DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q8WI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00494

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245028**

2.STATE VENDOR OR MEDICAID NO.
(L2) **299242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HIGHLAND CHATEAU HEALTH CARE CENTER**
(L4) **2319 WEST SEVENTH STREET**
(L5) **SAINT PAUL, MN** (L6) **55116**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2004**

6. DATE OF SURVEY **03/14/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)
13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/09/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/24/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

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.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245028 Y1	A. Building B. Wing Y2	3/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
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	Reg. # 483.25(l)	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. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	SR/KJ	03/21/2016	16022	03/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245028	A. Building 01 - MAIN BUILDING 01 B. Wing	3/18/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 01/31/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/KJ	DATE 03/21/2016	SIGNATURE OF SURVEYOR 37010	DATE 03/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q8WI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00494

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245028**

2.STATE VENDOR OR MEDICAID NO.
(L2) **299242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HIGHLAND CHATEAU HEALTH CARE CENTER**
(L4) **2319 WEST SEVENTH STREET**
(L5) **SAINT PAUL, MN** (L6) **55116**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2004**

6. DATE OF SURVEY **01/28/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II — 02/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/09/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/10/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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: tom.linhoff@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	01/28/2016

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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.	F 000	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of our agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** 2/26/16 SEK RECEIVED FEB 26 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF 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 by: 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: R19's admission minimum data set (MDS) dated 12/23/15, indicated R19 was cognitively intact. The current care plan indicated resident was a fall risk, was continent of bowel and bladder, and used the front wheeled walker to ambulate with moderate independence in room.	F 241		

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

Heather Wetter, LNHA | Executive Director | 2/24/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245028	A. BUILDING _____ B. WING _____	01/28/2016

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F 241	Continued From page 1 R19 was interviewed in R19's room on 1/26/16 at 9:27 a.m. A facility commode was observed placed against the outside wall of the resident's room. R19 reported having to wait up to an hour in the past for the call light to be answered and reported having had incontinent accidents while waiting. R19 explained that approximately 1 ½ weeks ago, after putting the call light on to get assistance to get up to use the commode, a staff person came in and instructed her to go in the brief she was wearing. R19 indicated the staff person implied not being able to assist her. R16 further added that it seemed once you were in bed in the evening, staff did not want to get you up again; they act like they don't care. R19 indicated trying to do more for herself and stated that its really hard when told to do something like that, "it was just wrong." On 1/27/16 during the afternoon, R19 was observed to be up walking in the hallway using a front wheeled walker, a transfer belt and being assisted by a staff person. On 1/28/16 at 10:39 a.m. during interview, the director of nursing indicated this was not the expectation of the facility to wait that long on a call light and to be told to void in one's incontinent product rather than being assisted out of bed to use a commode. R123's admission minimum data set (MDS) dated 12/22/15 indicated R123 is totally dependent on staff for transfers and incontinent of bowel and bladder.	F 241	**F241 – Care plans for R19 and R123 have been reviewed and NAR (Nursing Assistant Registered) care sheets have been updated to reflect R 19 and R123 current assistance needs. Three day Bowel and Bladder re-assessments initiated on R19 and R123. Based on R123's assessments and appointment schedule, R123's care plan has been revised to meet resident's care needs. R19 has progressed to increased independence and is currently maintaining continence.** **All residents are at risk for treatment lacking dignity and respect as an individual. Education has been provided to staff on standards of resident care and treatment, and response to residents' requests for assistance is to be performed in a timely manner guaranteeing individual resident respect and dignity.** **Call light response time audits will be completed 3 x weekly x 12 weeks and reviewed for timeliness with follow up as needed. Findings will be reviewed monthly at Quality Council (QC) x 3 months with follow-up to Committee recommendations.** **Deficient practice will be corrected by March 8, 2016.**	3/8/16

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F 241	Continued From page 2 The initial care plan indicated R123 needed assist of two staff persons and the use of a mechanical standing lift for transfers. On 1/25/16 at 4:28 p.m. R123 was interviewed and reported an event when a nursing assistant had answered his call light one evening. R123 stated he told the nursing assistant (NA) that he was soiled and needed to be cleaned up. Without checking, the NA told R123 that he had already been cleaned up. The nursing assistant returned with the nurse and again R123 told staff he needed to be cleaned up. R123 reported the nurse did not check him but told him he had already been cleaned up. Staff then left the room without changing R123. R123 explained that he was having diarrhea and needed to be cleaned. R123 reported another incident when he put the call light on to use the bed pan. There was a delay in answering the call light. When the nursing assistant arrived to the room, R123 reported the nursing assistant said he had already been changed for the night. R123 said that his wife was present and told the nursing assistant again that he needed to be cleaned and changed. R123 reported the nursing assistant finally did follow through. R123 stated that its "very demoralizing" and asked, "why do they have the job if they don't want to do the job?" On 1/26/16 at 8:30 a.m. during an interview, the family member recalled the incident and reported being in the room when the conversation occurred. The family member added when R123 put the call light on, he needed to use the bedpan, but by the time the nursing staff answered, R123 needed to be cleaned and changed. Family member added: "I don't know	F 241		

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F 241	Continued From page 3 what would have happened if I wasn't there, my fear is he wouldn't be cleaned up." On 1/27/16 at approximately 1:30 p.m. the director of nursing indicated not knowing about the above incidents, stated this was not the expectation of the facility and that additional training needed to be provided.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a plan of care related to psychotropic medications for 2 of 2	F 279	**F279 – R68 and R22 care plans have been reviewed and updated to include name of psychotropic medication, side effect monitoring, orthostatic blood pressure, non-pharmacological interventions and target behavior monitoring. R95's care plan has been updated to include resident's diagnosis of diabetes, use of insulin and monitoring for signs and symptoms of high/low blood sugar. Care plans for all residents receiving psychotropic medications have been reviewed and updated to include care and monitoring according to the psychotropic medication. Care plans for all diabetic residents will be reviewed and revised to include diagnoses, use of insulin and monitoring for high/low blood sugar. All residents are at risk for receiving care not inclusive of needs according to diagnoses and medications received. Nurse managers and clinical staff were educated that care plans for all residents receiving psychotropic medications need to include name of medication, adverse side effect monitoring and target behavior monitoring, and care plans for all diabetic residents need to include diagnosis, use of insulin and monitoring for high/low blood sugar.**	3/8/16

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F 279	Continued From page 4 residents (R68, R22) and failed to develop a plan of care related to diabetes and insulin use for 1 of 1 resident (R95). Findings include: R68's care plan lacked side effect monitoring, orthostatic blood pressure, non-pharmacological interventions and target behavior monitoring for use of a psychotropic medication. The Physician Orders dated 1/13/16, indicated R68 had an order for Abilify 15 mg 1 tablet by mouth daily, which was initiated on 12/7/15. R68's care plan dated 9/25/15, identified R68 received an antidepressant medication related to depression and bipolar. The care plan did not identify Abilify as an antipsychotic medication and lacked direction for staff to monitor for side effects, orthostatic blood pressure and target behaviors. During interview, on 1/27/16 at 1:03 p.m. the director of nursing (DON) stated, facility was treating resident with Abilify as antidepressant instead of antipsychotic medication and this was the reason there was nothing on the care plan to monitor for side effects, effectiveness of medication, monitoring behavior and orthostatic B/P. On 1/27/16 at 2:29 p.m. the pharmacy consultant stated, being aware that R68 was on Abilify and the classification was antipsychotic medication. The pharmacy consultant explained that recommendations had been made for the facility to monitor side effects, effectiveness, orthostatic blood pressure and target behavior monitoring.	F 279	**DON/ designee will audit all new psychotropic medication orders weekly x 12 weeks to assure appropriate assessments, care planning and monitoring is completed. DON/Designee will audit all new admissions with diagnosis of diabetes and also new or changed diabetic agent orders weekly x 12 weeks to assure appropriate assessments, care planning and monitoring is completed. Findings will be reported monthly at QC x 3 months with follow-up to Committee recommendations.** **Deficient practice will be corrected by March 8, 2016.**	

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F 279	Continued From page 5 Policy and procedure title UNNECESSARY DRUGS - ANTIPSYCHOTIC DRUGS-HDGR dated 4/2009, reads, 5. Monitor side effect of medication. A. If resident experiences a decline in functional status, it may be a side effect of the medication. B. Review side effects, contact physician if indicated." R22's care plan lacked psychotropic medications. Signed physician orders dated 12/31/15, included donepezil (used in the palliative treatment of Alzheimer's disease) 5mg daily for dementia, escitalopram (used to treat anxiety and major depressive disorder) 20mg daily for depression, and Risperidone (an antipsychotic medication) 0.5mg, 1&1/2 tablets (0.75mg) orally at bedtime for depressive disorder. The quarterly Minimum Data Set (MDS) dated 10/29/16, indicated R22 was cognitively intact. Diagnoses included dementia and depressive disorder. The medical data sheet included diagnoses of bipolar disorder and paranoia. The psychotropic drug use care area assessment (CAA) dated 8/13/15, identified use of antipsychotic and antidepressant medications with adverse consequences of increased risk for falls and depression. On 1/26/16, review of the care plan dated 9/30/15, included "alteration in mood related to depression as evidenced by changes in mood", but did not include a care plan for antipsychotic medications. On 1/27/16, at 7:49 a.m. R22 was observed at	F 279		

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F 279	Continued From page 6 the breakfast table eating and conversing with tablemates. Licensed Practical Nurse (LPN)-A arrived at the table with R22's medications and observed R22 take medications without behaviors. When interviewed on 1/28/16, at 10:41 a.m. registered nurse (RN)-A confirmed the medical record lacked a care plan for antipsychotic medications. R95's care plan lacked interventions regarding R95's diagnosis of diabetes, and use of insulin. Review of R95's current physician orders signed 12/21/15 indicated the following ordersfor insulin: -Levemir INJ Inject 26 units subcutaneously every morning. -Levemir INJ Inject 15 units Subcutaneously every evening. -Novolog INJ 100/ml Inject Subcutaneously 3 times daily with meals per sliding scale (PSS) -Novolog INJ 100/ml Inject subcutaneously 3 times daily with meals PSS: Review of R95's plan of care did not address diabetes, use of insulin or information for monitoring signs and symptoms of high/low blood sugar. Interview with RN-A on 1/27/16 at 11:55 a.m., stated R95 had diabetes, received insulin, and that blood sugars were checked four times a day. RN-A acknowledged R95's care plan lacked information pertaining to diabetes, insulin use, symptoms to monitor for, and stated the plan of care should contain that information.	F 279		

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F 282 F 282 SS=D	Continued From page 7 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 2 of 2 residents (R86, R129) who required staff assist with shaving and nail care. Findings include: Review of R86's care plan, revised 12/15, directed staff that R86 required assist with grooming and indicated R86, "will be clean and well groomed every day". On 1/25/16 at 6:33 p.m., R86, was observed to have several gray/black facial hairs to the upper lip and chin area. R86's right toe nails were untrimmed and unclean with build up under the nails. On 1/26/16 at 10:13 a.m., and 1/27/16 at 9:05 a.m., R86 was observed to still be unshaven. During interview 1/27/16 at 8:57 a.m. R86 indicated he would like to be shaved daily. On 1/27/16 at 9:55 a.m. licensed practical nurse (LPN)-B verified R86's right toe nails were not trimmed and had a hard substance under the nails. LPN-B, added, R86 was not a diabetic	F 282 F 282	**F282 – R129 has discharged from facility since survey. R86 was re-approached to provide assistance with shaving and care of toenails; with re-approach resident accepted assistance with shaving and reduction of toenails. R86 care plan and NAR care sheet have been reviewed and revised to include staff re-approach to care if R86 declines personal hygiene cares.** **All residents are at risk for sub-optimal personal hygiene.** **Staff were educated to follow resident care plans in accordance with resident choice; in situations where personal hygiene cares are declined/refused, care planning/care plans will include re-approaches to provide assistance with personal hygiene, towards the goal of maintaining optimal personal hygiene of residents.** **DON/ designee will audit the delivery of assistance with cares 3 x weekly x 12 weeks. Findings will be reviewed monthly at QC x 3 months with follow-up to Committee recommendations.** **Deficient practice will be corrected by March 8, 2016.**	3/8/16

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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. R129's initial care plan dated 1/11/16, directed staff that R129 required, "Grooming partial assist". On 1/26/16 at 9:43 a.m., R129 was observed to have several white grayish facial hairs to the upper lip and chin area and when interviewed stated being unable to shave self and facility staff normally assisted with shaving. R129 expressed, "looking bad". On 1/27/16 at 8:49 a.m. R129 was observed sitting in wheel chair in the dining room unshaven. On 1/27/16 at 10:17 a.m., DON acknowledged R129 was unshaven and the expectation was for residents to be shaved daily.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and	F 311		

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F 311	Continued From page 9 services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal hygiene care for 2 of 2 residents (R86, R129) who were dependent on staff for personal cares. Findings include: R86's annual Minimum Data Set (MDS) dated 6/19/15, identified R86 required total assist with bed mobility, transfers and toileting. Requires extensive assist with dressing, eating and personal hygiene needs. R86 is severely impaired. Nursing assistant assignment sheet undated, reads, "A1 (assist of one) with all ADLs (activities of daily livings) ..." The care plan revision goal dated 12/15, identified R86 had "Self Care Deficit related to: CVA (cardiovascular disease) with hemiparesis and TBI (traumatic brain injury). Will be clean and well groomed every day through review period. 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	F 311	**F311 – R129 has been discharged from the facility since survey. R86 was re-approached and assistance with personal hygiene care was provided, resident was shaved and all toenails were reduced. R86 Care plan was reviewed and revised to include re-approaches to resident's refusal of cares.** **All residents are at risk for lacking personal hygiene cares.** **Nursing staff were educated on the need for residents to maintain good personal hygiene and encouraging residents to participate in ADL's. Education included documenting refusals of care, notifying nurse of refusals of care and the need to re-approach.** **Weekly audits by DON/designee x 12 weeks to assure that personal hygiene cares are completed according to resident choice and for those residents who decline or refuse cares, re-approach interventions are initiated to maintain optimal resident hygiene. Findings will be reported to monthly to QC x 3 months with follow-up to Committee recommendations.** **Deficient practice will be corrected by March 8, 2016.**	3/8/16

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F 311	Continued From page 10 have numerous facial hairs. On 1/27/16 at 9:05 a.m., R86 was observed to have several black grayish facial hairs to the upper lip and the chin area while lying in bed. On 1/27/16 at 8:57 a.m. R86 stated, "Yes" when queried by surveyor if he would like to be shaved daily. On 1/27/16 at 9:55 a.m. licensed practical nurse (LPN)-B verified R86's right toe nails were not trimmed had a hard substance under the nails. LPN-B added that R86 was not a diabetic resident, so nursing assistants were supposed to do the nail cares. LPN-B did not know why it was not done and stated R86 had a weekly bath. 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. R129 was observed to have several facial hairs on 1/26/16, and 1/27/16. R129's clinical record noted R129 was admitted to facility on 1/11/16, and had diagnoses, which included dementia, cerebral infarction, hemiplegia and hemiparesis. R129's admission Minimum Data Set (MDS)	F 311		

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F 311	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, "Grooming partial assist". On 1/26/16 at 9:43 a.m., R129 was observed to have several white grayish facial hairs to the upper lip and the chin area and stated facility staff normally assist with shaving and now looking bad and unable to shave self. On 1/27/16 at 8:49 a.m. R129 was observed sitting in wheel chair in the dining room and was unshaven with facial hairs. On 1/27/16 at 10:17 a.m., DON acknowledged R129 was unshaven and indicated her expectation was that residents were supposed to be shaved daily. Policy and procedure titled NAIL CARE, dated 4/1/08, Policy Statement indicated, "It is the facility's policy to keep a resident's fingernails and toenails cleaned and trimmed. 1. Fingernails and toenails are checked daily and cleaned as necessary. 2. Fingernails and toenails are trimmed weekly during bathing or more often, if necessary. 3. A licensed professional does toenail trimming calluses, and bunions on diabetic residents. 4. Notify the charge nurse or designee of any abnormalities." Policy and procedure titled SHAVING - ELECTRIC RAZOR, dated 3/1/14, Policy	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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F 311	Continued From page 12 Statement directed, "Resident will be provided care and services daily which includes shaving as per resident needs and/or care plan." Policy and procedure titled SHAVING - SAFETY RAZOR, dated 4/1/08, Policy Statement indicated, "Resident will be provided care and services daily which includes shaving as per resident needs and/or care plan."	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate monitoring of an antipsychotic medication for 1 of 5 residents (R68) who used Abilify (antipsychotic). Findings include: R68 had diagnoses that included Bipolar disorder, schizoaffective disorder and depression. The Physician Orders dated 1/13/16, indicated R68 had an order for Abilify 15 mg 1 tablet by mouth daily, which was initiated on 12/7/15. On 1/27/16 at 7:32 a.m. R68 was observed to be awake, lying on his back in bed. When approached and interviewed regarding the medication, Abilify, that he takes, R68, stated he did not notice or experience any side effects from the medication but did identify that he likes to stay in his room. During the interview R68 was observed to be relaxed with no behaviors noted. R68's care plan dated 9/25/15, identified R68 received an antidepressant medication related to depression and bipolar. The care plan did not identify Abilify as an antipsychotic medication and lacked direction for staff to monitor for side effects, orthostatic blood pressure and target behaviors. During interview, on 1/27/16 at 1:03 p.m. the director of nursing (DON) stated, facility was treating resident with Abilify as antidepressant instead of antipsychotic medication and this was the reason there was no monitoring for side effects, effectiveness of medication, monitoring	F 329	**F329 – R68 medication regimen has been reviewed for diagnoses specific to medication orders. R68 was receiving Abilify, classified as an antipsychotic for use as an antidepressant. R68 was assessed for potential adverse side effects of antipsychotic drug therapy through completion of a DISCUS assessment and target behavior and side effect monitoring was established. All residents using antipsychotic medications have been reviewed for current assessments, target behaviors and side effect monitoring, and their care plans reflect the use and monitoring of antipsychotic medications. All residents receiving antipsychotics are at risk for lack of appropriate monitoring. Nursing staff have been educated on medications classified as antipsychotics and the necessary assessments and monitoring of residents receiving antipsychotic medications.** **All new orders for antipsychotics will be audited weekly x 12 weeks to assure a DISCUS assessment is completed and target behavior and side effect monitoring is implemented. Findings will be reviewed monthly at QC x 3 months with follow-up to Committee recommendations.** **Deficient practice will be corrected by March 8, 2016.**	3/8/16

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F 329	Continued From page 14 behavior and orthostatic B/P. On 1/27/16 at 2:29 p.m. the pharmacy consultant stated, being aware that R68 was on Abilify and the classification was antipsychotic medication. The pharmacy consultant explained that recommendations had been made for the facility to monitor side effects, effectiveness, orthostatic blood pressure and target behavior monitoring. Further mentioned, the recommendation had been re-issued on the last visit to the facility. Policy and procedure title UNNECESSARY DRUGS - ANTIPSYCHOTIC DRUGS-HDGR dated 4/2009, reads, "Psychotropic drug therapy shall be used only when it is necessary to treat a specific condition as diagnosed and documented in the clinical record ... 3. Complete Tardive Dyskinesia - AIMS or DISCUS assessment prior to initiation of medication and within six months thereafter and/or prior to any increase in medication. 4. Establish target behavior sheet which must include quantitative and objective information in the resident's medical record or medication administration record. 5. Monitor side effect of medication. A. If resident experiences a decline in functional status, it may be a side effect of the medication. B. Review side effects, contact physician if indicated."	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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F 431	Continued From page 15 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to add dosage change information to the label of medications for 2 of 7 residents (R16, R123) reviewed for medication administration. Findings include: On 1/27/16 at 7:55 a.m. R16 requested his pain	F 431	**F431 – R16 and R123 medications have been reviewed for correct name, dosage, frequency and route and direction change labels applied as indicated.** **All residents receiving medications are at risk of medication errors due to improperly labeled medications.** **Nursing staff educated on proper labeling for medications and policy of applying dosage change labels to medication when indicated.** **DON/designee will audit medications of 3 residents weekly x 12 weeks to assure medications are labeled correctly in accordance with physician orders and MARS. Findings will be reviewed monthly at QC x 3 months with follow-up to Committee recommendations.** **Deficient practice will be completed by March 8, 2016.**	3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 16 medication. RN-B removed a small brown bottle and, with the plunger, pulled out 3 milliliters (ml) of oxycodone for the resident. The label indicated 100 mg/ml (milligrams/milliliter), 30 mg. The medication was then given to the resident. The label did not indicate when or how often the oxycodone was to be received. At 8:00 a.m., RN-B drew up 30 units of Lantus insulin for R16. The label indicated the resident should have received 27 units. At 8:10 a.m., RN-B administered Tramadol 50 mg to the resident. The label on the card indicated it could be received every 6 hours as needed. When questioned about the timing, RN-B indicated the order had been changed and it was now on a schedule. RN-B indicated the facility had change of direction labels but verified none had been used on medication changes for R16. At 8:15 a.m. RN-B went to administer medication to R123. A bottle labeled Voriconazole 40mg/ml was opened and medication was dispensed from the bottle. A bottle labeled Rapamune 1 mg/ml was also opened and medication was dispensed from the bottle. RN-B stated the medications are used for bone marrow transplants and acknowledged both bottles were not labeled with name, dose, route or frequency of the medication. RN-B did not offer an explanation of why a label was missing. The physician orders were reviewed on 1/27/16 at 9:45 a.m. for R16. On 1/25/16 a physician order read increase Lantus 30 units in the morning and 17 units in the evening. On 1/20/16 a physician order read increase oxycodone to 10 mg every 2 hours as needed orally. On 1/22/16 a physician order was received to schedule Tramadol 50 mg 2 times a day and okay to give oxycodone as	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 17 needed either liquid or pill form. The physician orders were reviewed on 1/27/16 at 9:55 a.m. for R123. The physician's ordered verified R123 had a current order for Voriconazole suspension 40mg/ml 5 mls (200 mg) per gastrostomy tube every 12 hours for infection/status bone marrow transplant and had an alternating days order for Rapamune Solution 1mg/1ml. It read, "give 0.3 mg + 0.3 ml per gt (gastronomy tube) daily from 1/5/16 through 1/18/16 then give Rapamune Solution 0.2 mg = 0.2 ml per gt daily for 12 days from 1/19/16 through 1/30/16 then give Rapamune Solution 0.2 mg every other day via gt daily till 2/12/16 and then Rapamune Solution 0.2 mg via gastric tube daily on 2/16/16, 2/18/16 2/21/16 then discontinue". On 1/27/16 at 11:51 a.m. the director of nursing (DON) was informed of the mislabeling of medication and lack of direction change labels to alert staff of changes. The DON stated that labels were available and that it is the facility's policy to use them. The facility policy and procedures, dated 3/1/14, indicated medications are labeled in accordance with state and federal laws. Labels include the resident's name, drug name, dose, frequency, route instructions for use and expiration date. Label change stickers should be utilized to identify any medication dose changes until a new pharmacy label is obtained.	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5028026

PRINTED: 02/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2318 WEST SEVENTH STREET SAINT PAUL, MN 55116

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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.	F 000	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of our agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF 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 by: 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: R19's admission minimum data set (MDS) dated 12/23/15, indicated R19 was cognitively intact. The current care plan indicated resident was a fall risk, was continent of bowel and bladder, and used the front wheeled walker to ambulate with moderate independence in room.	F 241		

RECEIVED
FEB 29 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Wester, LNHA	Executive Director	2/24/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2318 WEST SEVENTH STREET SAINT PAUL, MN 55116

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Highland Chateau Healthcare Center is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fire sprinkler protected throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor and resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 64 beds and had a census of 64 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	APPROVED By Tom Linhoff at 1:44 pm, Feb 29, 2016	

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K 144 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. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 64 residents. Findings include: On facility tour between 09:30 AM and 12:30 PM on 01/26/2016, documentation review of the inspection logs for the emergency generator revealed that There was no documentation of the minimum 5 minute cool down time after the generator is run under load. This deficient practice was confirmed by the Plant Operations Supervisor (JD) at the time of discovery.	K 144	**K 144C – Generator Inspection was completed on 1/31/16 by the facility Plant Operations Director (POM) that included a check of 5 minute cool down time after the generator was run under load.** **Plant Operations Director/Maintenance documents weekly monitoring of generator that includes a check of 5 minute cool down time after the generator is run under load.**	

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RECEIVED
FEB 26 2016
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS 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. 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 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 DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000		

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

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	245028	A. BUILDING 01 - **MAIN BUILDING 01** B. WING _____	**01/28/2016**

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HIGHLAND CHATEAU HEALTH CARE CENTER	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Highland Chateau Healthcare Center is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fire sprinkler protected throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor and resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 64 beds and had a census of 64 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144 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. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 64 residents. Findings include: On facility tour between 09:30 AM and 12:30 PM on 01/26/2016, documentation review of the inspection logs for the emergency generator revealed that There was no documentation of the minimum 5 minute cool down time after the generator is run under load. This deficient practice was confirmed by the Plant Operations Supervisor (JD) at the time of discovery.	K 144		

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K 000	INITIAL COMMENTS 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. 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 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 DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER 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 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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