P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

February 17, 2021

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

RE: CCN: 245028
Cycle Start Date: January 26, 2021

Dear Administrator:

On February 17, 2021, we informed you that we may impose enforcement remedies.

On February 8, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 26, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 26, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 26, 2021.

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.

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 April 26, 2021, 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 April 26, 2021. 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 July 26, 2021 (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 § 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 17, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: K0NW11

Dear Administrator:

The above facility was surveyed on February 8, 2021 through February 8, 2021 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

Minnesota Department of Health

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 **02/08/2021**

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: On 2/8/21, 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	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.	

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5028084C (MN69686) with licensing orders issued. The following complaints were found to be unsubstantiated: H5028085C (MN67951), H5028086C (MN65341). 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.	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced	21805		2/28/21

Minnesota Department of Health

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21805	Continued From page 2 by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 3 residents (R1) reviewed for dignity concerns. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/16/21, indicated R1 had a Brief Inventory of mental status (BIMS) score of 7, which indicated severely impaired cognition. R1 had not rejected cares. R1 required extensive assist from staff with dressing and personal hygiene. R1 required total assist from two staff for transfers. R1's diagnoses included seizure disorder and hemiparesis/ hemiplegia (weakness or the inability to move on one side of the body). R1's care plan dated 5/10/19, had a focus area for activities of daily living. The care plan indicated R1 was totally dependent on staff for dressing. Staff were to change R1's clothing in the AM (morning) daily. During observation on 2/8/21, at 9:46 a.m. nursing assistant (NA)-A and (NA)-B assisted R1 with his morning cares. They removed R1's bed gown and helped him wash up. NA-B asked R1 if he wanted to keep his gown on or have clothing on. R1 stated he wanted clothing. NA-B got a t-shirt out of R1's closet and put it on R1. NA-B looked through R1's closet and dresser and was unable to find pants for R1 to wear. NA-B told R1 they could not find any pants. R1 did not respond. NA-A stated they thought R1 normally had clothing including pants and t-shirts. NA-A and NA-B used the mechanical lift and assisted R1 out of bed and into the wheelchair. R1 then sat in his wheelchair with only his incontinent brief	21805	Corrected	

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21805	Continued From page 3	21805		

on his lower body. NA-A stated they had called down to the laundry department and there were not any clothes for R1 to wear. NA-A and NA-B left the room, and left the surveyor and R1 in the room. R1 did not have anything that covered his legs. Licensed practical nurse (LPN)-A then entered R1's room, took a blanket off the bed, put it on R1's legs and placed his call light on the left side.

During interview on 2/8/21, at 12:23 p.m. the director of nursing (DON) stated residents should be covered. If a resident ran low on clothing, the expectation of nursing staff would be to have obtained clothing from the lost and found collection in the laundry room. Additionally, family would be notified if the resident needed more clothing.

During interview on 2/8/21, at 1:40 p.m. registered nurse (RN)-A stated the laundry room has a bin full of clothing and there was no reason why R1 should have to go without a full set of clothing. RN-A stated she went to the laundry room that day (2/8/21) for another resident to find a shirt and there was clothing was available.

During interview on 2/8/21, at 3:15 p.m. the administrator stated they planned to set up a table to include the lost and found clothing from laundry. They planned to have staff sort and select clothing for the residents that might have lacked clothing.

Facility policy titled Activities of Daily Living (ADL) dated 11/16, indicated a resident who was unable to carry out ADLs would have received the necessary services to maintain good nutrition, grooming and personal hygiene (bathing, dressing, grooming and oral care).

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21805	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with exposed body parts, have appropriate clothing, and are offered and assisted to appropriately cover their exposed skin. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a call light within reach for 1 of 3 residents (R1) who were dependent and needed staff assistance for daily care needs. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/16/21, indicated R1 had a Brief Inventory of	21810	Corrected	2/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21810	Continued From page 5	21810		

Mental Status (BIMS) score of 7, which indicates severely impaired cognition. R1 had not rejected cares. R1 required extensive assist from staff with dressing and personal hygiene. R1 required total assist from two staff for transfers. R1's diagnoses included seizure disorder and hemiparesis/ hemiplegia (weakness or the inability to move on one side of the body).

R1's care plan dated 4/12/19, with a focus area for seizure disorder directed staff to keep call light within reach at all times.

During interview and observation on 2/8/21, at 9:33 a.m. R1's door to his room was open. R1 was laying in bed and waved his hand at surveyor in the hallway. When asked if surveyor could enter room, R1 smiled, said "yes" and nodded his head up and down. R1's call light was observed to be laying on the floor, under the head of R1's bed. When asked if R1 needed something he replied "yes". R1 then spoke but his words were indiscernible. When R1 was asked how he would get ahold of staff, R1 looked around his bed and picked up his bed remote (which adjusts the height, head and foot).

During interview and observation on 2/8/21, at 9:40 a.m. nursing assistant (NA)-B was observed in the hallway. NA-B was updated by surveyor that R1 needed help with something and surveyor could not decipher his words. NA-B went into R1's room, asked him what he wanted and said they would be in shortly to help R1 get washed up and out of bed. When asked by surveyor where R1's call light was, NA-B looked around and found the call light on the floor, under the head of the bed. NA-B got down on his hands and knees, picked it up and put the call light on the bed. NA-B was asked where R1's call light should be,

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

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21810	Continued From page 6 NA-B replied "He [R1] doesn't understand how to use it, so we don't have to give it to him." During interview on 2/8/21, at 9:57 a.m. nursing assistant (NA)-A stated R1 would use the call light once in a while. NA-A stated all residents should have their call light within reach. During interview on 2/8/21, at 9:57 a.m. licensed practical nurse (LPN)-A stated all residents should have their call light within reach at all times. During observation on 2/8/21, at 10:54 a.m. R1 was observed to be in his bed laying down. R1's door was open and he again waved at surveyor and said it was ok to enter his room. R1 pointed to his dresser and asked for his comb. R1 was asked by surveyor to push his call light. R1 looked around his bed and shook his head side to side. Surveyor exited the room and asked LPN-A to come in the room. LPN-A asked R1 what he needed and provided him the comb. When LPN-A was asked where R1's call light was, she looked around and found it on the floor under the head of the bed. LPN-A picked the call light up and put it on the bed in R1's hand. During interview on 2/8/21, at 12:23 p.m. the director of nursing (DON) stated with R1 should have his call light within reach at all times. R1 had a history of falls. DON further stated the expectation is all residents should have their call light within reach and clipped in place. During interview on 2/8/21, at 1:40 p.m. registered nurse (RN)-A stated all residents are provided call lights to use and call lights should be within reach at all times.	21810		

Minnesota Department of Health

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 **02/08/2021**

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21810	Continued From page 7 Policy titled "Resident Call System" dated 4/1/08, indicated all residents were to have call system access while in bed or while sitting at their bedside or in the bathroom. Resident who were unable to use their call system, due to decreased physical or mental ability would be identified with needs anticipated to beds of abilities. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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	245028	A. BUILDING ______ B. WING ______	C 02/08/2021

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F 000	INITIAL COMMENTS On 2/8/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5028084C (MN69686) with deficiencies identified at F550 and F558. The following complaints were found to be unsubstantiated: H5028085C (MN67951), H5028086C (MN65341). 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. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		2/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/23/2021

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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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 3 residents (R1) reviewed for dignity concerns. Findings include:	F 550	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	

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F 550	Continued From page 2 R1's quarterly Minimum Data Set (MDS) dated 1/16/21, indicated R1 had a Brief Inventory of mental status (BIMS) score of 7, which indicated severely impaired cognition. R1 had not rejected cares. R1 required extensive assist from staff with dressing and personal hygiene. R1 required total assist from two staff for transfers. R1's diagnoses included seizure disorder and hemiparesis/ hemiplegia (weakness or the inability to move on one side of the body). R1's care plan dated 5/10/19, had a focus area for activities of daily living. The care plan indicated R1 was totally dependent on staff for dressing. Staff were to change R1's clothing in the AM (morning) daily. During observation on 2/8/21, at 9:46 a.m. nursing assistant (NA)-A and (NA)-B assisted R1 with his morning cares. They removed R1's bed gown and helped him wash up. NA-B asked R1 if he wanted to keep his gown on or have clothing on. R1 stated he wanted clothing. NA-B got a t-shirt out of R1's closet and put it on R1. NA-B looked through R1's closet and dresser and was unable to find pants for R1 to wear. NA-B told R1 they could not find any pants. R1 did not respond. NA-A stated they thought R1 normally had clothing including pants and t-shirts. NA-A and NA-B used the mechanical lift and assisted R1 out of bed and into the wheelchair. R1 then sat in his wheelchair with only his incontinent brief on his lower body. NA-A stated they had called down to the laundry department and there were not any clothes for R1 to wear. NA-A and NA-B left the room, and left the surveyor and R1 in the room. R1 did not have anything that covered his legs. Licensed practical nurse (LPN)-A then	F 550	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. 1)Resident #1 received his laundered clothing and dressed appropriately at the time of survey. 2)Residents currently residing at facility have potential to be affected. Resident□s currently residing in the facility have had their clothes laundered and returned. 3)Laundry and nursing staff were re-educated on the labeling of resident clothing and process of resident laundry services. 4)The Director of Housekeeping / Laundry / Designee will audit the resident personal clothing laundry system 3-times per week	

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F 550	Continued From page 3 entered R1's room, took a blanket off the bed, put it on R1's legs and placed his call light on the left side. During interview on 2/8/21, at 12:23 p.m. the director of nursing (DON) stated residents should be covered. If a resident ran low on clothing, the expectation of nursing staff would be to have obtained clothing from the lost and found collection in the laundry room. Additionally, family would be notified if the resident needed more clothing. During interview on 2/8/21, at 1:40 p.m. registered nurse (RN)-A stated the laundry room has a bin full of clothing and there was no reason why R1 should have to go without a full set of clothing. RN-A stated she went to the laundry room that day (2/8/21) for another resident to find a shirt and there was clothing was available. During interview on 2/8/21, at 3:15 p.m. the administrator stated they planned to set up a table to include the lost and found clothing from laundry. They planned to have staff sort and select clothing for the residents that might have lacked clothing. Facility policy titled Activities of Daily Living (ADL) dated 11/16, indicated a resident who was unable to carry out ADLs would have received the necessary services to maintain good nutrition, grooming and personal hygiene (bathing, dressing, grooming and oral care).	F 550	for 4 weeks, then weekly for 4 weeks, then monthly for two months to monitor compliance. Audit results will be given to quarterly QAPI committee for additional direction.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive	F 558		2/28/21

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F 558	Continued From page 4 services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a call light within reach for 1 of 3 residents (R1) who were dependent and needed staff assistance for daily care needs. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/16/21, indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 7, which indicates severely impaired cognition. R1 had not rejected cares. R1 required extensive assist from staff with dressing and personal hygiene. R1 required total assist from two staff for transfers. R1's diagnoses included seizure disorder and hemiparesis/ hemiplegia (weakness or the inability to move on one side of the body). R1's care plan dated 4/12/19, with a focus area for seizure disorder directed staff to keep call light within reach at all times. During interview and observation on 2/8/21, at 9:33 a.m. R1's door to his room was open. R1 was laying in bed and waved his hand at surveyor in the hallway. When asked if surveyor could enter room, R1 smiled, said "yes" and nodded his head up and down. R1's call light was observed to be laying on the floor, under the head of R1's bed. When asked if R1 needed something he replied "yes". R1 then spoke but his words were	F 558	1)Resident #1s call light was provided at the time of survey. 2)Residents currently residing at the facility have potential to be affected. Resident call lights were evaluated and clips were replaced to ensure call lights remain in residents reach. 3)Staff were educated on policies and procedures related to call light use and placement. 4)The Director of Nursing / designee will audit proper call light placement daily on all shifts for 1 week; then 3 - times per week for 4 weeks; then monthly for 1 month to monitor compliance. Audit results will be given to quarterly QAPI committee for additional direction.	

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F 558	Continued From page 5 indiscernible. When R1 was asked how he would get ahold of staff, R1 looked around his bed and picked up his bed remote (which adjusts the height, head and foot). During interview and observation on 2/8/21, at 9:40 a.m. nursing assistant (NA)-B was observed in the hallway. NA-B was updated by surveyor that R1 needed help with something and surveyor could not decipher his words. NA-B went into R1's room, asked him what he wanted and said they would be in shortly to help R1 get washed up and out of bed. When asked by surveyor where R1's call light was, NA-B looked around and found the call light on the floor, under the head of the bed. NA-B got down on his hands and knees, picked it up and put the call light on the bed. NA-B was asked where R1's call light should be, NA-B replied "He [R1] doesn't understand how to use it, so we don't have to give it to him." During interview on 2/8/21, at 9:57 a.m. nursing assistant (NA)-A stated R1 would use the call light once in a while. NA-A stated all residents should have their call light within reach. During interview on 2/8/21, at 9:57 a.m. licensed practical nurse (LPN)-A stated all residents should have their call light within reach at all times. During observation on 2/8/21, at 10:54 a.m. R1 was observed to be in his bed laying down. R1's door was open and he again waved at surveyor and said it was ok to enter his room. R1 pointed to his dresser and asked for his comb. R1 was asked by surveyor to push his call light. R1 looked around his bed and shook his head side to side. Surveyor exited the room and asked LPN-A	F 558		

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F 558	Continued From page 6 to come in the room. LPN-A asked R1 what he needed and provided him the comb. When LPN-A was asked where R1's call light was, she looked around and found it on the floor under the head of the bed. LPN-A picked the call light up and put it on the bed in R1's hand. During interview on 2/8/21, at 12:23 p.m. the director of nursing (DON) stated with R1 should have his call light within reach at all times. R1 had a history of falls. DON further stated the expectation is all residents should have their call light within reach and clipped in place. During interview on 2/8/21, at 1:40 p.m. registered nurse (RN)-A stated all residents are provided call lights to use and call lights should be within reach at all times. Policy titled "Resident Call System" dated 4/1/08, indicated all residents were to have call system access while in bed or while sitting at their bedside or in the bathroom. Resident who were unable to use their call system, due to decreased physical or mental ability would be identified with needs anticipated to beds of abilities.	F 558		