Electronically delivered
November 18, 2020

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: October 30, 2020

Dear Administrator:

On October 30, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 3, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 3, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 3, 2020.

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

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 3, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Chateau Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 3, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 19, 2020

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

REVISED LETTER

RE: CCN: 245028
Cycle Start Date: October 30, 2020

This letter revises and replaces the letter dated November 18, 2020 to remove DPOC language.

Dear Administrator:

On October 30, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

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Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 18, 2020

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: Y8R611

Dear Administrator:

The above facility was surveyed on October 28, 2020 through October 30, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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
	00494	A. BUILDING: _____ B. WING _____	C 10/30/2020

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: From 10/28/20 through 10/30/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5028077C and H5028079C, with a licensing order issued. The following complaints were found to be UNSUBSTANTIATED: H5028078C and H5028080C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication	21545		12/1/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 2 error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication orders were correctly transcribed and administered in accordance with physician orders for 1 of 4 residents (R1) reviewed for medication administration. This resulted in actual harm when R1 required hospitalization as a result of receiving metoprolol (used to treat high blood pressure) and potassium (mineral that contributes to properly functioning kidneys, heart, muscles and nerves) after the order for these medications had been discontinued. The facility further failed to ensure proper medication administration when R1 received amiodarone (used to treat heart rhythm problems), amlodipine (used to treat high blood pressure), and clonidine (used to treat high blood pressure) after the order for these medications had been discontinued on a separate occasion.	21545	Corrected	

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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) COMPLETE DATE
21545	Continued From page 3 Findings include: R1's quarterly Minimum Data Set (MDS) dated, 9/25/20, identified R1 was cognitively intact. R1's diagnoses include hypertension, diabetes, atrial fibrillation (irregular, often fast heart rate) and end stage renal disease. R1's progress noted dated 10/16/20, at 12:28 p.m. indicated, "Resident readmitted from [hospital] at 12 p.m. via wheelchair [w/c] with principal problem hyperkalemia [high potassium blood level]. Resident denies pain or discomfort at this time. Vitals stable. Will continue to monitor." R1's discharge summary from hospital on 10/16/20, indicated, "STOP taking metoprolol succinate 100 milligrams (mg) 24 hr tablet" and "potassium chloride 20 [milliequivalent] MEQ tablet." R1's medication administration record (MAR) dated 10/16/20, indicated both metoprolol and potassium were administered on 10/17/20 and 10/18/20. R1's progress note dated 10/20/20, at 15:44 (3:44 p.m.) indicated, "Resident was sent to hospital at 0930 [9:30 a.m.] due the following vitals BP, 97/45, pulse of 33, temp, 98.8, oxygen sats 89%. She was also lethargic [unresponsive]." R1's discharge summary from hospital on 10/27/20, indicated R1 presented with a heart rate in the 30s and a potassium level of 7.3 (normal potassium range 3.5-5.0). "It was determined that patient was mistakenly receiving metoprolol at NH [nursing home] which was already discontinued." The discharge summary	21545		

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procedure note further indicated, "Patient presented with bradycardia cardiogenic shock with profound bradycardia; sinus node dysfunction [condition affecting heart rate]. Was hyperkalemic. Required urgent temporary pacemaker [which] was placed the right internal jugular vein." The discharge summary did not mention that R1 received potassium that had been discontinued.

R1's discharge instructions dated 10/27/20, indicated, "STOP taking amiodarone 200 mg tab, amlodipine 10 mg tab and clonidine 0.2 mg/24 hour."

R1's progress noted dated 10/27/20, at 15:11 [3:11 p.m.] indicated, "Resident returned from hospital prior to writer's arrival. Orders faxed to pharmacy by A.M. nurse. New, corrected orders faxed from discharging hospital. Those orders faxed to pharmacy. Vitals: T 97.5, P 68, R18, BP 159/90, O2 96%. Alert and oriented, able to make needs known. Fully oriented to room."

R1's MAR dated 10/27/20, indicated amiodarone, amlodipine and clonidine were all administered on 10/28/20.

During interview on 10/28/20, at 10:41 a.m. medical records administrator (MR)-A stated the normal process for admissions or readmissions was that the hospital would fax the resident's orders to the pharmacy and then the pharmacy would send the updated MAR to the facility. The facility would replace the old MAR with the new one from pharmacy. The new MAR would then be placed in the medication (med) book and the old MAR would be removed and filed in the paper chart. MR-A further stated nurses documented medication administration on the MAR that is

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21545	Continued From page 5 stored in the med book. During interview on 10/28/20, at 11:10 a.m. registered nurse (RN)-A stated new orders were faxed to the pharmacy and then the pharmacy sent back the new paper MAR. The nurse on duty when the MAR was received back from pharmacy would check the MAR against the orders. The MAR would sometimes come back from pharmacy with the discontinued orders still listed. RN-A further stated the correct process would be to follow the MAR. If a medication was discontinued, it would be yellowed out on the MAR by the nurse checking the MAR against the orders and the medication would be removed from the med cart. Discontinued medications would then be either returned to the pharmacy or disposed of properly. "I gave these meds [amiodarone, amlodipine and clonidine] this morning (10/28/20) they were not yellowed out." RN-A stated the previous nurse gave report on R1, but did not mention new orders. If there were new orders to be checked, the chart would be on the counter at the nurse's station or on top of the chart cart with the paper orders sticking out of the binder. RN-A could not recall where R1's chart was that morning. During interview on 10/28/20, at 11:52 a.m. RN-B stated R1's orders were faxed to pharmacy on 10/27/20, when R1 returned to the facility from the hospital. Pharmacy sent back R1's paper MAR on 10/27/20. Pharmacy should have checked to make sure all the orders were current. It was the nurse's responsibility to check and there should have been a second nurse to double check all orders against the MAR. Both nurses should sign, date and time the order sheet indicating that the orders have been checked. RN-B further stated the nurse assigned to the	21545		

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med cart when a new MAR was received should remove any discontinued medications from the med cart and return to pharmacy or dispose of properly.

During interview on 10/28/20, at 12:02 p.m. R1 stated that staff discovered her oxygen saturation level was in the 80's and was sent to the hospital on 10/20/20. R1 further stated staff at the hospital discovered her heart rate was low and her potassium was too high. "I was not feeling well. I was sleeping a lot." R1 further stated not knowing what medications were ordered or discontinued upon discharge from the hospital on 10/27/20. R1 confirmed and stated a patch (clonidine) was applied behind her ear this morning (10/28/20) but the nurse just removed it.

During interview on 10/28/20, at 12:59 p.m. pharmacy senior triage tech (TT) described the normal process for pharmacy orders. Orders were faxed from the facility to the pharmacy intake department then routed to the order entry department. Order entry would enter new orders or make changes to orders in the resident's profile. Then a pharmacist would check the orders before the MAR was sent back to the facility.

During interview on 10/28/20, at 1:14 p.m. pharmacist (P)-A. stated order entry enters the orders into the resident's profile and a pharmacist checks the orders. If a medication was discontinued it should have been checked against the new orders and removed. P-A confirmed and stated R1's metoprolol was listed from a May order, but was not on R1's 10/16/20 orders for readmission to the facility. "It should have been removed on the 16th. It should have been double checked." P-A further stated that she could see

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there were orders to be discontinued for amiodarone, amlodipine and clonidine from 10/27/20, and were not removed from the MAR. These orders would have gone through order entry and then a pharmacist to be checked.

During interview on 10/28/20, at 2:58 p.m. RN-B stated was notified that R1 received some medications in error this morning (10/28/20) and notified the DON and [R1's] primary doctor. RN-B further stated, "I took her vitals and she is ok. She is oriented and eating just fine. No adverse effects from those medications this morning."

During interview on 10/29/20, at 1:53 p.m. P-B stated the two doses of potassium could have caused the hyperkalemia. P-B further stated that metoprolol could decrease heart rate but could not confirm that two doses given in error was the cause of R1's condition without knowing R1's history.

During interview on 10/28/20, at 4:58 p.m. RN-D stated R1's progress note in the hospital written by cardiologist (MD)-B dated 10/20/20, indicated severe bradycardia due to overdose of metoprolol.

During interview on 10/29/20, at 10:27 a.m. director of nursing (DON) stated R1's new MAR was received by fax at the nurse's station on 10/16/20, at 2251 (10:51 p.m.). The nurse on duty at the time the new MAR was received should have done the first check and the next shift nurse should have done the second check. Both nurses should sign and date the order sheet when they checked it. A check consisted of comparing admission orders with current orders on the MAR and verifying all discontinued medications were removed from the MAR. DON confirmed and

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21545	Continued From page 8 stated R1's new MAR and orders had not been checked, "That is where our system is broken." During interview on 10/29/20, at 11:15 a.m. license practical nurse (LPN)-A confirmed working on R1's unit on the night shift of 10/16/20. LPN-A stated not being aware that any new MAR came in that night for R1. During interview on 10/29/20, at 5:19 p.m. RN-C confirmed working on R1's unit the day shift on 10/17/20. RN-C stated that if there are were order changes or medication changes the night nurse would include that information in report in the morning. "I do not remember getting any report of any changes with R1. I looked at the MAR and gave the meds according to the MAR." RN-C stated the nurse working when the new MAR was received should check the MAR against the orders and then report to the next nurse to do the same for a second check. During interview on 10/29/20, at 3:25 p.m. R1's primary care provider (MD)-A stated the two doses of metoprolol and potassium wrongfully administered to R1 could have contributed to R1's hospitalization due to R1 developing bradycardia (low heart rate), heart block, cardiogenic shock and hyperkalemia (high blood potassium level). The facility policy Admission Orders dated 4/1/08, identified at the time of a resident's admission, the facility must have physician orders for the resident's immediate care to include dietary, medications and for routine care. The facility policy Medication Administration Record dated 3/1/14, identified all prescribed medications by the physician were to be listed on	21545		

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21545	Continued From page 9 the resident's MAR. The policy indicated when a resident was discharge to the hospital, a new MAR must be initiated upon readmission. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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F 000	INITIAL COMMENTS From 10/28/20 through 10/30/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5028077C and H5028079C, with a deficiencies cited at F678 and F760. The following complaints were found to be UNSUBSTANTIATED: H5028078C and H5028080C. 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		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's	F 678		12/1/20

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

Electronically Signed | 11/28/2020

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F 678	Continued From page 1 advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure their code carts were stocked and supplied with the appropriate equipment to provide emergency basic life support immediately, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel and subject to related physician orders and the residents' advanced directives. This had the potential to affect 37 of 56 residents in the building who had a CPR status which included R2. R2 was admitted to the facility on 10/23/20, with diagnoses that included cerebrovascular accident, hypertension, cervical radiculopathy, and hyperlipidemia. During an interview on 10/28/20, at 1:00 p.m., registered nurse (RN)-E stated nursing assistant (NA)-A placed R2 on a bedpan on 10/24/20, at 12:50 p.m. NA-A returned to check on R2 at 1:00 p.m. and found R2 unresponsive. NA-A left the room to summon RN-E. RN-E entered the room and determined R2 was not breathing and pulseless. RN-E left the room to retrieve the code cart and summon additional assistance. RN-E returned to the room within a minute with the code cart. RN-E discovered the oxygen (O2) tank was not working properly and the face mask for the bag valve mask (BVM) system was missing. RN-E sent NA-A to summon a physical therapist that was experienced in CPR. RN-E left the area to retrieve a different O2 tank. RN-E	F 678	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. R2 no longer resides at facility. All residents residing at Highland Chateau Care Center with a full code status may be effected by this practice. All current resident's code status have been verified and POLSTs are being completed. All crash carts will be properly stocked and	

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F 678	Continued From page 2 found mask on the code cart detached from the BVM system. RN-E estimated he was away from the room for less than five minutes. During an interview on 10/28/20, at 12:30 p.m., physical therapist (PT) A was in the physical therapy department when approached by a NA (NA was unknown to PT-A) and asked to report to R2's room. PT-A was CPR certified as was RN-E. When PT-A arrived, no one was in the room with R2. PT-A stated RN-E followed PT-A into the room and began cardiac compressions. The exact time elapsed was not known. CPR continued until the paramedic ambulance arrived at approximately 1:25 p.m. Resuscitation attempts were discontinued after the paramedics assessed R2 and determined R2 was deceased. On 10/28/20, at 2:00 p.m. the code cart for the first floor was observed. The cart was stocked in accordance with the inventory list. The O2 tank was full (2200 pounds per square inch [psi]). A suction machine with tubing and various suction catheters were present. Various O2 delivery systems, a second O2 tank yoke, a rigid backboard, and the BVM system were present. The code cart checklist indicated the inventory was last checked on 10/28/20. The inventory list was attached to the signature page. There were no other signatures on the checklist. During an interview on 10/28/20, at 2:10 p.m., RN-F stated the cart was checked by the night shift staff. RN-F did not know where the sign off sheets were kept. RN-F acknowledged, there were no signatures prior to 10/28/20. On 10/28/20, at 2:30 p.m. the code cart for the second floor was observed. The cart was stocked	F 678	suppled with appropriate equipment to provide basic life support immediately. All nursing staff and therapy staff will be educated on the crash carts and resident code status. All Licensed staff will continue to need to be CPR certified. The DON/Designee will audit the crash cart weekly to ensure they are appropriately stocked. (Attachment #1) DON/Designee will report audit findings to monthly QAPI meetings.	

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in accordance with the inventory list, the O2 tank was half full (1100 psi), a suction machine was present, and the BVM system was present but the mask was detached and located in a different area of the cart. The code cart checklist indicated the inventory was checked on 10/28/20. The inventory list was attached to the signature page.

During an interview on 10/28/20, at 2:45 p.m., RN-B stated the cart was checked by the night shift staff. RN-B did not know where the sign off sheets were kept. RN-B acknowledged there were no signatures prior to 10/28/20. RN-B stated the O2 tank would be changed later that day.

On 10/29/20, at 10:00 a.m., both code carts were observed by the surveyor. Both carts were stocked in accordance with the inventory list, both O2 tanks were full (2200 psi), suction machines were present, and both had BVM systems with the masks attached to the system. Code cart checklists indicated that both carts were inventoried and checked on 10/29/20.

During an interview on 10/29/20, at 11:30 a.m., director of nursing (DON) was asked for the policies that pertained to the management of the code carts, the maintenance of the supply levels, maintenance of the equipment and expectation of staff responses to medical emergencies. DON stated there were no code cart inventory checklists done prior to 10/28/20. There were no policies or procedures related to the maintenance of the equipment or supplies on the code cart. DON stated that the investigation into this incident was ongoing at that time. The investigation so far had shown the time to the performance of CPR was not a factor in R2's outcome. The investigation has shown that CPR was performed

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F 678	Continued From page 4 effectively. During an interview on 10/29/20, at 11:30 a.m., DON provided verification at least one person per shift was CPR certified. This was also verified through staff schedules for October 2020. During an interview on 10/29/20, at 11:30 a.m., DON stated all annual staff education was done online through a contractor (Medcom). There was no facility-specific training that pertained to response to medical emergencies, CPR equipment, or related supply maintenance on the list of Medcom course offerings.	F 678		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication orders were correctly transcribed and administered in accordance with physician orders for 1 of 4 residents (R1) reviewed for medication administration. This resulted in actual harm when R1 required hospitalization as a result of receiving metoprolol (used to treat high blood pressure) and potassium (mineral that contributes to properly functioning kidneys, heart, muscles and nerves) after the order for these medications had been discontinued. The facility further failed to ensure proper medication administration when R1 received amiodarone (used to treat heart rhythm problems), amlodipine (used to treat high blood pressure), and clonidine (used to treat high blood	F 760	R1 medications have been reviewed and confirmed since admission. All residents have a potential for being affected by this practice. All resident's medication records have now been transferred to electronic medication records. All orders have been verified using pharmacy orders and MD orders upon transcribing in EMAR, any issues identified were clarified and revised. All prescribed medication and treatment orders will be implemented in EMAR. All discontinued medication orders will be discontinued in EMAR. If a resident is	12/1/20

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F 760	Continued From page 5 pressure) after the order for these medications had been discontinued on a separate occasion. Findings include: R1's quarterly Minimum Data Set (MDS) dated, 9/25/20, identified R1 was cognitively intact. R1's diagnoses include hypertension, diabetes, atrial fibrillation (irregular, often fast heart rate) and end stage renal disease. R1's progress noted dated 10/16/20, at 12:28 p.m. indicated, "Resident readmitted from [hospital] at 12 p.m. via wheelchair [w/c] with principal problem hyperkalemia [high potassium blood level]. Resident denies pain or discomfort at this time. Vitals stable. Will continue to monitor." R1's discharge summary from hospital on 10/16/20, indicated, "STOP taking metoprolol succinate 100 milligrams (mg) 24 hr tablet" and "potassium chloride 20 [milliequivalent] MEQ tablet." R1's medication administration record (MAR) dated 10/16/20, indicated both metoprolol and potassium were administered on 10/17/20 and 10/18/20. R1's progress note dated 10/20/20, at 15:44 (3:44 p.m.) indicated, "Resident was sent to hospital at 0930 [9:30 a.m.] due the following vitals BP, 97/45, pulse of 33, temp, 98.8, oxygen sats 89%. She was also lethargic [unresponsive]." R1's discharge summary from hospital on 10/27/20, indicated R1 presented with a heart rate in the 30s and a potassium level of 7.3	F 760	admitted to the hospital all current orders will be discontinued upon admit to the hospital, upon return to facility resident orders will be entered from hospital discharge orders. All Licensed Nurses will be educated on implementing and discontinuing medications in the electronic medical record. All new orders will be reviewed by DON/Designee within 24 hours after admission. See attachment #2 for audit. (Audit is attached) DON/Designee will bring audit report to QAPI monthly.	

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	245028	A. BUILDING _____ B. WING _____	C 10/30/2020

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

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F 760	Continued From page 6	F 760		

(normal potassium range 3.5-5.0). "It was determined that patient was mistakenly receiving metoprolol at NH [nursing home] which was already discontinued." The discharge summary procedure note further indicated, "Patient presented with bradycardia cardiogenic shock with profound bradycardia; sinus node dysfunction [condition affecting heart rate]. Was hyperkalemic. Required urgent temporary pacemaker [which] was placed the right internal jugular vein." The discharge summary did not mention that R1 received potassium that had been discontinued.

R1's discharge instructions dated 10/27/20, indicated, "STOP taking amiodarone 200 mg tab, amlodipine 10 mg tab and clonidine 0.2 mg/24 hour."

R1's progress noted dated 10/27/20, at 15:11 [3:11 p.m.] indicated, "Resident returned from hospital prior to writer's arrival. Orders faxed to pharmacy by A.M. nurse. New, corrected orders faxed from discharging hospital. Those orders faxed to pharmacy. Vitals: T 97.5, P 68, R18, BP 159/90, O2 96%. Alert and oriented, able to make needs known. Fully oriented to room."

R1's MAR dated 10/27/20, indicated amiodarone, amlodipine and clonidine were all administered on 10/28/20.

During interview on 10/28/20, at 10:41 a.m. medical records administrator (MR)-A stated the normal process for admissions or readmissions was that the hospital would fax the resident's orders to the pharmacy and then the pharmacy would send the updated MAR to the facility. The facility would replace the old MAR with the new

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F 760	Continued From page 7	F 760		

one from pharmacy. The new MAR would then be placed in the medication (med) book and the old MAR would be removed and filed in the paper chart. MR-A further stated nurses documented medication administration on the MAR that is stored in the med book.

During interview on 10/28/20, at 11:10 a.m. registered nurse (RN)-A stated new orders were faxed to the pharmacy and then the pharmacy sent back the new paper MAR. The nurse on duty when the MAR was received back from pharmacy would check the MAR against the orders. The MAR would sometimes come back from pharmacy with the discontinued orders still listed. RN-A further stated the correct process would be to follow the MAR. If a medication was discontinued, it would be yellowed out on the MAR by the nurse checking the MAR against the orders and the medication would be removed from the med cart. Discontinued medications would then be either returned to the pharmacy or disposed of properly. "I gave these meds [amiodarone, amlodipine and clonidine] this morning (10/28/20) they were not yellowed out." RN-A stated the previous nurse gave report on R1, but did not mention new orders. If there were new orders to be checked, the chart would be on the counter at the nurse's station or on top of the chart cart with the paper orders sticking out of the binder. RN-A could not recall where R1's chart was that morning.

During interview on 10/28/20, at 11:52 a.m. RN-B stated R1's orders were faxed to pharmacy on 10/27/20, when R1 returned to the facility from the hospital. Pharmacy sent back R1's paper MAR on 10/27/20. Pharmacy should have checked to make sure all the orders were current.

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It was the nurse's responsibility to check and there should have been a second nurse to double check all orders against the MAR. Both nurses should sign, date and time the order sheet indicating that the orders have been checked. RN-B further stated the nurse assigned to the med cart when a new MAR was received should remove any discontinued medications from the med cart and return to pharmacy or dispose of properly.

During interview on 10/28/20, at 12:02 p.m. R1 stated that staff discovered her oxygen saturation level was in the 80's and was sent to the hospital on 10/20/20. R1 further stated staff at the hospital discovered her heart rate was low and her potassium was too high. "I was not feeling well. I was sleeping a lot." R1 further stated not knowing what medications were ordered or discontinued upon discharge from the hospital on 10/27/20. R1 confirmed and stated a patch (clonidine) was applied behind her ear this morning (10/28/20) but the nurse just removed it.

During interview on 10/28/20, at 12:59 p.m. pharmacy senior triage tech (TT) described the normal process for pharmacy orders. Orders were faxed from the facility to the pharmacy intake department then routed to the order entry department. Order entry would enter new orders or make changes to orders in the resident's profile. Then a pharmacist would check the orders before the MAR was sent back to the facility.

During interview on 10/28/20, at 1:14 p.m. pharmacist (P)-A. stated order entry enters the orders into the resident's profile and a pharmacist checks the orders. If a medication was

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F 760	Continued From page 9	F 760		

discontinued it should have been checked against the new orders and removed. P-A confirmed and stated R1's metoprolol was listed from a May order, but was not on R1's 10/16/20 orders for readmission to the facility. "It should have been removed on the 16th. It should have been double checked." P-A further stated that she could see there were orders to be discontinued for amiodarone, amlodipine and clonidine from 10/27/20, and were not removed from the MAR. These orders would have gone through order entry and then a pharmacist to be checked.

During interview on 10/28/20, at 2:58 p.m. RN-B stated was notified that R1 received some medications in error this morning (10/28/20) and notified the DON and [R1's] primary doctor. RN-B further stated, "I took her vitals and she is ok. She is oriented and eating just fine. No adverse effects from those medications this morning."

During interview on 10/29/20, at 1:53 p.m. P-B stated the two doses of potassium could have caused the hyperkalemia. P-B further stated that metoprolol could decrease heart rate but could not confirm that two doses given in error was the cause of R1's condition without knowing R1's history.

During interview on 10/28/20, at 4:58 p.m. RN-D stated R1's progress note in the hospital written by cardiologist (MD)-B dated 10/20/20, indicated severe bradycardia due to overdose of metoprolol.

During interview on 10/29/20, at 10:27 a.m. director of nursing (DON) stated R1's new MAR was received by fax at the nurse's station on 10/16/20, at 2251 (10:51 p.m.). The nurse on duty

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F 760	Continued From page 10	F 760		

at the time the new MAR was received should have done the first check and the next shift nurse should have done the second check. Both nurses should sign and date the order sheet when they checked it. A check consisted of comparing admission orders with current orders on the MAR and verifying all discontinued medications were removed from the MAR. DON confirmed and stated R1's new MAR and orders had not been checked, "That is where our system is broken."

During interview on 10/29/20, at 11:15 a.m. license practical nurse (LPN)-A confirmed working on R1's unit on the night shift of 10/16/20. LPN-A stated not being aware that any new MAR came in that night for R1.

During interview on 10/29/20, at 5:19 p.m. RN-C confirmed working on R1's unit the day shift on 10/17/20. RN-C stated that if there are were order changes or medication changes the night nurse would include that information in report in the morning. "I do not remember getting any report of any changes with R1. I looked at the MAR and gave the meds according to the MAR." RN-C stated the nurse working when the new MAR was received should check the MAR against the orders and then report to the next nurse to do the same for a second check.

During interview on 10/29/20, at 3:25 p.m. R1's primary care provider (MD)-A stated the two doses of metoprolol and potassium wrongfully administered to R1 could have contributed to R1's hospitalization due to R1 developing bradycardia (low heart rate), heart block, cardiogenic shock and hyperkalemia (high blood potassium level).

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F 760	Continued From page 11 The facility policy Admission Orders dated 4/1/08, identified at the time of a resident's admission, the facility must have physician orders for the resident's immediate care to include dietary, medications and for routine care. The facility policy Medication Administration Record dated 3/1/14, identified all prescribed medications by the physician were to be listed on the resident's MAR. The policy indicated when a resident was discharge to the hospital, a new MAR must be initiated upon readmission.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2020

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: October 30, 2020

Dear Administrator:

On November 18, 2020, we notified you a remedy was imposed. On December 3, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 1, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 3, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 18, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 3, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 1, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2020

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

Re: Reinspection Results
Event ID: Y8R612

Dear Administrator:

On December 3, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 3, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File