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

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 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,

Kamala Fiske-Downing

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 11/18/2021

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 On 11/18/21, 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 complaints was found to be SUBSTANTIATED: H5028118C (MN78537) with deficiencies sited at F600 and F609 H5028119C (MN73870), however, no deficiencies were cited due to actions taken by the facility. 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 that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		12/24/21

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

Electronically Signed | 12/21/2021

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 11/18/2021

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 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R3) reviewed for abuse when R1 hit R3 in the face during dinner. Findings include: On 11/15/21, at 11:03 a.m. the facility report to the state agency (SA) indicated on 11/12/21, at 6:00 p.m. R3 was calling R1 names, and R1 struck R3 in the face. R3's Diagnosis List printed on 11/15/21, indicated R3 had diagnosis of intracranial injury, adult personality disorder with behaviors, and bipolar disorder. R3's annual MDS dated 9/17/21, indicated he was cognitively impaired. R3's Care Plan dated 9/11/21, indicated R3 was at risk for behaviors due to a traumatic brain injury (TBI), R1's Diagnosis List printed on 11/18/21, indicated R1 had diagnosis of chronic diastolic heart failure, seizures, and dementia with behavioral disturbance. R1's annual Minimum Data Set (MDS) dated	F 600	Corrective Action Resident 1 and resident 3 care plans have been audited and modified to prevent recurrence of resident-to-resident altercation. Identification of Other Residents All resident records and reports were audited for potential for allegations that must be reported immediately but no later than two hours after the incident occurs. Measures Put in Place The Interdisciplinary Team will educate facility staff on the facility policy of Freedom from Abuse, Neglect, and Exploitation. Monitoring Mechanisms Executive Director or designee will audit education weekly for 1 month and monthly for 2 months and report results at QAPI.	

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 11/18/2021

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 600	Continued From page 2	F 600		

6/22/21, indicated he was cognitively impaired.

R1's Care Plan revised on 12/29/20, indicated R1 was at risk for physically aggressive and assualtive behaviors due to dementia.

On 11/18/21, at 9:25 a.m. R1 was interviewed and stated he did not have any memory of the incident.

On 11/18/21, at 9:32 a.m. R3 was interviewed and stated he recalled the altercation when R1 hit him on the right side of his face. R3 stated he had not had any conflict with R1 in the past. R3 stated he and R1 were in the dining room and had a verbal exchange, R1 then approached R3 and hit him in the face.

On 11/18/21, at 12:07 p.m. nursing assistant (NA)-A was interviewed. NA-A stated she was in the dining room feeding another resident dinner when a kitchen aide began yelling that R1 and R3 were fighting and yelling. NA-A stated R3 was yelling at R1 and calling R1 a variety of racial slurs. NA-A stated R1 began to get up out of his chair and tried to approach R3. NA-A stated she grabbed R1 from behind and tried to hold him back from R3. NA-A stated R1 was able to step forward and attempted to punch R3. NA-A stated R3 immediately said he was hit by R1. NA-A told NA-B to go find the nurse and tell her while she separated the residents. NA-A stated she did not see any injury to R3 or R1. NA-A stated R3 finished eating his meal in his room.

On 11/18/21, at 2:04 p.m. NA-C was interviewed and stated she heard a kitchen staff member yelling for help because R1 and R3 were fighting. NA-C stated R3 was calling R1 names and racial

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 11/18/2021

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 600	Continued From page 3 slurs, R1 got upset and started going after R3. NA-C saw NA-A holding R1 back as he tried to attack R3, and NA-C saw R1 hit R3 in the face. NA-C stated more staff arrived, and they were able to separate R1 and R3. NA-C stated she did tell a nurse about the altercation, but could not remember her name. On 11/18/21, at 2:48 p.m. the administrator was interviewed and stated R1 and R3 were eating dinner when R3 started calling R1 names. The administrator stated R1 got up and went after R3 before they were separated by staff. The administrator stated she did not believe R1 hit R3. The administrator stated she interviewed staff who did not tell her R3 had been hit. The administrator stated R1 and R3 were separated after the altercation, and no other interventions were implemented. On 11/18/21, at 2:48 p.m. the director of nursing (DON) was interviewed and stated none of the staff interviewed said they saw R1 hit R3. The facility's Freedom from Abuse, Neglect, and Exploitation Policy revised on 5/20, directed abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy further directed resident to resident altercations are incidents involving a nursing home resident who willfully inflicts injury upon another resident.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		12/24/21

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 11/18/2021

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 609	Continued From page 4 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the state agency (SA) for 1 of 3 residents (R3) reviewed for abuse. Findings include: On 11/15/21, at 11:03 a.m. the facility report to the state agency (SA) indicated on 11/12/21, at 6:00 p.m. R3 was calling R1 names, and R1	F 609	Corrective Action Resident 1 and resident 3 care plans have been audited and modified to prevent recurrence of resident-to-resident altercation. Facility staff present during the incident were immediately educated on proper reporting procedures. Identification of Other Residents	

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 11/18/2021

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 609	Continued From page 5 struck R3 in the face. The report was submitted over two days following the incident. R3's Diagnosis List printed on 11/15/21, indicated R3 had diagnosis of intracranial injury, adult personality disorder with behaviors, and bipolar disorder. R3's annual MDS dated 9/17/21, indicated he was cognitively impaired. R3's Care Plan dated 9/11/21, indicated R3 was at risk for behaviors due to a traumatic brain injury (TBI), R1's Diagnosis List printed on 11/18/21, indicated R1 had diagnosis of chronic diastolic heart failure, seizures, and dementia with behavioral disturbance. R1's annual Minimum Data Set (MDS) dated 6/22/21, indicated he was cognitively impaired. R1's Care Plan revised on 12/29/20, indicated R1 was at risk for physically aggressive and assualtive behaviors due to dementia. On 11/18/21, at 9:32 a.m. R3 was interviewed and stated he recalled the altercation when R1 hit him on the right side of his face. R3 stated he had not had any conflict with R1 in the past. R3 stated he and R1 were in the dining room and had a verbal exchange, R1 then approached R3 and hit him in the face. On 11/18/21, at 12:07 p.m. nursing assistant (NA)-A was interviewed. NA-A stated she was in the dining room feeding another resident dinner when a kitchen aide began yelling that R1 and R3	F 609	All resident records and reports were audited for potential for allegations that must be reported immediately but no later than two hours after the incident occurs. Measures Put in Place The Interdisciplinary Team will educate facility staff on the facility policy of Freedom from Abuse, Neglect, and Exploitation and proper reporting procedures. Monitoring Mechanisms Executive Director or designee will audit education weekly for 1 month and monthly for 2 months and report results at QAPI. Reportable incidents will be audited weekly for 1 month, then monthly for 2 months to ensure proper reporting procedures are followed. Results will be reported to QAPI.	

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 11/18/2021

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 609	Continued From page 6	F 609		

were fighting and yelling. NA-A stated R3 was yelling at R1 and calling R1 a variety of racial slurs. NA-A stated R1 began to get up out of his chair and tried to approach R3. NA-A stated she grabbed R1 from behind and tried to hold him back from R3. NA-A stated R1 was able to step forward and attempted to punch R3. NA-A stated R3 immediately said he was hit by R1. NA-A told NA-B to go find the nurse and tell her while she separated the residents. NA-A stated she did not see any injury to R3 or R1. NA-A stated R3 finished eating his meal in his room.

On 11/18/21, at 2:04 p.m. NA-C was interviewed and stated she heard a kitchen staff member yelling for help because R1 and R3 were fighting. NA-C stated R3 was calling R1 names and racial slurs, R1 got upset and started going after R3. NA-C saw NA-A holding R1 back as he tried to attack R3, and NA-C saw R1 hit R3 in the face. NA-C stated more staff arrived, and they were able to separate R1 and R3. NA-C stated she did tell a nurse about the altercation, but could not remember her name.

On 11/18/21, at 2:48 p.m. the administrator was interviewed. The administrator stated none of the staff she interviewed said R3 was hit. The administrator stated the morning of 11/15/21, R3 reported the abuse to the facility; the facility then reported it to the SA at 11:03 a.m. The administrator stated she expected staff to inform management of abuse immediately so it could be reported to the SA within two hours.

The facility Freedom from Abuse, Neglect, and Exploitation Policy revised on 5/20, directed abuse must be reported to the SA immediately, but no later than two hours after it occurs.

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 11/18/2021

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

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 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:

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

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
	00494	A. BUILDING: _____ B. WING _____	C 11/18/2021

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 11/18/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 11/18/2021

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	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5028118C (MN78537) with a deficiency cited at 626.557 Subd 3. H5028119C (MN73870), with no deficiencies. 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 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 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	2 000		

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 11/18/2021

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	Continued From page 2 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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	21980		12/24/21

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 11/18/2021

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
21980	Continued From page 3 reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the state agency (SA) for 1 of 3 residents (R3) reviewed for abuse. Findings include: On 11/15/21, at 11:03 a.m. the facility report to the state agency (SA) indicated on 11/12/21, at 6:00 p.m. R3 was calling R1 names, and R1 struck R3 in the face. The report was submitted over two days following the incident. R3's Diagnosis List printed on 11/15/21, indicated R3 had diagnosis of intracranial injury, adult personality disorder with behaviors, and bipolar	21980	Corrected.	

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 11/18/2021

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
21980	Continued From page 4 disorder. R3's annual MDS dated 9/17/21, indicated he was cognitively impaired. R3's Care Plan dated 9/11/21, indicated R3 was at risk for behaviors due to a traumatic brain injury (TBI), R1's Diagnosis List printed on 11/18/21, indicated R1 had diagnosis of chronic diastolic heart failure, seizures, and dementia with behavioral disturbance. R1's annual Minimum Data Set (MDS) dated 6/22/21, indicated he was cognitively impaired. R1's Care Plan revised on 12/29/20, indicated R1 was at risk for physically aggressive and assualtive behaviors due to dementia. On 11/18/21, at 9:32 a.m. R3 was interviewed and stated he recalled the altercation when R1 hit him on the right side of his face. R3 stated he had not had any conflict with R1 in the past. R3 stated he and R1 were in the dining room and had a verbal exchange, R1 then approached R3 and hit him in the face. On 11/18/21, at 12:07 p.m. nursing assistant (NA)-A was interviewed. NA-A stated she was in the dining room feeding another resident dinner when a kitchen aide began yelling that R1 and R3 were fighting and yelling. NA-A stated R3 was yelling at R1 and calling R1 a variety of racial slurs. NA-A stated R1 began to get up out of his chair and tried to approach R3. NA-A stated she grabbed R1 from behind and tried to hold him back from R3. NA-A stated R1 was able to step forward and attempted to punch R3. NA-A stated	21980		

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 11/18/2021

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
21980	Continued From page 5 R3 immediately said he was hit by R1. NA-A told NA-B to go find the nurse and tell her while she separated the residents. NA-A stated she did not see any injury to R3 or R1. NA-A stated R3 finished eating his meal in his room. On 11/18/21, at 2:04 p.m. NA-C was interviewed and stated she heard a kitchen staff member yelling for help because R1 and R3 were fighting. NA-C stated R3 was calling R1 names and racial slurs, R1 got upset and started going after R3. NA-C saw NA-A holding R1 back as he tried to attack R3, and NA-C saw R1 hit R3 in the face. NA-C stated more staff arrived, and they were able to separate R1 and R3. NA-C stated she did tell a nurse about the altercation, but could not remember her name. On 11/18/21, at 2:48 p.m. the administrator was interviewed. The administrator stated none of the staff she interviewed said R3 was hit. The administrator stated the morning of 11/15/21, R3 reported the abuse to the facility; the facility then reported it to the SA at 11:03 a.m. The administrator stated she expected staff to inform management of abuse immediately so it could be reported to the SA within two hours. The facility Freedom from Abuse, Neglect, and Exploitation Policy revised on 5/20, directed abuse must be reported to the SA immediately, but no later than two hours after it occurs. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop, review, and/or revise policies and procedures that addresses timely reporting abuse no later than 2 hours after the event occured.	21980		

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 11/18/2021

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
21980	Continued From page 6 The administrator, DON, or designee could educate all appropriate staff on the policies and procedures for reporting abuse The administrator, DON, or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		