m. with nurse (LPN)-C:  Novolog (medication for ned, undated and potentially m. LPN-C verified the pened and undated. LPN-C was delivered on 10/25/14 and enurse manager to be tion storage tour on 12/11/14, irrector of nursing (DON), in the latiple medication bottles and ad to be opened and undated: sulin and Novolin vials abetes) were opened, undated d. medication for ocular drop bottle was opened,		431				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245028	B. WING		anapanan gasaramanya <u>n apanaman anapanaman anapanaha d</u> alah diban mera hari kalik di Meli k	12/0	04/2014
	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				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 441 SS=D	eye drop bottle had medications to R12  During interview or director of nursing needed to be labele added that opened when opened and medication bottles expired medication pharmacy. DON fu vials would be ordenew eye drop bottle.  The facility's undat storage and usage other multidose injufirst use written on refrigerated after o manufacturer's received 483.65 INFECTION SPREAD, LINENS  The facility must expressed infection Control P safe, sanitary and to help prevent the of disease and infection Control The facility must exprogram under who (1) Investigates, coin the facility; (2) Decides what p should be applied	d been used to administer the 24 and R141.  In 12/3/14 at 8:18 a.m. the (DON) verified the medications ed and stored properly. DON medications should be dated staff were supposed to date when opened, check for is and re-order them from the orther indicated that new insulin ered for R79 and R124, and a ere for R141.  ed, Injectable medications policy directed, "Insulin and ections should have the date of the vial. Insulin vials not pened should be discarded per ommendations."  IN CONTROL, PREVENT  stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.  DI Program establish an Infection Control ich it controls, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective		441	• F441  Nursing assistant "A" has be educated on proper hand wa procedures, including use of sanitizer.  All residents who use the stalift are at risk of breach of incontrol by lack of hand wash between toileting and clothin assistance when up in the stalift.  Nursing staff educated on prehand hygiene when using the including option for hand say Audits will be completed were DON/designee to assure adherence to this policy.  Deficient practice to be corresponded.	ashing If hand	, ,

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245028	B. WING	Corwania Color		12/	04/2014
	PROVIDER OR SUPPLIE			2319	ET ADDRESS, CITY, STATE, ZIP CODE WEST SEVENTH STREET NT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	(b) Preventing Sp (1) When the Infedetermines that a prevent the spreatisolate the reside (2) The facility mucommunicable diffrom direct contact will (3) The facility muchands after each hand washing is professional practical times.	pread of Infection section Control Program a resident needs isolation to ad of infection, the facility must int. Lust prohibit employees with a sease or infected skin lesions of with residents or their food, if a transmit the disease. Lust require staff to wash their direct resident contact for which indicated by accepted	F4	41			
	by: Based on observer review, the facilit hygiene was con of 2 (R81) reside Findings include: Review of R81's (MDS) dated 9/1 memory or cogniextensive assistants. R81 was observed during morning of	vation, interview, and document y failed to ensure proper hand ducted after personal care for 1 ints reviewed in the sample.  quarterly Minimum Data Set 0/14, indcated R81 had no litive problems and required ance with most ADL's.  ed on 12/3/14, at 7:30 a.m., cares. Nursing Assistant (NA)-A, om to complete morning cares.					

Q-141 L1	TO TOTTIVILLE TO THE	CONTRACTOR CENTRACT	·		The second secon		0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245028	B. WING	i		12/0	04/2014
NAME OF PROVIDER OR SUPPLIER  HIGHLAND CHATEAU HEALTH 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	At 7:39 a.m., NA-B assisted NA-A to tra	age 18 entered the room and ansfer R81 from the bed onto Z Stand. NA-B then left the	F	441			
	the bathroom and a was completed, NA Stand and cleansed disposable wipe. Note that the glowest without completing transferred R81 to Stand handles, approduct, and pulled discarded her glowest wheelchair touching wheelchair handles	nands with soap and water in applied gloves. After toileting the Astood R81 using the EZ did the perineal area using a IA-A disposed of the wipe; ves; applied new gloves; and ock area. NA-A discarded the s, and applied new gloves hand hygiene. NA-A the bedroom holding the EZ slied a clean incontinent tup R81's pants. NA-A es and lowered R81 into the g the EZ Stand controls and s. NA-A then completed hand g hands with soap and water in					
	she had not washe personal cares. Not that way as R81 had to be in the EZ Stallonger to wash han On 12/3/14, at app Director of Nursing hand wash their had DON added, maybo	is p.m., NA-A confirmed that dher hands after R81's A-A stated, she typically does it is expressed she does not like not for too long and it takes ds with soap and water.  Toximately 1:15 p.m., the (DON) verified staff should nds after personal cares. The e it would benefit the facility to				:	
	takes to perform hat The Perineal Care	zer to decrease the time it and hygiene.  Policy dated 4/1/08, directed wash, hands after					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245028	B. WING			12/04/2014	
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIF 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) GOMPLETION DATE
F 441	The Hand Washing	pplying new gloves.  g Policy dated 4/1/08, states: liquids should be used when le. They should not be the	F	441			

丰50 280 25

PRINTED: 12/18/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 245028 12/04/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2319 WEST SEVENTH STREET HIGHLAND CHATEAU HEALTH CARE CENTER SAINT PAUL, MN 55116 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 K050 Fire drill practice has been updated FIRE SAFETY to include varying times throughout THE FACILITY'S POC WILL SERVE AS YOUR all three shifts. Audits will be reviewed at QAA for ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR three months to ensure adherence SIGNATURE AT THE BOTTOM OF THE FIRST to this policy. PAGE OF THE CMS-2567 FORM WILL BE Deficient practice to be corrected by USED AS VERIFICATION OF COMPLIANCE. 1/13/2015 UPON RECEIPT OF AN ACCEPTABLE POC, AN POCOK 10 18-15 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Highland Chateau Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY JAN - 8 2015 DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 01/08/15 Or by email to: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE TITLE 02/8/14

Any deficiency statement ending with an asterist (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient potection 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPL ING I	(X3) DATE SURVEY COMPLETED		
		245028	B. WING			12/	04/2014
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH CARE CENTER				2:	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET AINT 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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of volto correct the deficing to correct the deficing to correct the deficing to correct the actual, or proposed to the actual of the proposed to the proposed	tate.mn.us and n@state.mn.us  RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  If title of the person rection and monitoring to ence of the deficiency.  Healthcare Center is a 2-story al basement. The building was ferent times. The original ucted in 1963 and was if Type II(222) construction. In vas constructed to the south that was determined to be of uction. Because the original ditions meet the construction sting buildings, the facility was illding.  sprinkler protected throughout, omplete fire alarm system with the corridors and spaces and resident rooms, that is matic fire department cility has a licensed capacity of census of 58 at the time of the		000			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245028	B. WING		12	/04/2014	
	PROVIDER OR SUPPLIER	H CARE CENTER	231	EET ADDRESS, CITY, STATE, ZIP O 9 WEST SEVENTH STREET INT PAUL, MN 55116	CODE		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
K 050 SS=C	Fire drills are held varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to coqualified to exercis conducted between announcement malarms. 19.7.1.2  This STANDARD is Based on review of interview, it was do to conduct fire drills LSC (00) Section 1 could affect how start Findings include;  On facility tour betwon 12/04/2014, based ocumentation it which is the drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities. Day shift - 3 of 4 drills are not visibilities.	is not met as evidenced by: In reports, records and Intermined that the facility failed Is in accordance with NFPA 101 Interpretation of a fire. Int	K 050	DEFICIENCY)			



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4547

December 18, 2014

Ms. Erin Shvetzoff Hennessey, Administrator Highland Chateau Health Care Center 2319 West Seventh Street Saint Paul, Minnesota 55116

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5028025

Dear Ms. Shvetzoff Hennessey:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 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

Highland Chateau Health Care Center December 18, 2014 Page 2 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.

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: <a href="mailto:susanne.reuss@state.mn.us">susanne.reuss@state.mn.us</a>

Telephone: (651) 201-3793

Fax: (651) 201-3790

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,

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Health Regulations Division

Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00494	B. WING		12/04	4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HIGHLAN	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Department of the corrected requires or 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	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	surveyors of this De above provider and orders are issued. completed, please these orders and re	hrough the 4th, 2014 epartment's staff, visited the the following correction When corrections are sign and date, make a copy of eturn the original to the Health; Licensing and Certification		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00494	B. WING		12/04/2014
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	•
		2319 WFS	ST SEVENTH		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	UL, MN 551		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 000	Continued From pa	nge 1	2 000		
	Program; Minnesot	a Department of Health; P.O. al, Minnesota 55164-0900.		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Metho Correction and the Time Period Form Correction.  PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SOF MINNESOTA SOFTATIONS OF MINNESOTA	Tag." I the Ithe Itute/rule Iies" Iply" Inis Is which I after the Is veyors I of I or I THIS I O I THIS I O I ON FOR
				STATUTES/RULES.	
2 555	MN Rule 4658.0409 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555		
	must develop a cor each resident within completion of the c assessment as defi comprehensive pla	elopment. A nursing home mprehensive plan of care for a seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	X3) DATE SURVEY COMPLETED
00494 B. WING	12/04/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HIGHLAND CHATEAU HEALTH CARE CENTER 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the plan of care related to central venous catheter (CVC) hemodialysis site for 1 of 1 resident (R42) care plan reviewed.  Findings include:  R42's care plan related to hemodialysis treatment was not revised to include the monitoring for potential infection and bleeding of current CVC site.  During observations on 12/03/14, at 2:00 p.m. R42 was sitting in her wheelchair in her room and was watching television. R42 stated she went to a dialysis clinic three times per week to receive life sustaining treatment. When asked regarding her dialysis site, R24 pointed to her right upper chest stating, "here is the catheter". The site had a dressing on it. When asked how frequently the staff monitored her site for infection and bleeding, R24 stated, "the nurses don't look at it or do anything to it."  During record review on 12/03/14, the dialysis plan of care, dated 10/19/14, revealed R24 went to dialysis three times per week due to End Stage Renall Disease (ESRD). The interventions	

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Minnesota Department of Health

			E SURVEY PLETED				
		00494	В.	. WING		12/	04/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2	TREET ADDRE	SEVENTH			
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2 555	pressure dressing a bleeding occurs fro bleeding continues emergency room. of a graft or fistula's pure draw blood or take graft. Although a has the social service's sublcavian dressing dialysis site, there will be the nursing staff mod CVC site integrity dinfections, bleeding dislodging of CVC of the control of the current dialysis plan of care graft and the only subclavian site for current dialysis plan of care graft care and add RN-C reviewed the records to see if the documenting CVC and found there was the CVC site monitor add the CVC site monitor and the cVC site monitor and founds for nurses for the cords fo	after dialysis per order am the site apply pressuransport R24 to the check for bruit/thrill (to reatency) every shift, do blood pressure in the amount and written undated not plan of care indicated by changes occurred at the vas no documentation on tored and recorded furing each shift to limit concerns and potential catheters.  On a.m. Registered Nu 42 did not have a fistulate R42 had was the dialysis. After reviewing of care, RN-C stated, a needed revision to recover cover and monitorical medication and treatments.	and if ure, if monitor not urm with the under R24's the whether R42's /prevent al of rse a or g R42's the move ng. I lent cords garding would ent te R42's	2 555			
	The director of nursidevelop and impler to ensure that resid timely manner; edu monitoring systems	ETHOD FOR CORRECTION (DON) or designed nent policies and proceed ents plan of care revised cate all staff. Then develor to ensure ongoing port the findings to	e could edures ed in a relop				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00494	B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	,,	.,
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER 2319 WES	ST SEVENTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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) COMPLETE DATE
2 555	Continued From pa	ige 4	2 555			
	Assurance Commit	tee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care I personnel involved in the t.				
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure 2 of 3 residents reviewed y living, R80 and R27 were to their plan of care.				
	9/18/14, collection i	Minimum Data Set, dated revealed no concerns with ty or cognitive skills for daily				
	revised 9/23/14, di and supervision wit treatment record di	ated to Self Care Deficit, last rected staff to provide assist th shower. R80's November rected staff, "Bath/Shower kin check by nurse. Nurse to				
		on 12/1/14 at 3:38 p.m., R80 tion regarding bathing and				

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF CORRECTION (X3) DATE STATEMENT OF COMPLETE CONSTRUCTION (X3) DATE STATEMENT OF COMPLETE CONSTRUCTION (X3) DATE STATEMENT OF COMPLETE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE STATEMENT OF CONSTRUCTION (X6) DATE STATEMENT (X6) DATE STA		E SURVEY PLETED			
		00494	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WE	DRESS, CITY, S ST SEVENTH LUL, MN 551	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	responded, "If I don' it for that week, ever explained that he had and was supposed. A review of the Nov resident body audit and November treat received showers of 12/1/14 for the time 12/3/14.  A review of Interdist through 12/3/14 did bathing at any point. On 12/3/14 at 8:00 second floor, [RN]-I should be completed bathed or refused. It is staff should offer a scheduled day. If a shower at that time re-approached and RN-B confirmed the showers being give and 12/1/14. RN-B circumstances surreshower each week. Although, on 12/4/1 nursing [DON] reported 11/10/14, the DON reflected in R80's mere and the shower shower each week.	and the period of 11/3/14, 11/17/14 could not explain the resident choices.  The resident c				
		8/14/14, was reviewed and cognitively intact. A review of				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00494	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S	STATE, ZIP CODE	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
HIGHLA	ND CHATEAU HEALTI	H CARE CENTER	WEST SEVENTH	_		
(VA) ID	STAMMADV STA	TEMENT OF DEFICIENCIES	PAUL, MN 551	PROVIDER'S PLAN OF CORRECT	TION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	weakness, Parkinson revised 9/25/11, directed staff to ensign and the control of	ed "Self Care Deficit related on's and dementia", last ected staff "Assist with f R27's November and ion administration record sure R27 used a prescription Sulfate Lotion 2.5%) with kly.				
	was asked about he R27 responded that shower every night,	12/1/14 at 6:09 p.m., R27 er shower/bathing schedule. t ideally she would like a but decided to go along witecause she does'nt like				
	reported that some showered weekly a shower recently. R2	12/4/14 at 8:25 a.m. R27 times she was noteven nd had missed a weekly 27 explained that she was to eed to be skipped because h staff to assist her.	old			
	treatment and medi body audits and unt through 12/3/14 rev on 11/7/14, 11/14/14	ember and December ication administration recorditled bath forms for 11/1/14 realed R27 received a show 4 and 11/28/14. No form wated a refusal of shower.	er			
		ciplinary notes for 11/1/4 realed R27 did not decline a				
	[DON] confirmed sh	a.m. the director of nursing ne had provided all records ovember and December. At				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETION (X3) DATE SUR A. BUILDING:					
			A. BOILDING.			
		00494	B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH UL, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	12:09 p.m. the DOI assistant should kn the shower schedu the shower was concompleted due to a attempt an intervenshowered and if un The nursing staff or made aware of misalternate time. The aware of missed shadevelop and impler to ensure that residute to provide proper or develop monitoring compliance and rep Assurance Commit	N reported the nursing now to shower R27 because of le. The nurse should ensure impleted. If the shower was not a refusal the nurse should attion to ensure the resident successful offer alternatives. In the next shift should be used showers in order to try an nurse manager should be nowers.  ETHOD FOR CORRECTION: Sing (DON) or designee could ment policies and procedures dents' plan of care is followed are; educate all staff. Then it systems to ensure ongoing port the findings to the Quality	2 565			
2 830	Subpart 1. Care in receive nursing car custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from to	general. A resident must re and treatment, personal and supervision based on a preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00494	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	L CARE CENTER 2319 WE	DDRESS, CITY, S ST SEVENTH AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	by: Based on observation review, the facility for plan of care related (CVC) hemodialysis to provide necessar.  Findings include: R42's care plan relawas not revised to inpotential infection as site.  During observations R42 was sitting in hwas watching televial a dialysis clinic threlife sustaining treather dialysis site, R2 chest and said, "hehad a dressing on inthe staff monitored bleeding, R24 state or do anything to it.  During record review plan of care, dated to dialysis three times Renal Disease (ES included monitor lal pressure dressing as bleeding occurs fro bleeding continues	ent is not met as evidenced on, interview and document ailed to review and revise the to central venous catheter is site for 1 of 1 resident (R42) by care and services.  Attend to hemodialysis treatment include the monitoring for ind bleeding of current CVC of on 12/03/14, at 2:00 p.m. were wheelchair in her room and sion. R42 stated she went to be times per week to receive ment. When asked regarding 4 pointed to her right upper re is the catheter. The site to the work of the catheter of t				

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			(X3) DATE COMP	SURVEY LETED		
		00494	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	STREET ALL  STREET ALL  2319 WE	DDRESS, CITY, S ST SEVENTH AUL, MN 551		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	a graft or fistula's pure draw blood or take graft. Although a has the social service's sublcavian dressing dialysis site, there withe nursing staff moderated consumers of the nursing consume	patency) every shift, do not blood pressure in the arm with and written undated note under plan of care indicated R24's g changes occurred at the was no documentation whether onitored and recorded R42's uring each shift to limit/prevent concerns and potential of catheters.  On a.m. Registered Nurse 42 did not have a fistula or ite R42 had was the dialysis. After reviewing R42's nof care, RN-C stated, the eneeded revision to remove CVC care and monitoring, medication and treatment	t			
	The director of nurs develop and implen to ensure that resid care and treatment educate all staff. The systems to ensure of	ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures ents receive proper nursing regarding dialysis catheter; nen develop monitoring ongoing compliance and to the Quality Assurance				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00494	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 W	ADDRESS, CITY, 3 /EST SEVENTH PAUL, MN 551	STREET		
(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 T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	•	ge 10 R CORRECTION: Twenty on	2 830 e			
2 915	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condipart, activities of da resident's ability to:  (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the as, and groom; d ambulate;	2 915			
	by: Based on interview facility failed to prove residents (R80, R2) daily living that required bathing.  Findings include: R80's most recent I 9/18/14, collection in	and document review, the vide assistance to 2 of 3 of 3 of 2 of 3 of 3 of 2 of 3 of 3	е			

Minnesota Department of Health

_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00494	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WES	DRESS, CITY, S ST SEVENTH LUL, MN 551		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	decision making.  R80's care area asset [MDS], dated 9/supervision by staff requires assist with and is able to batheup."  During interview, or was asked how mabath or shower?" Ron Monday, I don't really want it. I got obitched." R80 addelast week at all. R80 due to staffing issue R80's care plan related to: dx [diagr weakness", last rev "Provide assist and R80's November tre "Bath/Shower once nurse. Nurse to ver A review of the Nov resident body audit and November trea received showers of 12/1/14 for the time 12/3/14.  A review of Interdist through 12/3/14 at 8:00.	sessment and minimum data (18/14 assessed R80 to need while bathing, noting, "He setting up bathing utensils himself after utensils are set in 12/1/14 at 3:38 p.m. R80 my times a week R80 took a 80 responded, "If I don't get in get it for that week, even if I one today because I really d that he had not been bathed 0 reported he was told it was es.  Atted to "Self Care Deficit mosis] of progressive rised on 9/23/14, directed staff supervision with shower."  Featment record directed staff a week with skin check by ify."  Fember and December 2014 forms, untitled bathing forms the trecord revealed R80 on 11/3/14, 11/17/14 and a period of 11/1/14 through	2 915			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00494	B. WING		12/0	4/2014
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	should be completed bathed or refused. staff should offer a scheduled day. If a shower at that time re-approached and RN-B confirmed the showers being give and 12/1/14. RN-B circumstances surreshower each week.  Although on 12/4/17 nursing [DON] reported and reported.	ed to reflect if resident was At 9:25 a.m. RN-B reported shower weekly on the resident chose not to have a, the resident should be offered different choices. ere was no evidence of in, outside of 11/3/14,11/17/14 could not explain the ounding R80 not receiving a 4 at 8:15 a.m. the director of orted an aide [NA]-C had been a she showered R80 on confirmed this was not	2 915			
	was asked how ofte shower?" R27 resp shower every night just one because the A review of R27's communicate her noted "Triggered be with cares. She doe Parkinson's and show times. She is alert a communicate her noted that she with cares though to possible that she with cares with cares though to possible that she with cares though to show the care with cares though the care with cares though the care with care wit	ed on 12/1/14 at 6:09 p.m. and en R27 took a bath or onded that ideally she would but decided to go along with he waiting is "horrible".  are area assessment and (MDS), dated 8/14/14, red physical help by staff in e care area assessment further ecause she required assist es have a diagnosis of e does become more stiff at and oriented and able to needs to the staff. She has had mount of assistance needed based on her diagnosis it is ill have a change/deterioration sistance need as her disease				

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STATEMENT OF DEFICIENCIES (X1) F

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 501251110.			
		00494	B. WING		12/0	4/2014
NAME OF PR	ROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HIGHLAN	D CHATEAU HEALTI	H CARE CENTER	ST SEVENTH LUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	R27 was cognitively A review of R27's compelicit related to: work dementia", last reviews and December medial directed staff to ensure shampoo (Selenium showers once weekshowers on 11/7/14, 11/14/12 provided that reflect A review of interdisc through 12/3/14 reviews on 11/7/14, 11/14/12 provided that reflect A review of interdisc through 12/3/14 reviews on 12/3/14 reviews on the shower of the shower duck shower duck shower duck shower duck shower duck the shower schedulithe shower was corcompleted due to a completed due to a completed duck of the shower was corcompleted duck of the shower was corcompleted.	MDS, dated 8/14/14, revealed y intact.  are plan titled "Self Care eakness, Parkinson's and sed 9/25/11 directed staff "A review of R27's November dication administration record sure R27 used a prescription in Sulfate Lotion 2.5%) with		DELITION )		

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00494	B. WING		12/04	1/2014
	PROVIDER OR SUPPLIER	L CARE CENTER 2319 W	ADDRESS, CITY, S /EST SEVENTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	JLD BE	(X5) COMPLETE DATE
2 915	2 915 Continued From page 14  The nursing staff on the next shift should be made aware of missed showers in order to try an alternate time. The nurse manager should be aware of missed showers.		2 915 n			
	A SUGGESTED ME The director of nurs develop and implen to ensure that resid based on their com assessments; educ monitoring systems compliance and rep Assurance Commit	ETHOD FOR CORRECTION sing (DON) or designee counent policies and procedures ents activities of daily living i prehensive resident ate all staff. Then develop to ensure ongoing port the findings to the Qualit	d s s			
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and content of the content of the control of trans D. in-service exprevention and content of the	O Subp. 4 A-I Infection Contrand procedures. The infection is include policies and provide for the following: based on systematic data or nosocomial infections in a detection, investigation, and is of infectious diseases; disprecautions systems to mission of infectious agents ducation in infection trol; ealth program including an am, a tuberculosis program	on i			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00494	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WE	DDRESS, CITY, S 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21390	defined in part 465 procedures of resid the prevention and F. the development of the practices, including defined in part 4656 G. a system for H. a system for products which affed disinfectants, antiscincontinence product. I. methods for current standards of the product of 2 (R81) residents findings include:  Review of R81's quantity findings include:	8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and cts; and maintaining awareness of of practice in infection control.  Lent is not met as evidenced and interview, and document ailed to ensure proper hand cted after personal care for 1 is reviewed in the sample.  Larterly Minimum Data Set 14, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 14, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 14, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 15, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 17, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 17, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 17, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 17, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 17, indicated R81 had no e problems and required the with most ADL's.  Larterly Minimum Data Set 17, indicated R81 had no e problems and required the with most ADL's.	21390			
		applied gloves. After toileting I-A stood R81 using the EZ				

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AND DUAN OF CORRECTION INDESTRUCTION NUMBER:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING:		
00494 B. WING		12/04/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S	STATE, ZIP CODE	
HIGHLAND CHATEAU HEALTH CARE CENTER  2319 WEST SEVENTH SAINT PAUL, MN 551		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
21390 Continued From page 16  Stand and cleansed the perineal area using a disposable wipe. NA-A disposed of the wipe; disposed of the gloves; applied new gloves; and washed R81's buttock area. NA-A discarded the wipe and the gloves, and applied new gloves without completing hand hygiene. NA-A transferred R81 to the bedroom holding the EZ Stand handles, applied a clean incontinent product, and pulled up R81's pants. NA-A discarded her gloves and lowered R81 into the wheelchair touching the EZ Stand controls and wheelchair handles. NA-A then completed hand hygiene by washing hands with soap and water in the bathroom.  On 12/3/14, at 12:55 p.m., NA-A confirmed that she had not washed her hands after R81's personal cares. NA-A stated, she typically does it that way as R81 has expressed she does not like to be in the EZ Stand for too long and it takes longer to wash hands with soap and water.  On 12/3/14, at approximately 1:15 p.m., the Director of Nursing (DON) verified staff should hand wash their hands after personal cares. The DON added, maybe it would benefit the facility to provide hand sanitizer to decrease the time it takes to perform hand hygiene.  The Perineal Care Policy dated 4/1/08, directed staff to remove gloves and wash hands after cares and before applying new gloves.  The Hand Washing Policy dated 4/1/08, states: "Sanitizer gels and liquids should be used when soap is not available. They should not be the primary cleansing agent."	DEFICIENCY)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00494	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WES	DRESS, CITY, S BT SEVENTH UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	LD BE	(X5) COMPLETE DATE
21390	A SUGGESTED METhe director of nurs develop and implent to ensure that infector procedures are developeducate all staff. The systems to ensure the findings to committee.	ge 17 ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures tion control policy and reloped and implemented; nen develop monitoring ongoing compliance and to the Quality Assurance  R CORRECTION: Twenty one	21390			
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines of States Centers for Disease tion (CDC), Division of eation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.	21426			
	This MN Requireme	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00494	B. WING		12/0	04/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WE	DDRESS, CITY, SEST SEVENTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	by: Based on interview facility failed to ens assessment was concenters for Disease (CDC) guidelines, for (E-A, E-B and E-C) reviewed, (R43 and to impact all resider Findings include:  The facility failed to assessment used the facility was low document, Guideling Transmission of My Health-Care Faciliti During interview on director of nursing (aware she was using was not aware she Guidelines for Prev Myobacterium tube Facilities, 2005; Aprisk assessment word Disease Control and TB Risk Assessment Settings Licensed by of Health (MDH).  The facility failed to	and document review, the ure a tuberculosis (TB) risk ompleted, using current e Control and Prevention or 3 of 5 employees reviewed for TB and 2 of 5 residents I R67). This had the potential nts residing at the facility.  The ensure the facility TB risk the most current guidelines etermining risk level.  Risk Assessment the facility TB risk the most current guidelines etermining risk level.  Risk Assessment from the facility TB risk the most current guidelines etermining risk level.	<b>y</b>			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00494	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	A review of a new end E-A had a history of (TST) per clinic examination of the transmission of not patients/resider of not per conduct initial and of the transmission of not patients/resider of transmission of not patients/resider of (TST) per clinic examination of the following that the transmission of not patients/resider of the transmission of not patients/resider of the transmission of the following t	employee file for (E)-A revealed f a positive tuberculin skin test am record, dated 10/24/13. The total have a chest x-ray file with the facility.  The efile for (E)-C revealed no ning was completed prior to total to	21426			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
			D WING			
		00494	B. WING		12/0	4/2014
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALT	H CARE CENTER	ST SEVENTH UL, MN 551			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21426	Continued From page 20		21426			
	the setting. The TB the types of adminirespiratory-protectic setting and serves the quality of TB infidentification of need control measures." staff "All residents vadmission and will TB, including cough loss, etc. If the TST be done and the att medical director will laboratory studies a further directed star initial two-step TST annual TST of indice determine risk of pedisease." The police	risk assessment determines strative, environmental, and on controls needed for a as an ongoing evaluation of fection control and for the eded improvements in infection. The policy further directed will have a two-step TST upon be evaluated for symptoms of a, fever, night sweats, weight is positive, a chest x-ray will tending physician and/or I determine if further are indicated." The policy of "All employees will have an on hire and a single step eated, or symptom review to possible progression to active y did not direct staff to TB symptom screening and				
21620	MN Rule 4658.1349  Drugs used in the rin accordance with	nursing home must be labeled	21620			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 5 residents (R79, R124, R141) whose medications were observed for medication storage.  Findings include:					
	_	s of multiple medication				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00494	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER  ND CHATEAU HEALT	H CARE CENTER 2319 WES	DRESS, CITY, S 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21620	storage areas throufor R79, R124 and and eye drops, lack they were opened, expired.  The medication sto was reviewed on 12 licensed practical in R79's insulin vial, N diabetes) was open expired. At 8:08 a.m medication was open stated the insulin would give it to the destroyed.  During the medication at 8:16 a.m. with diffirst floor east, multivials were observed R124's Novolog ins (medication for diable and had been used R141's Travatan (medication) eye of undated and used.  Review of R124's a administration reconvealed the impropeye drop bottle had medications to R12  During interview on director of nursing (needed to be labele added that opened	ighout the facility, medications R141, which included insulin ted dates to indicate when or when the medications were rage area of first floor east 2/3/14, at 8:05 p.m. with urse (LPN)-C: lovolog (medication for ned, undated and potentially n. LPN-C verified the ened and undated. LPN-C as delivered on 10/25/14 and nurse manager to be sion storage tour on 12/11/14, rector of nursing (DON), in the iple medication bottles and did to be opened and undated: ulin and Novolin vials petes) were opened, undated in edication for ocular drop bottle was opened,	21620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00494	B. WING		12/0	04/2014
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WE	DDRESS, CITY, S ST SEVENTH AUL, 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 CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21620	expired medications pharmacy. DON fur vials would be ordenew eye drop bottle. The facility's undate storage and usage other multidose injetirst use written on refrigerated after opmanufacturer's recommanufacturer's recommanufa	s and re-order them from the other indicated that new insulin red for R79 and R124, and a e for R141.  Ed, Injectable medications policy directed, "Insulin and ections should have the date of the vial. Insulin vials not bened should be discarded performendations."  ETHOD FOR CORRECTION:  Sing (DON) or designee could ment policies and procedures edications are labeled and ucate all staff. Then develop to ensure ongoing port the findings to the Quality	f			
21805	Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe employees of or pe health care facility. This MN Requirements by: Based on interview	ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a ent is not met as evidenced and document review, the ure 1 of 3 residents (R27),	21805			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00494	B. WING		12/	04/2014
	PROVIDER OR SUPPLIER  ND CHATEAU HEALTI	H CARE CENTER 2319 WE	DDRESS, CITY, S ST SEVENTH AUL, MN 5511	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21805	reviewed for dignific way that maintained living.  Findings include:  R27's most recent I dated 8/14/14, reve intact and required staff for transfers, to On 12/1/14 at 6:13 staff treated her wit	ed treatment, was treated in a dignity with activities of daily with ac		DEFICIENCY		
	having to wait a ha get off the toilet. R2 time for help in beir dressed and undres made her feel, R27 here, like their playi being. I'm human b human. I just get tre something."  R27's care plan for weakness and Park directed staff to pro for transfers and ar care plan, last revise	long for help. R27 added If hour to get help from staff to 7 added she waited a long ag transferred into bed, assed. When asked how that responded "Like I'm not even ng games with a human ut I don't get treated like eated like a wall flower or impaired mobility related to kinson's, last revised 6/9/14, vide assistance of one staff inbulation. The fall prevention ed 11/19/14 directed staff to st with getting up in the				
	morning. The self c revised 9/25/11, dire assistance of one s On 12/2/14 at 3:25 R27's unit, (NA)-E,	are deficit care plan, last ected staff to provide				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00494	B. WING		12/	04/2014	
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 W	ADDRESS, CITY, S EST SEVENTH PAUL, MN 551	STREET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	HOULD BE COMPLETE	
21805	three nursing assist NA-E explained if r 2 or 3 staff for care assistant to help an sometimes resident wait for help.  On 12/2/14 at 3:25 (NA)-D, on R27's urfrequently had to waget answered, partiassistants were schinstead of four. NA-physical and mental assistance from staff to help with On 12/4/14 at 2:06 working on R27's uresidents have to waing the toilet. R27 toilet alone after trashe has not been a NA-A reported R27 needed something for staff to help with On 12/4/14 at 2:08 working on R27's uresidents worked explained if nursing onto the toilet and tunit needed help, the need to wait for end staff to return and fit toileting.  A review of R27's or R27's o	tants were on second floor. resident required assistance is, that did not leave a nursing swer call lights. NA-E reported to complained about having the p.m. a nursing assistant, not reported residents ait a long time for call lights the cularly when three nursing needuled on the second floor, and added residents had many lissues and required timely lissues and required timely list.  p.m. a nursing assistant not, (NA)-A, reported regularly rait a long time for help with resident assistance, but recently llowed to be left in there along usually would yell when she but has also needed to wait a cares.  p.m. a nursing assistant not, (NA)-B, reported resident in cares.  p.m. a nursing assistant not, (NA)-B, reported resident in second floor. NA-B aides helped one resident then another resident on the nen the one on the toilet might bugh staff to be available for inish helping them with	ged oo oo y y e. y e.				
		realed the call light was wenty minutes before staff					

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PRINTED: 12/18/2014

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING \_ 00494 12/04/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET HIGHLAND CHATEAU HEALTH CARE CENTER SAINT PALIE MN 55116

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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
				DATE				

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