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: Q8WI Facility ID: 00494		
 MEDICARE/MEDICAID PROVIDER N (L1) 245028 STATE VENDOR OR MEDICAID NO. (L2) 299242600 		(L3) HIGHLAND	DRESS OF FACILIT CHATEAU HEAI SEVENTH STREI L, MN	LTH CARI	(L6)	55116	 TYPE OF ACTION: Initial Termination Validation On-Site Visit 	<u>7</u> (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other		
 5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2004 6. DATE OF SURVEY 03/14 		7. PROVIDER/SUF 01 Hospital 02 SNF/NF/Dual	PPLIER CATEGORY 05 HHA 06 PRTF	09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 14 CORF) 22 CLIA	8. Full Survey After Co	omplaint		
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	; DATE: (L35)		
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12. Total Facility Beds 13. Total Certified Beds	64 (L18) 64 (L17)	B. Not in Com	nce With quirements	rs:	2. Tec 3. 24 I 4. 7-D	hnical Personnel	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 3 9. Beds/Room (L12)	rices Limit ctor		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 64	19 SNF	ICF	IID		15. FACILITY N 1861 (e) (1) or		(L15)			
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	LATION DATE):							
17. SURVEYOR SIGNATURE Date :								_		
17. SURVETOR SIGNATURE		Date			18. STATE SUR	VEY AGENCY API	PROVAL	Date:		
Susanne Reuss, Ur	•	r	03/15/2016	(L19)	Kate Joł	nnsTon, Pro	ogram Specialis			
	PART II - TO	r BE COMPLETE 20. COM		GIONAL	Kate Joh OFFICE OR 21. 1. 2.	nnsTon, Pro	ogram Specialis	<u>ot</u> 03/09/2016 (L20)		
Susanne Reuss, Ur 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par	PART II - TO	r BE COMPLETE 20. COM RIGH	D BY HCFA RE IPLIANCE WITH CI	GIONAL	Kate Joh OFFICE OR 21. 1. 2.	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above :	DESTIMATION OF CONTRACT OF CONTRACT.	<u>ot</u> 03/09/2016 (L20)		
Susanne Reuss, Ur 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible	PART II - TO ticipate (L21)	r BE COMPLETE 20. COM RIGH	D BY HCFA RE IPLIANCE WITH CI HTS ACT:	GIONAL VIL	Kate Joh OFFICE OR 21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Close	INSTON, Prospective SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: 00 ure	Degram Specialis E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF/ 	<u>st</u> 03/09/2016 (L20) (L20) A-1513)		
Susanne Reuss, Ur 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 01/01/1967 (L24)	PART II - TO , ticipate (L21) 23. LTC AGREEMI BEGINNING (L41)	r 20. com Righ ENT 2 DATE	D BY HCFA RE IPLIANCE WITH CT ITS ACT: 24. LTC AGREEMEN	GIONAL VIL	COFFICE OR 21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfaction	INSTON, Prospective SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: <u>00</u> ure n W/ Reimbursemer	Degram Specialis	<u>st</u> 03/09/2016 (L20) A-1513) (L30) <u>FARY</u>		
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245028 March 21, 2016

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

Dear Ms. Welter:

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 March 8, 2016 the above facility is certified for or recommended for:

64 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Highland Chateau Health Care Center March 21, 2016 Page 2

Sincerely,

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

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 21, 2016

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

RE: Project Number S5028026

Dear Ms. Welter:

On February 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. 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 March 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 18, 2016 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 January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 8, 2016 and therefore remedies outlined in our letter to you dated February 10, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Highland Chateau Health Care Center March 21, 2016 Page 2

Sincerely,

Kato Comston

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

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
	B. Wing	Y2	3/14/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAND CHATEAU HEALTH CA	ARE CENTER	2319 WEST SEVENTH STREET		
		SAINT PAUL, MN 55116		

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

ITEI	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. #	F0241 483.15(a)	Correction Completed 03/08/2016	Reg. #	(d), 483.20(k)(1)	Correction Completed 03/08/2016	ID Prefix Reg. #	F0282 483.20(k)(3)(ii)	Correction Completed 03/08/2016
LSC		03/08/2016	LSC		03/08/2016	LSC		03/08/2016
ID Prefix	F0311	Correction	ID Prefix F0329		Correction	ID Prefix	F0431	Correction
Reg. #	483.25(a)(2)	Completed	483.25 Reg. #	(1)	Completed	Reg. #	483.60(b), (d), (e)	Completed
LSC		03/08/2016	LSC		03/08/2016	LSC		03/08/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # LSC		Completed	Reg. # 		Completed	Reg. # LSC		Completed
REVIEWE STATE AG	/	REVIEWED BY (INITIALS) SR/KJ	date 03/21/2016	SIGNATURE OF SU		022	DA (те 03/14/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOWI	JP TO SURVEY CO	OMPLETED ON		ANY UNCORRECTED TED DEFICIENCIES (YES 🗌 NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245028 _{Y1}	B. Wing	Y2	3/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAND CHATEAU HEALTH CA	ARE CENTER	2319 WEST SEVENTH STREET		
		SAINT PAUL, MN 55116		

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

ITE	М	DATE	ITEM	DATE	ITEM	DATE	
Y4		Y5	Y4	Y5	Y4	Y5	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed	
LSC	K0144	01/31/2016	LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
REVIEWE		REVIEWED BY (INITIALS) TL/KJ	date 03/21/2016	SIGNATURE OF SURVEYOR	010	date 03/18/2016	
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWL	JP TO SURVEY CO	DMPLETED ON		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATI PART I - TO BE COMPLETED BY THE							D: Q8WI Facility ID: 00494
1. MEDICARE/MEDICAID PROVIDER N (L1) 245028	łO.	3. NAME AND ADD (L3) HIGHLAND			E CENTER		4. TYPE OF ACTION: 1. Initial	<u>2 (</u> L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 299242600		(L4) 2319 WEST S (L5) SAINT PAUL		ET	(L6)	55116	 Termination Validation 	 CHOW Complaint
 5. EFFECTIVE DATE CHANGE OF OW (L9) 04/01/2004 	NERSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
	3/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC		FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY I	IS CERTIFIED AS:				I	
From (a):		A. In Complian	nce With		And/Or Approv	ed Waivers Of The	Following Requirements:	
To (b) :		Program Req Compliance	-		3. 24 H		6. Scope of Servi	
12. Total Facility Beds	64 (L18)	1. A	cceptable POC		4. 7-Da	y RN (Rural SNF)	8. Patient Room S	Size
13. Total Certified Beds	64 (L17)	-	pliance with Program			Safety Code	9. Beds/Room (L12)	
Requirements and/or Applied Waivers:			rs.	* Code: 15. FACILITY M	B*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		100					(1.15)	
18 SNF 18/19 SNF 64	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY API	PROVAL	Date:
Momodou Fatty, HFE NE II 02/26/2016								
Momodou Fatty	7, HFE NE II	[0	02/26/2016	(L19)	Kate Joh	nsTon, Pro	ogram Specialis	<u>t</u> 03/09/2016 (L20)
Momodou Fatty	•	BE COMPLETEI		· · /			U	
19. DETERMINATION OF ELIGIBILITY	PART II - TO	BE COMPLETEI 20. COM		GIONAL	21. 1. S 21. 21. 21. 21. 21. 21. 21. 21. 21. 21.	SINGLE STAT itatement of Financi Ownership/Control I	U	(L20)
19. DETERMINATION OF ELIGIBILITY	PART II - TO	BE COMPLETEI 20. COM	D BY HCFA RE PLIANCE WITH CI	GIONAL	21. 1. S 21. 21. 21. 21. 21. 21. 21. 21. 21. 21.	SINGLE STAT	E AGENCY al Solvency (HCFA-2572)	(L20)
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19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 01/01/1967	PART II - TO (ticipate (L21) 23. LTC AGREEMI BEGINNING	BE COMPLETEI 20. COM RIGH ENT 2. DATE E SANCTIONS	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE	GIONAL VIL	21. 1. S 21. 1. S 2. C 3. E 26. TERMINAT <u>VOLUNTARY</u> 01-Merger, Closu 02-Dissatisfaction	SINGLE STAT itatement of Financi iwnership/Control I Both of the Above : NON ACTION: 	E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	(L20) A-1513) L30) <u>FARY</u> ieet Health/Safety
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2700 February 10, 2016

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

RE: Project Number S5028026

Dear Ms. Welter:

On January 28, 2016, 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;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, 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 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 April 28, 2016 (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 July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: <u>tom.linhoff@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Y ale Compton

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

Enclosure

cc: Licensing and Certification File

		ID HUMAN SERVICES MEDICAID SERVICES			٩.	FORM): 02/10/2016 / APPROVED
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		245028	B. WING			01	28/2016
NAME OF PR	ROVIDER OR SUPPLIER		·····	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	LUILUIU
HIGHLANI	O CHATEAU HEALTH CA	RECENTER			319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	8E	(X5) COMPLETION DATE
F 000	as your allegation of o Department's accepta enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verificatio Upon receipt of an ac on-site revisit of your validate that substant	correction (POC) will serve compliance upon the ance. Because you are ar signature is not required rst page of the CMS-2567 submission of the POC will	F 2 26 SE	000	Preparation, submission and implementation of this Plan of Corn do not constitute an admission of c agreement with the facts and conc set forth on the survey report. Our Correction is prepared and execute means to continuously improve the of care and to comply with all appli state and federal regulatory requir RECEIVE FEB 26 2016	our Usions Plan of d as a e quality cable ements.	
F 241 SS=D	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in	F	241	COMPLIANCE MONITORING LICENSE AND CERTIFIC	DIVI SI O ATION	N
	by: Based on observatio review, the facility fail manner which promot residents (R19, R123 Findings include: R19's admission mini 12/23/15, indicated R The current care plan risk, was continent of	is not met as evidenced n, interview and document ed to provide services in a ted dignity for 2 of 2) in the sample. mum data set (MDS) dated 19 was cognitively intact. indicated resident was a fall bowel and bladder, and d walker to ambulate with					
	moderate independer	nce in room.					
	RECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
KUQ	Marial	to, LNHA		Ð	Recutive Divector	2	124/110

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3)) DATE S COMPL	
		245028	B. WNG			01/2	8/2016
NAME OF PI	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	D CHATEAU HEALTH C			23	19 WEST SEVENTH STREET		
IIGHLAN	D CHATEAU REALTH C	ARE CENTER		S,	AINT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
F 241	Continued From pag	ge 1	F	241	F241 – Care plans for R19 and R123 hav been reviewed and NAR (Nursing Assis	tant	
	R19 was interviewe	d in R19's room on 1/26/16 at			Registered) care sheets have been upd	ated	3/8/16
		commode was observed			to reflect R 19 and R123 current assista		-10114
	placed against the c	outside wall of the resident's			needs. Three day Bowel and Bladder r		
		having to wait up to an hour			assessments initiated on R19 and R123	i.	
		all light to be answered and			Based on R123's assessments and		
	waiting R19 explai	l incontinent accidents while ned that approximately 1 ½			appointment schedule, R123's care pla has been revised to meet resident's car	n	
		tting the call light on to get			needs. R19 has progressed to increased		
	assistance to get up	to use the commode, a staff			independence and is currently maintain		
		instructed her to go in the			continence.	mig	
		ng. R19 indicated the staff			All residents are at risk for treatment		
		being able to assist her. R16 seemed once you were in			lacking dignity and respect as an		
		staff did not want to get you			individual. Education has been provide	d to	
		ke they don't care. R19			staff on standards of resident care and		
		o more for herself and stated			treatment, and response to residents'		
		hen told to do something like			requests for assistance is to be perform	ned	
	that, "it was just wro	ong."			in a timely manner guaranteeing individ	dual	
	0n 1/27/16 during t	he afternoon, R19 was			resident respect and dignity.		
		valking in the hallway using a			Call light response time audits will be		
	front wheeled walke	er, a transfer belt and being			completed 3 x weekly x 12 weeks and		
	assisted by a staff p				reviewed for timeliness with follow up	as	
	0= 4/00/40 -1 40:00				needed. Findings will be reviewed mon	thly	
) a.m. during interview, the ndicated this was not the			at Quality Council (QC) x 3 months with follow-up to Committee		
		acility to wait that long on a			recommendations.		
	call light and to be t	old to void in one's incontinent			Deficient practice will be corrected by		
		being assisted out of bed to			March 8, 2016.		
	R123's admission n	ninimum data set (MDS) dated					
	12/22/15 indicated I staff for transfers ar	R123 is totally dependent on ind incontinent of bowel and					

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TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	(X3) DATI	D. 0938-039 E SURVEY PLETED	
		245028	B. WNG			01	/28/2016	
	ROVIDER OR SUPPLIER D CHATEAU HEALTH CA	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116				
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F 241	The initial care plan in of two staff persons a standing lift for transf On 1/25/16 at 4:28 p. and reported an ever had answered his cal stated he told the nur was soiled and needed checking, the NA told been cleaned up. The with the nurse and ag needed to be cleaned nurse did not check f already been cleaned without changing R12 was having diarrhea R123 reported anoth call light on to use the delay in answering the nursing assistant arri reported the nursing already been change that his wife was press assistant again that f changed. R123 repor finally did follow throu "very demoralizing" a the job if they don't w On 1/26/16 at 8:30 a. family member recall being in the room wh occurred. The family put the call light on, f bedpan, but by the til answered, R123 nee	ndicated R123 needed assist and the use of a mechanical ers. 	F	241				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00494

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TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245028	B. WING _		01/28/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
HIGHLAN	D CHATEAU HEALTH CA	ARE CENTER		2319 WEST SEVENTH STREET	
(X A) 15	STRATADY CT	ATEMENT OF DEFICIENCIES	<u> </u>	SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE
F 241	Continued From page	e 3	F 2	41	
	what would have hap fear is he wouldn't be	pened if I wasn't there, my cleaned up."			
F 279 SS=D	director of nursing inc the above incidents,	(1) DEVELOP	F 2	monitoring, orthostat	d to include name of sile of tion, side effect tic blood pressure,
	to develop, review an comprehensive plan The facility must deve plan for each residen objectives and timeta medical, nursing, and	e results of the assessment ad revise the resident's of care. elop a comprehensive care t that includes measurable bles to meet a resident's d mental and psychosocial ied in the comprehensive		non-pharmacological target behavior moni- plan has been update resident's diagnosis o insulin and monitorin symptoms of high/low plans for all residents psychotropic medicat reviewed and update monitoring according	toring. R95's care ed to include of diabetes, use of og for signs and w blood sugar. Care a receiving cions have been d to include care and
	to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's			medication. Care plat residents will be revie include diagnoses, use monitoring for high/le All residents are at ris not inclusive of needs diagnoses and medica Nurse managers and o educated that care plat receiving psychotropi	ns for all diabetic ewed and revised to e of insulin and ow blood sugar. sk for receiving care according to ations received. clinical staff were ans for all residents
	by: Based on observatio review, the facility fail	is not met as evidenced n, interview, and document ed to develop a plan of care ic medications for 2 of 2		to include name of me side effect monitoring monitoring, and care residents need to incl insulin and monitoring sugar.	edication, adverse g and target behavior plans for all diabetic ude diagnosis, use of

Event ID: Q8WI11

Facility ID: 00494

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STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NC (X3) DATE	APPROVE 0. 0938-039 SURVEY LETED
		0.15000				
	ROVIDER OR SUPPLIER	245028	B. WING		01/	28/2016
	D CHATEAU HEALTH CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	of care related to diab 1 resident (R95). Findings include: R68's care plan lacke orthostatic blood pres interventions and targ use of a psychotropic The Physician Orders R68 had an order for, mouth daily, which wa R68's care plan dated received an antidepre depression and bipola identify Abilify as an a lacked direction for sta effects, orthostatic blo behaviors. During interview, on 1 director of nursing (D0 treating resident with 7 instead of antipsychot the reason there was monitor for side effects	and failed to develop a plan betes and insulin use for 1 of d side effect monitoring, sure, non-pharmacological tet behavior monitoring for medication. dated 1/13/16, indicated Abilify 15 mg 1 tablet by as initiated on 12/7/15. I 9/25/15, identified R68 ssant medication related to ar. The care plan did not ntipsychotic medication and aff to monitor for side bod pressure and target /27/16 at 1:03 p.m. the DN) stated, facility was Abilify as antidepressant ic medication and this was nothing on the care plan to	F 27	DON/ designee will audit all new psychotropic medication orders 12 weeks to assure appropriate assessments, care planning and is completed. DON/Designee w new admissions with diagnosis and also new or changed diabet orders weekly x 12 weeks to ass appropriate assessments, care p and monitoring is completed. Fi be reported monthly at QC x 3 m with follow-up to Committee recommendations. Deficient practice will be correct March 8, 2016.	weekly x monitoring vill audit all of diabetes ic agent ure blanning indings will nonths	
	stated, being aware th the classification was The pharmacy consult recommendations had to monitor side effects	n. the pharmacy consultant hat R68 was on Abilify and antipsychotic medication. tant explained that I been made for the facility , effectiveness, orthostatic rget behavior monitoring.				

Facility ID: 00494

If continuation sheet Page 5 of 18

						F	ITED: 02/10/2016 ORM APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) [NO. 0938-0391 DATE SURVEY COMPLETED
		245028	B. WING				01/28/2016
	ROVIDER OR SUPPLIER D CHATEAU HEALTH CA			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	<u>і</u> іх	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Continued From page	9 5	F	279			
	DRUGS - ANTIPSYC dated 4/2009, reads, medication. A. If resic functional status, it m medication. B. Review physician if indicated. R22's care plan lacke Signed physician orde donepezil (used in the Alzheimer's disease) escitalopram (used to depressive disorder) and Risperidone (an a 0.5mg, 1&1/2 tablets for depressive disorder) and Risperidone (an a 0.5mg, 1&1/2 tablets for depressive disorder) The quarterly Minimu 10/29/16, indicated R Diagnoses included of disorder. The medica diagnoses of bipolar of The psychotropic drug (CAA) dated 8/13/15, antipsychotic and ant with adverse consequ falls and depression. On 1/26/16, review of 9/30/15, included "alto depression as eviden but did not include a of medications.	ed psychotropic medications. ers dated 12/31/15, included e palliative treatment of 5mg daily for dementia, o treat anxiety and major 20mg daily for depression, antipsychotic medication) (0.75mg) orally at bedtime er. m Data Set (MDS) dated 22 was cognitively intact. lementia and depressive I data sheet included disorder and paranoia. g use care area assessment identified use of idepressant medications uences of increased risk for					
	On 1/27/16, at 7:49 a	.m. R22 was observed at					

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Facility ID. 00-94

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		MEDICAID SERVICES		·····		10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245028	B. WING		0	1/28/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		1120/2010
IGHLAN	D CHATEAU HEALTH C	ARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 279	tablemates. License arrived at the table v observed R22 take r behaviors. When interviewed or registered nurse (RN record lacked a care medications. R95's care plan lack R95's diagnosis of d Review of R95's cur 12/21/15 indicated tl -Levemir INJ Inject 2 morning. -Levemir INJ Inject 2 morning. -Levemir INJ Inject 2 morning. -Novolog INJ 100/m times daily with mea -Novolog INJ 100/m times daily with mea Review of R95's pla diabetes, use of inst monitoring signs and sugar. Interview with RN-A stated R95 had diab that blood sugars we	aating and conversing with d Practical Nurse (LPN)-A vith R22's medications and medications without n 1/28/16, at 10:41 a.m. N)-A confirmed the medical e plan for antipsychotic ed interventions regarding liabetes, and use of insulin. rent physician orders signed he following ordersfor insulin: 26 units subcutaneously every 15 units Subcutaneously I Inject Subcutaneously 3 als per sliding scale (PSS) I Inject subcutaneously 3	F 2			
	information pertainir	ng to diabetes, insulin use, or for, and stated the plan of				

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And a subscription of the

		MEDICAID SERVICES				3) DATE S	0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3	COMPLI	
		245028	B. WING			01/28/2016	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	D CHATEAU HEALTH CA	ARE CENTER			19 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	5	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ξ	(X5) COMPLETION DATE
F 282	PERSONS/PER CAR The services provide must be provided by accordance with eac care. This REQUIREMEN' by: Based on observation review, the facility fa 2 of 2 residents (R86 assist with shaving at Findings include: Review of R86's card directed staff that R6 grooming and indica well groomed every On 1/25/16 at 6:33 p have several gray/bl lip and chin area. R6 untrimmed and unclinails. On 1/26/16 at 10:13 a.m., R86 was obset During interview 1/2 indicated he would 10 On 1/27/16 at 9:55 (LPN)-B verified R8	VICES BY QUALIFIED RE PLAN ed or arranged by the facility qualified persons in h resident's written plan of T is not met as evidenced on, interview, and document iled to follow the care plan for 5, R129) who required staff and nail care. e plan, revised 12/15, 36 required assist with the R86, "will be clean and		282	F282 – R129 has discharged from facilities since survey. R86 was re-approached to provide assistance with shaving and car of toenails; with re-approach resident accepted assistance with shaving and reduction of toenails. R86 care plan at NAR care sheet have been reviewed at revised to include staff re-approach to if R86 declines personal hygiene cares. All residents are at risk for sub-optimal personal hygiene. Staff were educated to follow resident plans in accordance with resident choic in situations where personal hygiene of are declined/refused, care planning/ca plans will include re-approaches to provide assistance with personal hygiene, tow the goal of maintaining optimal personal hygiene of residents. DON/ designee will audit the delivery assistance with cares 3 x weekly x 12 weeks. Findings will be reviewed mo at QC x 3 months with follow-up to Committee recommendations. Deficient practice will be corrected by March 8, 2016.	to are nd nd o care al t care ice; cares are ovide vards mal of onthly	3 8/10

	OPPERIONN	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING		co	MPLETED
		245028	B. WING				01/28/2016
	ROVIDER OR SUPPLIER D CHATEAU HEALTH CA	RECENTER		231	RET ADDRESS CITY STATE, ZIP CODE 9 WEST SEVE ITH STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	INT PAUL, MN 55116 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
 F 282 Continued From page 8 resident so the nursing assistants were supposed to do nail care. LPN-B stated that R86 had a weekly bath and did not know why it hadn't been done. On 1/27/16 at 10:01 a.m. director of nursing (DON), looked at R86's toe nails. The left toenails were clipped, however, the right toe nails were not clipped and had a hard substance under the nails. DON also acknowledged that R86 was unshaven. DON commented not understanding why one foot was taken care of but not the other and explained the expectation was that nail care was to be completed on bath day and added that shaving was part of daily cares. 		F	282				
	staff that R129 require assist". On 1/26/16 at 9:43 a. have several white gr upper lip and chin are stated being unable to	n dated 1/11/16, directed ed, "Grooming partial m., R129 was observed to rayish facial hairs to the ea and when interviewed o shave self and facility staff n shaving. R129 expressed,					
F 311 SS=D	On 1/27/16 at 8:49 a. sitting in wheel chair i On 1/27/16 at 10:17 a	IENT/SERVICES TO	F	311			

Facility ID: 00494

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245028 B. WING 01/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET HIGHLAND CHATEAU HEALTH CARE CENTER SAINT PAUL, MN 55116 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 311 Continued From page 9 F311 – R129 has been discharged from the F 311 3/8/14 facility since survey. R86 was reservices to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. approached and assistance with personal hygiene care was provided, resident was shaved and all toenails were reduced. R86 This REQUIREMENT is not met as evidenced Care plan was reviewed and revised to by: include re-approaches to resident's refusal Based on observation, interview and document of cares. review the facility failed to provide personal All residents are at risk for lacking personal hygiene care for 2 of 2 residents (R86, R129) hygiene cares. who were dependent on staff for personal cares. Nursing staff were educated on the need Findings include: for residents to maintain good personal hygiene and encouraging residents to R86's annual Minimum Data Set (MDS) dated participate in ADL's. Education included 6/19/15, identified R86 required total assist with documenting refusals of care, notifying bed mobility, transfers and toileting. Requires nurse of refusals of care and the need to extensive assist with dressing, eating and re-approach. personal hygiene needs. R86 is severely Weekly audits by DON/designee x 12 impaired. weeks to assure that personal hygiene cares are completed according to resident Nursing assistant assignment sheet undated, reads, "A1 (assist of one) with all ADLs (activities choice and for those residents who decline of daily livings) ..." or refuse cares, re-approach interventions are initiated to maintain optimal resident The care plan revision goal dated 12/15, hygiene. Findings will be reported to identified R86 had "Self Care Deficit related to: monthly to QC x 3 months with follow-up CVA (cardiovascular disease) with hemiparesis to Committee recommendations. and TBI (traumatic brain injury). Will be clean and Deficient practice will be corrected by well groomed every day through review period. March 8, 2016. Assist with grooming: 1 staff ". On 1/25/16 at 6:33 p.m., during an attempt to interview R86, he was observed to have several gray/black facial hairs to the upper lip and the chin area. At 6:45 p.m. observed R86's right toes untrimmed with hard substances under the nails. On 1/26/16 at 10:13 a.m. R86 was observed in his room lying in bed and was observed to still

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Facility ID: 00494

If continuation sheet Page 10 of 18

PRINTED: 02/10/2016

TALEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				RM APPROV 10. 0938-03
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		245028	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	1/28/2016
HIGHLAN	ID CHATEAU HEALTH CA	ARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			
TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETI DATE
F 311			F 311			
	have numerous facial	hairs.				
i	On 1/27/16 at 9:05 a.	m., R86 was observed to				
	nave several black gr	ayish facial hairs to the area while lying in bed.				
q		n. R86 stated, "Yes" when				
	queried by surveyor if daily.	he would like to be shaved				
	trimmed had a hard su LPN-B added that R86 resident, so nursing as do the nail cares. LPN	/27/16 at 9:55 a.m. licensed practical nurse)-B verified R86's right toe nails were not led had a hard substance under the nails. B added that R86 was not a diabetic ent, so nursing assistants were supposed to e nail cares. LPN-B did not know why it was one and stated R86 had a weekly bath.				
	were clipped, nowever	s toe nails. The left toenails				
	unshaven. DON also acknow	hard substance under the wledged that R86 was ented not understanding n care of but not the other				
w a s R	and explained the expe	ectation was that nail care				
	R129 was observed to on 1/26/16, and 1/27/16	have several facial hairs 3.				
i i	o lacility on 1/11/16, an	oted R129 was admitted Id had diagnoses, which Ibral infarction, hemiplegia				
Б	129's admission Minin					

Event ID: Q8WI11

Facility ID: 00494

If continuation sheet Page 11 of 18

and the

		MEDICAID SERVICES					RM APPROVE NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	ATE SURVEY
		245028	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		01/28/2016
HIGHLAN	D CHATEAU HEALTH C	ARE CENTER		1	2319 WEST SEVENTH STREET		
				5	SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
	Continued From page 11 dated 1/18/16, identified R129 required extensive assist with bed mobility, transfers, dressing, toileting and personal hygiene. Nursing assistant assignment sheet undated. reads, "ADL assist A-1". The initial care plan dated 1/11/16, read,		F	311			
	"Grooming partial ass On 1/26/16 at 9:43 a. have several white gr upper lip and the chir	sist". m., R129 was observed to rayish facial hairs to the n area and stated facility staff shaving and now looking bad					
	On 1/27/16 at 8:49 a. sitting in wheel chair i unshaven with facial l	m. R129 was observed in the dining room and was hairs.					
	R129 was unshaven a	a.m., DON acknowledged and indicated her residents were supposed to					
	4/1/08, Policy Statem facility's policy to keep toenails cleaned and toenails are checked necessary. 2. Fingern trimmed weekly during necessary. 3. A licens toenail trimming callus	nails and toenails are g bathing or more often, if sed professional does ses, and bunions on diabetic e charge nurse or designee					
	Policy and procedure ELECTRIC RAZOR, c	titled SHAVING - dated 3/1/14, Policy					

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	}	ECONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
			A. BUILDING		co	MPLETED
	ROVIDER OR SUPPLIER	245028	B. WNG		01/28/2016	
NAME OF F	RONDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ID CHATEAU HEALTH C.	ARE CENTER		319 WEST SEVENTH STREET		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		SAINT PAUL, MN 55116		
PREFIX TAG	(EACH DEFICIENC	VALUENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 311	care and services da per resident needs a Policy and procedure RAZOR, dated 4/1/08	Resident will be provided ily which includes shaving as nd/or care plan." titled SHAVING - SAFETY	F 311			
F 329 SS=D	services daily which i resident needs and/o 483.25(I) DRUG REG UNNECESSARY DR	ncludes shaving as per r care plan." BIMEN IS FREE FROM UGS	F 329			
	unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mol indications for its use	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate to or in the presence of es which indicate the dose discontinued; or any easons above.				
	resident, the facility m who have not used an given these drugs unl therapy is necessary as diagnosed and doo record; and residents drugs receive gradual behavioral intervention	ensive assessment of a nust ensure that residents ntipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic dose reductions, and ns, unless clinically effort to discontinue these				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	D. 0938-039 E SURVEY PLETED
		245028	B. WING		04/00/2014	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 01	/28/2016
HIGHLAN	D CHATEAU HEALTH CA	RECENTER	2	319 WEST SEVENTH STREET GAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 329	This REQUIREMENT by: Based on observation review, the facility fail monitoring of an antip 5 residents (R68) who Findings include: R68 had diagnoses the disorder, schizoaffection The Physician Orders R68 had an order for , mouth daily, which was On 1/27/16 at 7:32 a.r awake, lying on his base approached and inter- medication, Abilify, that did not notice or expen- the medication but did in his room. During the observed to be relaxed R68's care plan dated received an antidepresidentify Abilify as an al lacked direction for stat effects, orthostatic blo behaviors. During interview, on 1/ director of nursing (DC treating resident with A instead of antipsychotic the reason there was not stated the reason there was not the reason there was not stated the reason there was not the reason there was not stated the reason there was not the reason there was not stated the reason there was not the reason there was not stated the reason the reaso	 is not met as evidenced n, interview and document ed to ensure appropriate sychotic medication for 1 of o used Abilify (antipsychotic). nat included Bipolar ive disorder and depression. dated 1/13/16, indicated Abilify 15 mg 1 tablet by as initiated on 12/7/15. m. R68 was observed to be tack in bed. When viewed regarding the at he takes, R68, stated he rience any side effects from l identify that he likes to stay e interview R68 was d with no behaviors noted. 9/25/15, identified R68 ssant medication related to r. The care plan did not ntipsychotic medication and aff to monitor for side od pressure and target (27/16 at 1:03 p.m. the DN) stated, facility was Abilify as antidepressant c medication and this was 	F 329	F329 – R68 medication regimen h reviewed for diagnoses specific to medication orders. R68 was rece Abilify, classified as an antipsych- use as an antidepressant. R68 was assessed for potential adverse sid of antipsychotic drug therapy thr completion of a DISCUS assessment target behavior and side effect m was established. All residents us antipsychotic medications have be reviewed for current assessment behaviors and side effect monito their care plans reflect the use an monitoring of antipsychotic medi All residents receiving antipsychot risk for lack of appropriate monit Nursing staff have been educated medications classified as antipsyc and the necessary assessments an monitoring of residents receiving antipsychotic medications. All new orders for antipsychotics audited weekly x 12 weeks to ass DISCUS assessment is completed target behavior and side effect m is implemented. Findings will be monthly at QC x 3 months with for to Committee recommendations. Deficient practice will be correctee March 8, 2016.	o ving otic for as de effects ough ent and onitoring een 5, target ring, and d cations. tics are at oring. on hotics nd will be ure a and onitoring reviewed llow-up	3/8/10

Facility ID: 00494

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TATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	OMB N (X3) DAT	MAPPROVE O. 0938-039 E SURVEY
			A. BUILDI	NG		CON	IPLETED
		245028	B. WING			01	1/28/2016
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	····•	·····
HIGHLAN	D CHATEAU HEALTH CA	RE CENTER			9 WEST SEVENTH STREET NT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
	Continued From page behavior and orthoste		F	329			
F 431 SS=D	stated, being aware ti the classification was The pharmacy consu recommendations ha to monitor side effects blood pressure and ta Further mentioned, th been re-issued on the Policy and procedure DRUGS - ANTIPSYC dated 4/2009, reads, shall be used only wh specific condition as o in the clinical record . Dyskinesia - AIMS or to initiation of medica thereafter and/or prio medication. 4. Establi which must include qu information in the res- medication. 8. physician if indicated. 483.60(b), (d), (e) DR LABEL/STORE DRUC The facility must emp a licensed pharmacis of records of receipt a	d been made for the facility s, effectiveness, orthostatic arget behavior monitoring. e recommendation had a last visit to the facility. title UNNECESSARY HOTIC DRUGS-HDGR "Psychotropic drug therapy en it is necessary to treat a diagnosed and documented 3. Complete Tardive DISCUS assessment prior tion and within six months r to any increase in sh target behavior sheet uantitative and objective ident's medical record or ation record. 5. Monitor side A. If resident experiences a tatus, it may be a side effect Review side effects, contact " UG RECORDS, GS & BIOLOGICALS loy or obtain the services of t who establishes a system and disposition of all fficient detail to enable an	F.	431			

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY PLETED
		245028	B. WNG			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	01	/28/2016
HIGHLAN	D CHATEAU HEALTH C	ARE CENTER		2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 431	controlled drugs is m reconciled. Drugs and biological labeled in accordance professional principle appropriate accesso instructions, and the applicable. In accordance with S facility must store all locked compartment controls, and permit have access to the k The facility must prov permanently affixed of controlled drugs liste Comprehensive Drug Control Act of 1976 a abuse, except when package drug distribut quantity stored is mir be readily detected. This REQUIREMENT by: Based on observation review the facility failed information to the lab	haintained and periodically is used in the facility must be exe with currently accepted es, and include the ry and cautionary expiration date when State and Federal laws, the drugs and biologicals in s under proper temperature only authorized personnel to eys. Vide separately locked, compartments for storage of d in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can F is not met as evidenced an, interview and record ed to add dosage change el of medications for 2 of 7	F 431	F431 – R16 and R123 medic been reviewed for correct n frequency and route and din labels applied as indicated. All residents receiving medi risk of medication errors du labeled medications. Nursing staff educated on p for medications and policy of dosage change labels to me indicated. DON/designee will audit me residents weekly x 12 weeks medications are labeled cor accordance with physician of MARS. Findings will be revi- at QC x 3 months with follow Committee recommendatio Deficient practice will be con March 8, 2016.	aame, dosage, rection change cations are at the to improperly oroper labeling of applying dication when edications of 3 s to assure rectly in orders and ewed monthly w-up to ins.	3 8/16
1	residents (R16, R123 administration. Findings include:) reviewed for medication				

Event ID: Q8WI11

Facility ID: 00494

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FOF	ED: 02/10/20 RM APPROV
IAIEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	IO. 0938-03 E SURVEY
		245028	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			070727	0	1/28/2016
				STREET ADDRESS, CITY, STATE, ZIP	CODE	
IOILAN	D CHATEAU HEALTH C	ARE CENTER		2319 WEST SEVENTH STREET		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		SAINT PAUL, MN 55116		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 431	Continued From page	- 40				<u> </u>
			F 4:	31		
	and with the number	noved a small brown bottle				
	and, with the plunger, pulled out 3 milliliters (ml) of oxycodone for the resident. The label indicated					
	100 mg/ml (milligram	s/milliliter), 30 mg. The				
	medication was then	given to the resident. The				
	label did not indicate	when or how often the				
F F T a T	oxycodone was to be	received. At 8:00 a m	1			
	RN-B drew up 30 unit	S Of Lantus insulin for P16				
	the label indicated th	e resident should have				
	received 27 units. At 8	3:10 a.m., RN-B				
	The label on the sourd	ol 50 mg to the resident.				
	The label on the card received every 6 hour	Indicated it could be				
	questioned about the	timing, RN-B indicated the				
	order had been chang	led and it was now on a				
	schedule. RN-B indica	ited the facility had change				
1	or direction labels but	verified none had been				
	used on medication ch	nanges for R16.				
	At 8:15 a.m. RN-B wei	nt to administer medication				
1	to R123. A bottle label	ed Voriconazole 40mg/ml				
	was opened and medi	Cation was dispensed from				
	was also opprod and	eled Rapamune 1 mg/ml				
	from the bottle RN P	nedication was dispensed stated the medications are				
	used for bone marrow	transplants and				
:	acknowledged both bo	ttles were not labeled with				
1	name, dose, route or fr	equency of the				
1	nedication. RN-B did r	10t offer an explanation of				
	why a label was missin	ig.				
-	The physician orders w	vere reviewed on 1/27/16 at				
	5.45 a.m. 10r R16, On 2	1/25/16 a nhysician order				
	eau increase Lantus 3	0 Units in the morning and				
	7 units in the evening.	On 1/20/16 a physician				
	nuel read increase ox	Codone to 10 mg even 2				
	iours as needed orally.	. On 1/22/16 a physician				
	nuer was received to s	chedule Tramadol 50 mg to give oxycodone as				
12	willos a GAV and okou	10	1	1		

If continuation sheet Page 17 of 18

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		245028	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	0	1/28/2016
HIGHLAN	ID CHATEAU HEALTH C	ARE CENTER	231	9 WEST SEVENTH STREET INT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431		Continued From page 17 needed either liquid or pill form.				
	 9:55 a.m. for R123. T verified R123 had a c Voriconazole suspens mg) per gastrostomy infection/status bone an alternating days on 1mg/1ml. It read, "giv (gastronomy tube) da 1/18/16 then give Rap 0.2 ml per gt daily for through 1/30/16 then mg every other day vi then Rapamune Solut daily on 2/16/16, 2/18 discontinue". On 1/27/16 at 11:51 a (DON) was informed of medication and lack o alert staff of changes. were available and that use them. The facility policy and indicated medications with state and federal resident's name, drug route instructions for u Label change stickers 	sion 40mg/ml 5 mls (200 tube every 12 hours for marrow transplant and had rder for Rapamune Solution e 0.3 mg + 0.3 ml per gt ily from 1/5/16 through pamune Solution 0.2 mg = 12 days from 1/19/16 give Rapamune Solution 0.2 a gt daily till 2/12/16 and tion 0.2 mg via gastric tube /16 2/21/16 then .m. the director of nursing of the mislabeling of f direction change labels to The DON stated that labels at it is the facility's policy to procedures, dated 3/1/14, are labeled in accordance laws. Labels include the name, dose, frequency, use and expiration date. should be utilized to n dose changes until a new				

Facility ID: 00494

If continuation sheet Page 18 of 18

PRINTED: 02/10/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES 5028026 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE DONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 245028 B. WING 01/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2318 WEST SEVENTH STREET HIGHLAND CHATEAU HEALTH CARE CENTER SAINT PAUL, MN 55116 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY Preparation, submission and F 000 INITIAL COMMENTS E 000 Implementation of this Plan of Correction do not constitute an admission of our The facility's plan of correction (POC) will serve agreement with the facts and conclusions as your allegation of compliance upon the set forth on the survey report. Our Plan of Department's acceptance. Because you are Correction is prepared and executed as a enrolled in ePOC, your signature is not required means to continuously improve the quality at the bottom of the first page of the CMS-2567 of care and to comply with all applicable form. Your electronic submission of the POC will state and federal regulatory requirements. be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 483.15(a) DIGNITY AND RESPECT OF F 241 F 241 \$S=D INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect In full recognition of his or her individuality. This REQUIREMENT is not met as evidenced bv: Based on observation, Interview and document review, the facility failed to provide services in a manner which promoted dignity for 2 of 2 residents (R19, R123) in the sample. Findings include: FEB 29 2016 R19's admission minimum data set (MDS) dated 12/23/15, Indicated R19 was cognitively intact. MN DEPT. OF PUBLIC SAFETY The current care plan indicated resident was a fall STATE FIRE MARSHAL DIVISION risk, was continent of bowel and bladder, and used the front wheeled walker to ambulate with moderate independence in room. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE TADA stoply LNHA Executive JUE. VIT JBYIC Any deficiency statement anding with an asterisk (*) danotes a deficiency which the institution may be excused from correcting providing it is determined that othar safeguards provide autilitiant protection to the patients. (Sea Instructions.) Except for nursing homes, the findings ateted above are disclosable 80 days

following the date of survey whether or not a plan of correction is provided. For nursing homes, the findings ateled above are discloseble 80 days 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.

FORM CM8-2567(02-88) Previous Versions Obsole(e

Event ID: 06W/11

Facility ID: 00484

If continuation sheet Page 1 of 18

ENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938	
	OF DEFICIENCIES	(X1) PROVIDERISUPPLIERICI, IA IDENTIFICATION NUMBER:		DLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	i
		245028	B. WING	· · · · · · · · · · · · · · · · · · ·	01/28/201	6
ME OF PR	ROVIDER OR SUPPLIER	histo a consideran and shirt		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
GHLAN	D CHATEAU HEALTH CA	RECENTER	4	2318 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMP	X6) PLETIO ATE
K 000	Continued From page	a 1	ко	00	\$) 2	
	Marian.Whitney@sta Angela.Kappenman@	te.mn.us and			1. 0	
		RECTION FOR EACH INCLUDE ALL OF THE MATION:		APPROVED	hu - Lll 4 pm, Feb 29, 2	1
	1. A description of whether the the test of test o	nat has been, or will be, done ncy.				
	2. The actual, or prop	oosed, completion date,				
	 The name and/or the responsible for corresponsible for correspondent a reoccurrent 	ction and monitoring to				
	building with a partia constructed at 2 diffe building was constru- determined to be of 1970, an addition was side of the building to Type II(222) construc- building and the add	ealthcare Center is a 2-story I basement. The building was orent times. The original cted in 1963 and was Type II(222) construction. In is constructed to the south nat was determined to be of ction. Because the original itions meet the construction ting buildings, the facility was ding.				
	The facility has a con smoke detection in the open to the corridor monitored for autom notification. The facil	prinkler protected throughout, nplete fire alarm system with ne corridors and spaces and resident rooms, that is atic fire department ity has a licensed capacity of ensus of 64 at the time of the				
	The requirement at 4 NOT MET as eviden	2 CFR Subpart 483.70(a) is				

	OF DEFICIENCIES	MEDICAID SERVICES		_		And and a state of the local of the local of	. 0938-03
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION UMBER:		(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED			
	245028	B. WING			01/28/2016		
ME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	· · · · · ·	
GHLAN	D CHATEAU HEALTH CA	ARE CENTER			9 WEST SEVENTH STREET INT PAUL, MN 65116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X8) COMPLETIO DATE
	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.		K 14		K 144C – Generator Inspection v completed on 1/31/16 by the fa Operations Director (POM) that check of 5 minute cool down tin generator was run under load. Plant Operations Director/Main documents weekly monitoring o generator that includes a check minute cool down time after the is run under load.	cility Plant Included a ne after the tenance of 5	
	Based on documenta interview, the facility f emergency generator requirements of 2000	in accordance with the NFPA 101 - 9.1,3 and 1999 4.1. The deficient practice			RECEIV FEB 26 2010 COMPLIANCE MONITORIN LICENSE AND CERTIFI) G DIVISION	
	On facility tour betwee on 01/26/2016, docum inspection logs for the revealed that There w minimum 5 minute co- generator is run under	r load.					
-	Operations Superviso discovery,	was confirmed by the Plant r (JD) at the time of					

F

TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NC	0. 0938-03
245028		IDENTIFICATION NUMBER:	A. BUILDING O	COMPLETED		
		B. WING	01/	28/2016		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
HIGHLAN	D CHATEAU HEALTH	I CARE CENTER	1.	319 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.		K 144	K 144C – Generator inspection w completed on 1/31/16 by the fac Operations Director (POM) that check of 5 minute cool down tim generator was run under load. Plant Operations Director/Maint documents weekly monitoring of generator that includes a check of minute cool down time after the is run under load.	cility Plant included a e after the enance f of 5 generator	
	Based on docume interview, the facili emergency genera requirements of 20 NFPA 110 Chapter could affect all 64 f Findings include: On facility tour betto on 01/26/2016, doc	is not met as evidenced by: entation review and staff ty failed to inspect the ator in accordance with the 000 NFPA 101 - 9.1.3 and 1999 6-4.1. The deficient practice residents. ween 09:30 AM and 12:30 PM cumentation review of the the emergency generator		RECEIVI FEB 26 2016 COMPLIANCE MONITORING LICENSE AND CERTIFIC	3 DIVISION	
	revealed that There minimum 5 minute generator is run un This deficient pract	e was no documentation of the cool down time after the				

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	1	01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		245028	B. WING		01/28/2016	
				STREET ADDRESS, CITY, STATE, ZIP CODE	1_01/2	.8/2016
HIGHL∆NI	D CHATEAU HEALTH C	ARE CENTER		2319 WEST SEVENTH STREET		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			SAINT PAUL, MN 55116		
PREFIX TAG	(EACH DEFICIEN(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID ^{>} REFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETIC DATE
K 000	INITIAL COMMENTS	3	K 000			
	FIRE SAFETY					
	THE FACILITY'S PO ALLEGATION OF CO	C WILL SERVE AS YOUR DMPLIANCE UPON THE				
	DEPARTMENT'S AC	CEPTANCE, YOUR				
	SIGNATURE AT THE	BOTTOM OF THE FIRST				
	USED AS VERIFICA	2567 FORM WILL BE TION OF COMPLIANCE.				
	UPON RECEIPT OF	AN ACCEPTABLE POC, AN				
1	CONDUCTED TO VA	YOUR FACILITY MAY BE				
	SUBSTANTIAL COM	PLIANCE WITH THE				
1	REGULATIONS HAS	BEEN ATTAINED IN YOUR VERIFICATION.				
	A Life Safety Code Su	Irvey was conducted by the				
1	time of this survey Hi	nt of Public Safety. At the ghland Chateau Healthcare				
	Senter was found not	in substantial compliance				
1	with the requirements	for participation in				
	Medicare/Medicaid at 483.70(a), Life Safety	42 CFR, Subpart from Fire, and the 2000				
e	ation of National Fire	Protection Association				
	Chapter 19 Existing H	Life Safety Code (LSC), ealth Care.				
F	LEASE RETURN TH	IE PLAN OF				
	CORRECTION FOR T DEFICIENCIES TO:	HE FIRE SAFETY				
H	EALTHCARE FIRE I	NSPECTIONS				
18	TATE FIRE MARSHA	AL DIVISION				
S	45 MINNESOTA STF T. PAUL, MN 55101-	5145 SUITE 145				
	r by email to:					

In y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for oursing homes, the findings stated above are disclosable 90 days allowing 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 asys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

ORM CMS-22-37(02-99) Previous Versions Obsolete

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT				IO. 0938-03	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
	245028		B. WNG_			01/28/2016		
AME OF PI	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		TILOILOTO	
IGHLAN	D CHATEAU HEALTH CA	ARE CENTER		2319 V	VEST SEVENTH STREET			
				SAIN	Г PAUL, MN 55116			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	1	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE OPRIATE	COMPLETIO	
K 000	Continued From page	e 1	κα					
	Marian.Whitney@sta							
	Angela.Kappenman@	Dstate.mn.us						
	THE PLAN OF CORF	RECTION FOR EACH						
	DEFICIENCY MUST	INCLUDE ALL OF THE						
	FOLLOWING INFOR	MATION:						
	1. A description of wh	at has been, or will be, done		i				
	to correct the deficier							
	2. The actual, or prop	osed, completion date.		1				
	3. The name and/or ti	itle of the person						
	responsible for correct	ction and monitoring to						
	prevent a reoccurrence	ce of the deficiency.						
	Highland Chateau Ho	althcare Center is a 2-story		1				
	building with a partial	basement. The building was						
	constructed at 2 differ	rent times. The original						
	building was construct	ted in 1963 and was						
	determined to be of T	ype II(222) construction. In						
	1970, an addition was	s constructed to the south		-				
	Type II(222) construct	at was determined to be of tion. Because the original						
	building and the addit	ions meet the construction						
	type allowed for existi	ng buildings, the facility was						
	surveyed as one build	ling.						
	The building is See							
	The facility has a com	rinkler protected throughout. plete fire alarm system with						
	smoke detection in the	e corridors and spaces						
	open to the corridor a	nd resident rooms, that is						
	monitored for automa	tic fire department						
	notification. The facilit	y has a licensed capacity of						
	64 beds and had a ce survey.	nsus of 64 at the time of the						
	•							
	The requirement at 42	CFR Subpart 483.70(a) is						
	NOT MET as evidence	ed by:						

If continuation sheet Page 2 of 3

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>VO. 0938-039</u> TE SURVEY
245028		IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01		MPLETED
		B. WING	a a su a		1/28/2016	
	ROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 144 SS=C	Generators are insp under load for 30 m accordance with NF This STANDARD is Based on documer interview, the facility emergency generat requirements of 200 NFPA 110 Chapter could affect all 64 re Findings include: On facility tour betw on 01/26/2016, doc inspection logs for revealed that There minimum 5 minute of generator is run uno	a not met as evidenced by: ntation review and staff y failed to inspect the or in accordance with the 00 NFPA 101 - 9.1.3 and 1999 6-4.1. The deficient practice esidents. where the deficient practice review of the the the emergency generator was no documentation of the cool down time after the	K 14			

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/10/2016 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			<u>O. 0938-0391</u> E SURVEY PLETED
	245028		B. WNG				10010040
NAME OF PI	ROVIDER OR SUPPLIER		- 	STI	REET ADDRESS, CITY, STATE, ZIP CODE		/28/2016
HIGHLAN	D CHATEAU HEALTH CA	ARE CENTER			19 WEST SEVENTH STREET		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		ка	000			
	FIRE SAFETY						
	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.						
	ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COMI REGULATIONS HAS	PLIANCE WITH THE					
	Minnesota Departmer time of this survey, Hi Center was found not with the requirements Medicare/Medicaid at 483.70(a), Life Safety edition of National Fire	42 CFR, Subpart from Fire, and the 2000 Protection Association , Life Safety Code (LSC)					
	PLEASE RETURN TH CORRECTION FOR T DEFICIENCIES TO:	IE PLAN OF THE FIRE SAFETY					
	HEALTHCARE FIRE I STATE FIRE MARSH/ 445 MINNESOTA STI ST. PAUL, MN 55101-	AL DIVISION REET, SUITE 145					
	Or by email to:						
BORATORY D	RECTOR'S OR PROVIDER/SI	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 lays 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.

ORM CMS-2567(02-99) Previous Versions Obsolete

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245028	B. WNG			1/28/2016	
	ROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 2319 WEST SEVENTH STREET			
04.0.15	STIMMADY C	TATEMENT OF DEFICIENCIES		SAINT PAUL, MN 55116 PROVIDER'S PLAN OF CO	DECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION	
K 000	Marian.Whitney@st Angela.Kappenman THE PLAN OF COF DEFICIENCY MUS' FOLLOWING INFO 1. A description of w to correct the deficie 2. The actual, or pro 3. The name and/or responsible for com- prevent a reoccurre Highland Chateau H building with a parti constructed at 2 diff building was constr determined to be of 1970, an addition w side of the building Type II(222) constru- building and the ad- type allowed for exis surveyed as one bu The building is fire a	ate.mn.us and @state.mn.us RECTION FOR EACH TINCLUDE ALL OF THE RMATION: what has been, or will be, done ency. posed, completion date. title of the person ection and monitoring to nce of the deficiency. Healthcare Center is a 2-story al basement. The building was ferent times. The original ucted in 1963 and was Type II (222) construction. In as constructed to the south that was determined to be of uction. Because the original ditions meet the construction sting buildings, the facility was	K 00				
	monitored for auton notification. The fac	and resident rooms, that is natic fire department ility has a licensed capacity of census of 64 at the time of the					
	The requirement at NOT MET as evide	42 CFR Subpart 483.70(a) is					

PRINTED: 02/10/2016