Electronically delivered
November 29, 2021

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

RE: CCN: 245028
Cycle Start Date: November 3, 2021

Dear Administrator:

On November 3, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that 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.

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.

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.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 3, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 3, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	C 11/03/2021

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) COMPLETION DATE
F 000	INITIAL COMMENTS From 11/2/21 through 11/3/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5028114C (MN76664), H5028115C (MN77322), and H5028117C (MN78104) with deficiencies cited at F580 and F919. H5028116C (MN77374) was also SUBSTANTIATED with a deficiency at F684 and F919. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		12/10/21

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

Electronically Signed | 12/06/2021

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 580	Continued From page 1 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to	F 580		

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F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify 1 of 1 resident's (R1) discharging physician (MD)-G when R1 was discharged back to the facility with wound care dressing orders that conflicted with the number of wound vacuums (vac) ordered. Finding include: R1's 11/4/21, Face Sheet identified R1 was re-admitted with diagnoses of Stage IV (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcers. R1's quarterly Minimum Data Set (MDS) assessment dated 9/5/21, indicated R1 was cognitively intact and required extensive assistance to total assistance for all activities of daily living (ADLs). Additionally, the MDS indicated R1 had a history of traumatic spinal cord dysfunction with quadriplegia and a previous Stage III (full thickness tissue loss but no bone, tendon or muscle is exposed,) pressure ulcer. R1's 10/29/21, hospital discharge summary orders identified R1 had 2 wounds noted. A left intertrochanter (IT) (point where the muscles of the thigh and hip attach) wound measuring 4 centimeters (cm) x 5.5 cm x 3 cm, and a right IT and buttock wound measuring 12 cm x 9 cm x 6.2 cm depth. MD-G noted it was a "debrided pressure injury". MD-G identified the dressing type as "contact layer over bone. Standard wound vac x 2". MD-G ordered staff to "cleanse the wound, apply skin prep, place a contact layer	F 580	Highland Chateau Health Care Center of Saint Paul Plan of correction is a written credible assertion of substantial compliance with the Federal and State requirements of Nursing Facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Highland Chateau Health Care Center of Saint Paul or the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification, and enforcement effort at issue. Corrective Action Resident 1□s wound orders were clarified and with the resident□s physician and updated. Identification of Other Residents All residents with wound treatments in the facility were audited to the treatment ordered. Measures Put in Place The Director of Nursing or designee will educate the nursing staff on the proper procedure for notification of changes. Monitoring Mechanisms The Director of Nursing or designee will	

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F 580	Continued From page 3 over bone, and cut vac sponge to fit wound". Staff then were to "cut strip of foam for bridge, cut landing pad, and place over vac drape. Cover wound and bridged area with Vac drape. Cut quarter sized hole in vac drape and place Trac pad. Connect to continuous suction...". Below these instructions was the documentation for "Standard wound vac x 2". At the bottom of the orders, was a number for staff to call with any questions or concerns. There was no indication staff contacted the ordering physician to clarify if the dressing instructions were correct or there were to be 2 wound vacs. R1's October 2021, Treatment Administration Record (TAR) identified the above orders. There was no indication staff had identified the order for 2 wound vac machines. R1's progress notes identified on: 1) 10/29/21, staff documented R1 arrived back at the facility at 3:00 p.m. from the hospital from septic (severe infection) ulcers which required surgical debridement (removal of dead or rotting tissue and/or bone). R1 did not come to the facility with the actual wound vac on. Staff documented R1 had "2 wound vac connectors, which were removed"and replaced with only 1 wound vac at that time. No call was placed to the discharging hospital or R1's surgeon to clarify the wound vac dressing order. 2) 11/2/21, staff noted they called the wound vac company to order a 2nd wound vac per hospital discharge orders. There was no indication staff called MD-G to clarify the wound care or amount of wound vacs ordered. Interview on 11/2/21 at 1:55 p.m., with licensed practical nurse (LPN)-A identified she caught the	F 580	randomly audit 4 treatments weekly for 4 weeks; then monthly for 2 months to ensure treatment is provided per physician order. The Director of Nursing will present audit results to the quarterly QAPI committee for determination on on-going review.	

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F 580	Continued From page 4 equipment error on 11/2/21 and ordered the 2nd wound vac. LPN-A identified staff was using 1 wound vacuum that was "bridged" across R1's buttocks from the wound on the right buttock to the wound on the left buttock. Interview on 11/3/21, at 1:45 p.m. with lead intake worker-A identified her role was to input orders into the electronic medical record for each resident. It was her responsibility to order equipment needed by residents and ordered by a physician. Lead intake worker-A stated she had ordered only 1 wound vac. lead intake worker-A was not aware of the order for 2 in the discharge summary. Interviewed on 11/3/21, at 2:21 p.m., with registered nurse (RN)-A identified R1's wound was large. He worked with a team of two other nurses to perform wound care. R1 only had 1 wound vac. RN-A further indicated if he did not have what he needed, he should notify a manager. RN-A had not notified a manager regarding R1's wound care or equipment. Interviewed on 11/3/21 at 4:24 p.m., with the director of nursing (DON) identified she would expect staff to check orders before providing treatment, and call the ordering physician if an order was unclear per instructions. There was no policy provided related to notification to the physician to clarify physician orders provided.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		12/10/21

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F 684	Continued From page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide wound care in accordance with the provider orders and treatment plan for 1 of 1 resident (R2) with orders for twice daily wound care. Finding include: R2's admission MDS dated 9/27/21, indicated R2 was moderately cognitively impaired and had a surgical wound. R2's 11/4/21, physician orders identified R2 had a diagnosis of Fournier gangrene (an acute necrotic infection of penis, scrotum, or perineum which was the area between the scrotum and anus). Staff were to provide wound care twice daily. R2's October and November 2021, Treatment Administration Record (TAR) indicated wound care was not documented as performed 6 of 28 times from 10/18/21 to 10/31/21 and 3 of 8 times from 11/1/21 to 11/4/21. Interview on 11/2/21 at 9:43 a.m., with R2 identified his wound care was missed completely "some days", and performed only once "some days". R2 stated he was aware he was supposed to have wound care twice daily.	F 684	Corrective Action Resident 2□s wound treatments were audited to ensure treatments are provided as ordered. Identification of Other Residents All residents with wound treatments in the facility were audited to the treatment ordered and frequency of treatment. Measures Put in Place The Director of Nursing or designee will educate the nursing staff on the proper procedure of treatments administered per physician orders. Monitoring Mechanisms The Director of Nursing or designee will randomly audit 4 treatments weekly for 4 weeks; then monthly for 2 months to ensure treatment is provided per physician order. The Director of Nursing will present audit results to the quarterly QAPI committee for determination on on-going review.	

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F 684	Continued From page 6 Interview on 11/3/21 at 9:50 a.m., with family member (FM)-A identified R2 told her his wound care was not performed twice daily by staff as ordered. Interview on 11/3/21 at 2:46 p.m., with MD-A stated the wound would heal faster if the wound care were performed as ordered. Interviewed on 11/3/21, at 4:17 p.m., with RN-A identified she felt "wound care does not get done when we [the facility] are short-staffed". RN-A would "tell the next nurse to do it" but had not documented she was unable to perform her nursing duties. RN-A verified she had not performed wound care 10/18/21, but "passed it on" to the next shift. Interview on 11/3/21, at 4:24 p.m. DON identified her expectation was staff were to provide care as ordered and alert her if they were unable to do so. Review of the November 2016, Pressure Ulcer/ Skin Integrity Wound Management policy identified a resident was to receive treatment and services consistent with professional standards of practice as ordered by the physician.	F 684		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.	F 919		12/10/21

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F 919	Continued From page 7 §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the call light was in reach for 1 of resident (R1) reviewed for call light access. Finding include: R1's quarterly Minimum Data Set (MDS) assessment dated 9/5/21, indicated R1 was cognitively intact and required extensive to total assistance for all Activities of Daily Living (ADLs). Additionally, the MDS indicated R1 had a traumatic spinal cord dysfunction with quadriplegia. R1's care plan dated 9/14/21, indicated R1's call light was to be within reach. Observation and interview on 11/2/21 at 11:51 a.m., with R1 in his room identified R1 was seated in his wheelchair on the opposite side of the bed as his call light. R1 stated he could not get to his call light when it was on the other side of the bed on the floor. R1 identified this had occurred before. If R1 was unable to reach his call light and he became incontinent, it would make him "feel bad" especially if he "smelled". He would like to be assisted right away to change. Staff who brought his meal replaced the call light. Observation and interview on 11/2/21 at 1:52 p.m., with R1 in his room. R1's call light was on the floor. R1 was getting a nebulizer treatment, and wanted help from the nurse. R1 stated he could not get to his call light to ask for help. Licenced practical nurse (LPN)-A came to room	F 919	Corrective Action Resident 1 call light placement and care plan were audited. It was ensured that Resident 1 had their call light in place and within reach. Identification of Other Residents All resident call light placements were audited to ensure proper placement of the resident□s call light. Measures Put in Place The Interdisciplinary Team will educate all staff on proper placement of resident call lights. Monitoring Mechanisms The Interdisciplinary Team will randomly audit 3 residents twice a week for 4 weeks; then monthly for 2 months to ensure resident call light is within reach. The Interdisciplinary Team will present audit results to the quarterly QAPI committee for determination on on-going review.	

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F 919	Continued From page 8 to removed nebulizer treatment at 1:55 pm and placed the call light next to the resident in his chair. Interview on 11/3/21 at 3:13 p.m., with registered nurse (RN)-B regarding R1's call light identified it had likely fallen. It was to be placed next to R1's face so R1 could activate the call light system. Interview on 11/3/21 at 4:24 p.m., with the director of nursing (DON) and administrator identified all call lights were to be within reach of the resident at all times while a resident was in their room. There was no policy related to use of the call light system provided by the end of the survey.	F 919		

Electronically delivered
November 29, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 4L6O11

Dear Administrator:

The above facility was surveyed on November 2, 2021 through November 3, 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:

Nicole Osterloh, RN, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 11/03/2021

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 11/2/21, through 11/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). 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	2 000		

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2 000	Continued From page 1 they will be completed. The following complaint was found to be SUBSTANTIATED: H5028114C (MN76664), H5028115C (MN77322), and H5028117C (MN78104). However, NO licensing orders were issued. H5028116C (MN77374) was also SUBSTANTIATED with a licensing order issued at 830. 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 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 evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide wound care in accordance with the provider orders and treatment plan for 1 of 1 resident (R2) with orders for twice daily wound care. Finding include:	2 830	Corrected	12/10/21

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2 830	Continued From page 3 R2's admission MDS dated 9/27/21, indicated R2 was moderately cognitively impaired and had a surgical wound. R2's 11/4/21, physician orders identified R2 had a diagnosis of Fournier gangrene (an acute necrotic infection of penis, scrotum, or perineum which was the area between the scrotum and anus). Staff were to provide wound care twice daily. R2's October and November 2021, Treatment Administration Record (TAR) indicated wound care was not documented as performed 6 of 28 times from 10/18/21 to 10/31/21 and 3 of 8 times from 11/1/21 to 11/4/21. Interview on 11/2/21 at 9:43 a.m., with R2 identified his wound care was missed completely "some days", and performed only once "some days". R2 stated he was aware he was supposed to have wound care twice daily. Interview on 11/3/21 at 9:50 a.m., with family member (FM)-A identified R2 told her his wound care was not performed twice daily by staff as ordered. Interview on 11/3/21 at 2:46 p.m., with MD-A stated the wound would heal faster if the wound care were performed as ordered. Interviewed on 11/3/21, at 4:17 p.m., with RN-A identified she felt "wound care does not get done when we [the facility] are short-staffed". RN-A would "tell the next nurse to do it" but had not documented she was unable to perform her nursing duties. RN-A verified she had not performed wound care 10/18/21, but "passed it on" to the next shift.	2 830		

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2 830	Continued From page 4 Interview on 11/3/21, at 4:24 p.m. DON identified her expectation was staff were to provide care as ordered and alert her if they were unable to do so. Review of the November 2016, Pressure Ulcer/ Skin Integrity Wound Management policy identified a resident was to receive treatment and services consistent with professional standards of practice as ordered by the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee should review this resident and all residents with wounds to assure they are receiving appropriate care and treatment of the wound along with the necessary treatment/services to promote healing. The director of nursing or designee should conduct random audits of the delivery of care to ensure appropriate care and services are implemented and reduce the risk of these wounds not being cared for properly. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		