

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 13, 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 29, 2021, we informed you that we may impose enforcement remedies.

On November 18, 2021, the Minnesota Department 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 February 3, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 3, 2022.

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

Highland Chateau Health Care Center December 13, 2021 Page 2 payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

### 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 February 3, 2022, 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 February 3, 2022. 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us

Office: (218) 302-6151 Mobile: (218) 766-2720

### 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 May 3, 2022 (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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 12/22/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245028	B. WING	_			C
NAME OF F	PROVIDER OR SUPPLIER		1	0	TREET ADDRESS, CITY, STATE, ZIP CODE	111/	18/2021
NAIVIE OF F	ROVIDER OR SUPPLIER						
HIGHLAN	ND CHATEAU HEALT	TH CARE CENTER			B19 WEST SEVENTH STREET AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
	conducted at your to be NOT in comp	andard abbreviated survey was facility. Your facility was found bliance with the requirements of eart B, Requirements for Long es.					
	The following comp SUBSTANTIATED	plaints was found to be :					
	F600 and F609 H5028119C (MN73	3870), however, no deficiencies actions taken by the facility.					
	as your allegation of Departments acce enrolled in ePOC, at the bottom of the form. Your electron	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will ation of compliance.					
	onsite revisit of you	nd Neglect	F 6	00			12/24/21
	Exploitation The resident has the neglect, misappropriate and exploitation as includes but is not corporal punishme any physical or chemical process.	from Abuse, Neglect, and he right to be free from abuse, briation of resident property, defined in this subpart. This limited to freedom from ent, involuntary seclusion and demical restraint not required to					
ABORATOR)	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIRE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

**Electronically Signed** 

12/21/2021

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		245028	B. WING _		l l	18/2021
	PROVIDER OR SUPPLIER	H CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	treat the resident's §483.12(a) The face §483.12(a)(1) Not uphysical abuse, corinvoluntary seclusic This REQUIREMENT by: Based on interview facility failed to ensabuse for 1 of 3 resabuse when R1 hit Findings include: On 11/15/21, at 11: the state agency (S6:00 p.m. R3 was of struck R3 in the face R3's Diagnosis List R3 had diagnosis of personality disorder disorder. R3's annual MDS disorder disorder. R3's Care Plan data trisk for behaviors injury (TBI), R1's Diagnosis List R1 had diagnosis of seizures, and demonstrated at risk for behaviors injury (TBI),	medical symptoms.  ility must- use verbal, mental, sexual, or reporal punishment, or on; NT is not met as evidenced or and document review, the ure residents were free from sidents (R3) reviewed for R3 in the face during dinner.  03 a.m. the facility report to sA) indicated on 11/12/21, at calling R1 names, and R1 ce.  a printed on 11/15/21, indicated of intracranial injury, adult rewith behaviors, and bipolar stated 9/17/21, indicated he	F 60	Corrective Action Resident 1 and resident 3 care pleen audited and modified to precurrence of resident-to-reside altercation.  Identification of Other Residents All resident records and reports audited for potential for allegation must be reported immediately be than two hours after the incident Measures Put in Place The Interdisciplinary Team will efacility staff on the facility policy Freedom from Abuse, Neglect, a Exploitation.  Monitoring Mechanisms Executive Director or designee reducation weekly for 1 month ar for 2 months and report results and report results.	event nt were ons that ut no later t occurs. ducate of and will audit nd monthly	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245028	B. WING				C <b>18/2021</b>
	PROVIDER OR SUPPLIER	I		231	REET ADDRESS, CITY, STATE, ZIP CODE  19 WEST SEVENTH STREET  INT PAUL, MN 55116	111/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	6/22/21, indicated here was at risk for physical assualtive behavior.  On 11/18/21, at 9:2 and stated he did not incident.  On 11/18/21, at 9:3 and stated he recal him on the right side not had any conflict he and R1 were in verbal exchange, Rhim in the face.  On 11/18/21, at 12:0 (NA)-A was intervied the dining room feet when a kitchen aid were fighting and yelling at R1 and casturs. NA-A stated in chair and tried to all grabbed R1 from be back from R3. NA-forward and attemproved and attemproved and attemproved and stated she head yelling for help because in the separated she head yelling for help because in t	ised on 12/29/20, indicated R1 sically aggressive and rs due to dementia.  5 a.m. R1 was interviewed of have any memory of the  2 a.m. R3 was interviewed led the altercation when R1 hit is of his face. R3 stated he had the with R1 in the past. R3 stated the dining room and had a rathen approached R3 and hit is of his face. R3 stated the dining room and had a rathen approached R3 and hit is of his face. R3 stated the dining room and had a rathen approached R3 and hit is of his face. R3 stated she was in reding another resident dinner is began yelling that R1 and R3 elling. NA-A stated R3 was alling R1 a variety of racial R1 began to get up out of his peroach R3. NA-A stated she ehind and tried to hold him A stated R1 was able to step of the high part of his peroach R3. NA-A stated dhe was hit by R1. NA-A told in urse and tell her while she dents. NA-A stated she did not rather than the resident of the residents. NA-A stated she did not rather than the resident of the residents. NA-A stated she did not rather than the resident of the reside	F6	600			

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	COM	E SURVEY MPLETED  C
		245028	B. WING _			18/2021
	PROVIDER OR SUPPLIER	H CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	NA-C saw NA-A ho attack R3, and NA-NA-C stated more sable to separate R2 tell a nurse about the remember her name. On 11/18/21, at 2:4 interviewed and state dinner when R3 state administrator states before they were seadministrator states R3. The administrator who did not tell her	and started going after R3. Iding R1 back as he tried to C saw R1 hit R3 in the face. staff arrived, and they were and R3. NA-C stated she did ne altercation, but could not	F 60			
F 609 SS=D	were implemented. On 11/18/21, at 2:4 (DON) was intervie staff interviewed sa The facility's Freede Exploitation Policy abuse is the willful unreasonable confi punishment with remental anguish. The resident to resident involving a nursing inflicts injury upon a Reporting of Allege CFR(s): 483.12(c) (\$483.12(c) In response	8 p.m. the director of nursing wed and stated none of the id they saw R1 hit R3.  om from Abuse, Neglect, and revised on 5/20, directed infliction of injury, nement, intimidation, or sulting physical harm, pain or ne policy further directed altercations are incidents home resident who willfully another resident.	F 60	09		12/24/21

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTR	UCTION	СОМ	E SURVEY PLETED
		245028	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			2319 WEST	DRESS, CITY, STATE, ZIP CODE  SEVENTH STREET  UL, MN 55116	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(E/	PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	involving abuse, n mistreatment, inclusiource and misapare reported immed hours after the alles that cause the alles serious bodily injuithe events that cause and do not the administrator officials (including adult protective sefor jurisdiction in leaccordance with Sprocedures.  §483.12(c)(4) Repinvestigations to the designated repressions accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMED by:  Based on intervie facility failed to enreported immediate to the state agency reviewed for abuse.  On 11/15/21, at 11 the state agency (	ure that all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, ediately, but not later than 2 egation is made, if the events egation involve abuse or result in ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and ervices where state law provides ong-term care facilities) in state law through established for the results of all the administrator or his or her entative and to other officials in state law, including to the State ethin 5 working days of the ealleged violation is verified extive action must be taken. ENT is not met as evidenced we and document review, the sure allegations of abuse were eally, but no later than two hours, by (SA) for 1 of 3 residents (R3)	F6	Correct Reside been a recurrect alterca Facility were in reporting	ctive Action ent 1 and resident 3 care plandited and modified to prevence of resident-to-resident tion. The staff present during the incommediately educated on prong procedures. The cation of Other Residents	ent	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		PLETED
		245028	B. WING			11/1	C 18/2021
	PROVIDER OR SUPPLIER	H CARE CENTER		23	TREET ADDRESS, CITY, STATE, ZIP CODE 319 WEST SEVENTH STREET AINT PAUL, MN 55116		10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	struck R3 in the factor over two days follow R3's Diagnosis List R3 had diagnosis opersonality disorder disorder.  R3's annual MDS dwas cognitively important R3's Care Plan date at risk for behaviors injury (TBI),  R1's Diagnosis List R1 had diagnosis of seizures, and demodisturbance.  R1's annual Minimum 6/22/21, indicated had R1's Care Plan reviews at risk for physical assualtive behavior On 11/18/21, at 9:3 and stated he recal him on the right sidnot had any conflict he and R1 were in the verbal exchange, Rhim in the face.  On 11/18/21, at 12: (NA)-A was interviet the dining room feet was a six of the six	e. The report was submitted ving the incident.  printed on 11/15/21, indicated f intracranial injury, adult with behaviors, and bipolar ated 9/17/21, indicated he aired.  ed 9/11/21, indicated he aired.  ed 9/11/21, indicated R3 was adue to a traumatic brain  printed on 11/18/21, indicated f chronic diastolic heart failure, entia with behavioral  um Data Set (MDS) dated he was cognitively impaired.  sed on 12/29/20, indicated R1 ically aggressive and	F 6	09	All resident records and reports we audited for potential for allegations must be reported immediately but in than two hours after the incident of than two hours and report reporting procedures.  Monitoring Mechanisms  Executive Director or designee will education weekly for 1 month and for 2 months and report results at the two hours are followed. Results were procedures are followed. Results were protected to QAPI.	that no later ccurs.  cate  audit monthly QAPI.  d or 2	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245028	B. WING		11	C / <b>18/2021</b>
	PROVIDER OR SUPPLIE	R TH CARE CENTER	,	STREET ADDRESS, CITY, STATE, ZIP 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 609	yelling at R1 and slurs. NA-A stated chair and tried to grabbed R1 from back from R3. NA forward and atter R3 immediately s NA-B to go find the separated the resea any injury to finished eating his On 11/18/21, at 2 and stated she he yelling for help be NA-C stated R3 slurs, R1 got ups NA-C saw NA-A lattack R3, and NA NA-C stated more able to separate tell a nurse about remember her na On 11/18/21, at 2 interviewed. The staff she interviewed administrator stated reported the abust reported it to the administrator statemanagement of a reported to the SA	yelling. NA-A stated R3 was calling R1 a variety of racial d R1 began to get up out of his approach R3. NA-A stated she behind and tried to hold him A-A stated R1 was able to step upted to punch R3. NA-A stated aid he was hit by R1. NA-A told he nurse and tell her while she sidents. NA-A stated she did not R3 or R1. NA-A stated R3 is meal in his room.  104 p.m. NA-C was interviewed eard a kitchen staff member ecause R1 and R3 were fighting. was calling R1 names and racial et and started going after R3. Holding R1 back as he tried to A-C saw R1 hit R3 in the face. The staff arrived, and they were R1 and R3. NA-C stated she did the altercation, but could not	F	509		
	Exploitation Polic abuse must be re	y revised on 5/20, directed ported to the SA immediately, two hours after it occurs.				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA <sup>-</sup> COI	(X3) DATE SURVEY COMPLETED			
		245028	B. WING			C / <b>18/2021</b>
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CO. 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 13, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: 4WUH11

#### Dear Administrator:

The above facility was surveyed on November 18, 2021 through November 18, 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us

Office: (218) 302-6151 Mobile: (218) 766-2720

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED			
		00494		B. WING			C <b>11/18/2021</b>	
NAME OF I		00494	OTDEET AD	<u> </u>	27ATE 7/D 00DE	11/	10/2021	
	PROVIDER OR SUPPLIER			BT SEVENTH	STATE, ZIP CODE I STRFFT			
HIGHLAI	ND CHATEAU HEALTI	H CARE CENTER		UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 000	Initial Comments			2 000				
	*****ATTE	NTION*****						
	NH LICENSING	CORRECTION ORE	DER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, setion order has been y. If, upon reinspectiency or deficiencies ected, a fine for each be assessed in accolines promulgated by artment of Health.	issued tion, it is cited violation ordance					
	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.							
	that may result from orders provided tha the Department witl	hearing on any asse n non-compliance wi t a written request is hin 15 days of receip nt for non-compliand	th these made to ot of a					
	at your facility by su Department of Hea found NOT in comp Licensure. Please in of correction you ha	rS:  Iplaint survey was conveyors from the Mirleth (MDH). Your facilibiliance with the MN Standicate in your elections reviewed these compared they will be comp	nnesota ity was State ronic plan orders and					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 12/21/21

TITLE

Minnesota Department of Health

winnesc	ota Department of He	eaun eaun				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					c	,
		00494	B. WING			
		00494			11/1	8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	STATE, ZIP CODE		
		2319 WE	ST SEVENTH	STREET		
HIGHLA	ND CHATEAU HEALT	U CADE CENTED	AUL, MN 551			
	011111111111111111111111111111111111111					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
	0 " 15		0.000			
2 000	Continued From pa	ige 1	2 000			
	The following comp	plaints were found to be				
	SUBSTANTIATED:					
		3537) with a deficiency cited at				
	626.557 Subd 3.	oor) with a deficiency cited at				
		8870), with no deficiencies.				
		partment of Health is				
		tate Licensing Correction				
		ral software. Tag numbers				
		d to Minnesota state				
		ursing Homes. The assigned				
		s in the far-left column entitled				
		e state statute/rule out of				
		d in the "Summary Statement				
		umn and replaces the "To				
		the correction order. This				
		es the findings which are in				
		e statute after the statement,				
		et as evidence by." Following				
		lings are the Suggested				
		on and Time Period for				
	Correction.					
		participate in the electronic				
	·	ensure orders consistent with				
	the Minnesota Depa					
		tin 14-01, available at				
		n.state.mn.us/facilities/regulati				
		4_1.html> The State licensing				
		ed on the attached Minnesota				
	•	Ith orders being submitted to				
		Although no plan of correction				
		ate Statutes/Rules, please				
		RRECTED" in the box				
		ou must then indicate in the				
		ensure process, under the				
		n date, the date your orders wil				
	be corrected prior to	o electronically submitting to				
	the Minnesota Depa	artment of Health. The facility				
		and therefore a signature is				
		bottom of the first page of				

Minnesota Department of Health

STATE FORM 6899 4WUH11 If continuation sheet 2 of 7

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00494	B. WING		11/1	) 8/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HIGHLAI	ND CHATEAU HEALTI	H CARE CENTER	ST SEVENTH NUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	state form.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
21980	MN St. Statute 626 Maltreatment of Vul	.557 Subd. 3 Reporting - Inerable Adults	21980			12/24/21
	reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained information to the condividual is a vulne the individual is admireporter is not require	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult easied injury which is not ead shall immediately report the formon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected individual that occurred prior s:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reaso been made to the c	s section requires a report of d maltreatment, if the reporter on to know that a report has				

Minnesota Department of Health

STATE FORM 6899 4WUH11 If continuation sheet 3 of 7

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		SURVEY PLETED
		00494	B. WING		I	C <b>18/2021</b>
	PROVIDER OR SUPPLIER	H CARE CENTER 2319 WES	DRESS, CITY, BT SEVENTI JUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21980	reporter from also ragency.  (e) A mandated reason to believe the 626.5572, subdivision. If the ragency will determine the reported error with the criteria under second to the criteria under second to the criteria under second to the lead of the country to t	reporting to a law enforcement reporter who knows or has nat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ts the criteria under section ion 17, paragraph (c), clause necy shall consider this naking an initial disposition of	21980			
	by: Based on interview facility failed to ens reported immediate to the state agency reviewed for abuse Findings include: On 11/15/21, at 11: the state agency (S 6:00 p.m. R3 was o struck R3 in the facover two days follow	03 a.m. the facility report to 6A) indicated on 11/12/21, at calling R1 names, and R1 ce. The report was submitted wing the incident.		Corrected.		
	R3 had diagnosis of	printed on 11/15/21, indicated of intracranial injury, adult r with behaviors, and bipolar				

Minnesota Department of Health

STATE FORM 6899 4WUH11 If continuation sheet 4 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00494		B. WING		<b>I</b>	C <b>18/2021</b>
	OVIDER OR SUPPLIER  CHATEAU HEALTH	I CARE CENTER	2319 WES	DRESS, CITY, S ST SEVENTH UL, MN 551	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F F V A A C A A A A A A A A A A A A A A A A	was cognitively important and cate risk for behaviors injury (TBI), R1's Diagnosis List R1 had diagnosis of seizures, and demediaturbance. R1's annual Minimur B/22/21, indicated had any conflict and stated he recall him on the right side and R1 were in the recall and R1 were in the dining room feet when a kitchen aide were fighting and yelling at R1 and cate in the recall and tried to approach from R3. NA-A stated Fichair and tried to approach from R3. NA-A stated Fichair and R3. NA-A	ated 9/17/21, indicated aired.  ed 9/11/21, indicated added to a traumatic by printed on 11/18/21, f chronic diastolic heating with behavioral aim Data Set (MDS) doe was cognitively imposed on 12/29/20, indically aggressive and	R3 was prain indicated art failure, ated paired. Icated R1 ewed hen R1 hit ed he had R3 stated had a record and R3 and hit estant er was in a record and R3 was racial and R3 was racial ated she d him to step	21980			

Minnesota Department of Health

STATE FORM 6899 4WUH11 If continuation sheet 5 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00494		B. WING			C 11/18/2021			
NAME OF PROVIDER OR SUPPLIER  HIGHLAND CHATEAU HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21980	NA-B to go find the separated the resid see any injury to R3 finished eating his r  On 11/18/21, at 2:0 and stated she hea yelling for help becan NA-C stated R3 was lurs, R1 got upset NA-C saw NA-A ho attack R3, and NA-NA-C stated more sable to separate R1 tell a nurse about the remember her name on 11/18/21, at 2:4 interviewed. The actification of the SA administrator stated reported the abuse reported it to the SA administrator stated management of abore ported to the SA administrator stated management of abore ported to the SA administrator, directly abuse must be reported than two suggested than two suggested and procedured	d he was hit by R1. No nurse and tell her whitents. NA-A stated she or R1. NA-A stated Repeal in his room.  4 p.m. NA-C was interred a kitchen staff memoral as calling R1 names at and started going after a light of the morning of 11/15. The dishe expected staff to use immediately so it of the facility; the facility is not considered as the expected staff to use immediately so it of the facility is not considered as the expected staff to use immediately so it of the facility is not considered as the expected staff to use immediately so it of the facility; the facility is not considered as the expected staff to use immediately so it of the facility; the facility is not considered as the expected staff to use immediately so it of the facility; the facility is not considered as the expected staff to use immediately so it of the facility; the facility is not considered as the expected staff to use immediately so it of the facility is not considered as the expected staff to use immediately so it of the facility is not considered as the expected staff to use immediately so it of the facility is not considered as the expected staff to use immediately so it of the facility.	le she did not 33  viewed ober fighting. Ind racial or R3. It is is face. It is were she did do not it is information or was the of the information of the informatio	21980				

Minnesota Department of Health STATE FORM

6899 4WUH11 If continuation sheet 6 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00494	B. WING			C <b>18/2021</b>
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	·	
HIGHLA	ND CHATEAU HEALT	H CARE CENTER	EST SEVENTH PAUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DATION (X5)		
21980	Ontinued From page 6					
		DON, or designee could riate staff on the policies and orting abuse				
		DON, or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM 6899 4WUH11 If continuation sheet 7 of 7