Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 17, 2026

Administrator
Highland Chateau Health And Rehabilitation Center
2319 WEST SEVENTH STREET
SAINT PAUL, MN 55116

RE: CCN: 245028
Cycle Start Date: December 30, 2025

Dear Administrator:

On February 11, 2026, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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February 17, 2026

Administrator
Highland Chateau Health And Rehabilitation Center
2319 WEST SEVENTH STREET
SAINT PAUL, MN 55116

Re: Reinspection Results
Event ID: 1DF69B-H2

Dear Administrator:

On February 10, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 30, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 22, 2026

Administrator

Highland Chateau Health and Rehab

2319 WEST 7TH STREET

St Paul, MN 55116

RE: CCN: 245028

Cycle Start Date: December 30, 2025

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On December 30, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
The date that each deficiency will be corrected.
An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

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

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 30, 2026, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 30, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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January 22, 2026

Administrator
Highland Chateau Health And Rehabilitation Center
2319 WEST SEVENTH STREET
SAINT PAUL, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: 1DF69B-H1

Dear Administrator:

The above facility survey was completed on December 30, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health And Rehabilitation Center	**2319 WEST SEVENTH STREET , SAINT PAUL, Minnesota, 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
F0000	INITIAL COMMENTS On 12/29/25 – 12/30/25 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H50282240C /MN2701141 & 2701246 with deficiencies issued at F657 and F727 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.	F0000		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F0657	R1 had a significant change assessment completed on 1/6/2026. R1 care plan was placed in review on 1/22/2026 and was thoroughly reviewed and updated by the IDT team. Current residents who require assistance with ADL's, their care plans were reviewed and updated as needed. Future residents who experience a change in condition, their care plan will be reviewed and updated and a significant change MDS will be initiated, if needed, per facility policy. Facility licensed nurses and the IDT team will be in-serviced on the Comprehensive Care Plan policy with emphasis on ongoing documentation of resident ADL status and that care plans are revised as information about the resident and the resident condition changes and that the IDT team updates care plan when there's been a significant change in the resident resident's condition, the outcome was not met, readmission from the hospital and at least quarterly during the MDS assessment period. Therapy recommendations will be discussed in morning meeting and the care plan will be	02/06/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health And Rehabilitation Center	2319 WEST SEVENTH STREET , SAINT PAUL, Minnesota, 55116

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F0657 SS = D	Continued from page 1 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to revise R1's care plan after a change occurred for 1 of 3 residents reviewed for care plan development and implementation. R1's care plan was not revised to include increased needs in cares for home exercise program dated 9/11/25 by physical therapy (PT), for R1's comprehensive assessment dated 9/21/25 for maximum assistance in some of her ADL's, and to restart therapy on 11/18/25. Findings include: R1's care plan dated 4/28/25 indicated R1's functional status required: · Dressing supervision and set-up only. · Eating – independent, no set-up or physical help. · Personal hygiene – independent, no set-up or physical help. · Toilet use – independent, no set-up or physical help. · Transfers - independent, no set-up or physical help. R1's Admission Minimum Data Set (MDS) dated 5/1/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 had no limited ROM in her upper extremities or lower extremities. She was independent in eating, oral hygiene, upper body dressing, personal hygiene, rolling in bed, lying to sitting on the side of the	F0657	Continued from page 1 updated by the MDS coordinator and/or designee after this discussion. Director of Nursing and/or designee is responsible for compliance. Audits on timely review of resident care plans, care plan revisions and therapy orders/recommendations will begin 2x week for 3 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator or designee, and the Administrator or designee will take audit results to QAPI for review and recommendation. Compliance: 02/06/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

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F0657 SS = D	Continued from page 2 bed, sitting to standing and toilet transfer. Ambulation and showering were not assessed. She used a manual wheelchair and was dependent to wheel at least 50 feet and make two turns. R1's pertinent diagnoses were metabolic encephalopathy (a brain dysfunction from a chemical imbalance due to a systemic illness), hypothyroidism, obesity, alcohol use, opioid dependence, paroxysmal atrial fibrillation (irregular heart rate that starts and stops on its own), aphasia following cerebral infarction (difficulty swallowing following a stroke), depression, anxiety, and heart failure. R1's PT discharge summary note dated 9/11/24 indicated R1 had a home exercise program for lower extremity strength and range of motion (ROM). This order did not indicate the frequency or staff involvement for R1. R1's progress note dated 8/18/25 indicated R1 was being sent to the hospital to evaluate severe back and hip pain not resolved with opioids. R1 stated she had a fall the previous day and did not tell anyone. R1's Hospital Encounter dated 8/18/25 indicated R1 was admitted with a urinary tract infection and falls, discharging on 8/20/25 with antibiotics. R1's Hospital service date 8/27/25 indicated R1 admitted on 8/27/25 with acute respiratory failure with hypercapnia, acute metabolic encephalopathy, congestive heart failure, chronic obstructive pulmonary disease hypercarbic encephalopathy. R1's progress noted dated 9/1/25 indicated R1 admitted back to the facility using a wheelchair, resident was bedfast most of the time. R1's re-admission MDS dated 9/21/25 indicated R1 required maximum assistance with toileting hygiene, rolling from left to right in bed, sitting to lying and lying to sitting, sitting to standing and chair to bed and bed to chair transferring. Ambulation was not assessed. R1's progress note dated 10/25/25 indicated R1 was sent to the hospital due to a fall and confusion.	F0657		

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F0657 SS = D	Continued from page 3 Hospital discharge dated 10/28/25 indicated R1 admitted with acute metabolic encephalopathy after a fall and was currently on Macrobid for a urinary tract infection. R1 had a history of morbid obesity, hypercapnic respiratory failure, heart failure with preserved ejection fraction. R1 believed to be back at baseline cognitively and has gotten up and ambulated with the help of staff. Her hospital course acute metabolic encephalopathy, resolved, urinary tract infection, acute kidney injury improving, right leg pain, history of falls, bilateral neuropathy, essential tremor is new. R1's neuropathy is likely contributing to frequency of falls, R1 was recommended for home physical therapy, neurology referral for neuropathy and follow-up with primary care physician. R1's quarterly Minimum Data Set (MDS) dated 11/1/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene, bathing, and lower body dressing. She required maximum assistance with upper body dressing and needed set-up with personal hygiene which included hair coming, shaving, applying make-up, washing and/drying face and hands. R1 was independent with rolling in bed, sitting to lying, sitting to standing and refused to transfer from the bed to the chair. R1's provider nursing home visit note dated 11/18/25 at 3:02 p.m. indicated R1's assessment indicated R1 had functional decompensation related to, deconditioning, decreased endurance, activity of daily Living (ADL's) impairment, abnormality of gait, muscle weakness, decreased activity tolerance, deep vein thrombosis risk due to decreased mobility, constipation risk due to decreased mobility and pain medication, skin breakdown risk due to decreased mobility. R1's plan was to continue with current medication regimen with the plan to increase gabapentin in two weeks if she was still having pain. R1 was ordered to participate in rehabilitation with services PT/OT/Rehab nursing. Evaluation and treatment of deficits in ADL's including patient and caregiver education, ROM/stretching, strengthening, neuromuscular re-education, modalities. This order was never processed. R1's goals were Goals being set forth as determined from the therapy evaluations. Attain/maintain patient's highest level of function and quality-of-life and reduce disability to maximize physical, mental, and social well-being. Opiate/Narcotic Management: Goal ls to minimize high doses and long-term usage with safe pain control plan	F0657		

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F0657 SS = D	Continued from page 4 while Improving patient function and quality of life. The goals were not added to the care plan. R1's care plan review on 12/29/25 indicated R1's functional status was not revised since her admission on 4/28/25. Upon interview on 12/29/25 at 1:38 p.m. via phone from the hospital R1 stated the hospital used a ceiling lift to transfer her from the bed to her chair or the toilet. She stated she was not certain how the facility was supposed to have transferred her as some of the staff would use a mechanical lift, other staff would get her up using two staff members and some staff would tell her she could get out of bed on her own. R1 believed staff was to assist her meal set-up and personal hygiene since she could not complete on her own due to hand tremors and shoulder pain. She stated did not recall a home exercise program or orders to restart therapy on 11/18/25. Upon interview on 12/29/25 at 2:02 p.m. nursing assistant (NA)-A stated when R1 was first admitted in the spring of 2025 she could walk on her own. NA-A had worked with her once in the past few weeks and believed R1 required a mechanical lift as there was a sling for the lift in her room. NA-A did not get R1 out of bed. Upon interview on 12/29/25 at 2:40 p.m. NA-B stated R1 required the use of the mechanical lift for the past 2-3 months, from approximately 9/2020 – 12/2025. NA-B stated prior to September R1 was independent and would walk around the facility. R1 could not get out of bed herself or comb her own hair or brush her teeth without assistance since approximately September. R1 had a "a lot" of urinary tract infections and then became confused and could not do any of her cares herself. Upon interview on 12/29/25 at 3:16 p.m. registered nurse (RN)-A stated in the summer of 2025 R1 was able to walk as she would see her walking to the smoking unit. She stated R1 had been admitted to the Transitional Care Unit (TCU) and then transferred to Long Term Care (LTC) and at that point required assistance to get up. RN-A was not certain how the staff got her up or what cares they assisted her with. Upon interview on 12/30/25 at 8:30 a.m. NA-C stated	F0657		

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F0657 SS = D	Continued from page 5 when he cared for R1 he got her up from her bed to her chair with the assistance of another staff. He did not transfer R1 often, because she refused to get out of bed on most days. He was not certain of what cares the staff assisted R1 with as her care plan indicated she was independent with her ADL's. Upon interview on 12/30/25 at 9:08 a.m. R1's current Medical Provider stated he had not met R1 yet and he was not the provider who wrote the orders to restart therapies. His expectations were if a provider writes an order that the facility follows the order and if there was a concern with an order to reach out and have a discussion with the provider. Upon interview on 12/30/25 at 12:36 p.m. licensed practical nurse (LPN)-A the RAI coordinator stated she did complete R1's MDS on 11/1/25 however did not update the care plan. She stated she was new to her job and recently had started updating care plans when MDS's are completed and have any changes. Upon interview on 12/30/25 at 2:22 p.m. the assistant director of nursing, licensed practical nurse (LPN)-B stated she had worked at the facility for three months and she was not aware that upon admission R1 was able to walk around the facility. R1 was noncompliant and no matter how much education she completed with R1 she would refuse to get out of bed. She stated she did not document the education and attempts to get R1 up. Documentation was something all the nurses at the facility were currently working on. She denied reaching out to therapy, the NP, the Pain clinic, or psychiatric services with R1's noncompliance and deconditioning. She stated the intradisciplinary team (IDT) converses about R1 often and the NP is in the room. LPN-B believed the NP was aware that R1 was not getting up and should have offer inventions since she heard them team talk about R1 in the meetings. LPN-B stated R1's current transfer status was via a mechanical lift. She denied awareness of R1 having home therapy orders following her therapy sessions in September and stated the facility must have missed the providers order on 11/18/25 because they were not initiated. Upon interview on 12/30/25 at 3:46 p.m. the Administrator stated her expectation was when a change was made to the comprehensive assessment the care plan would be updated at the same time.	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health And Rehabilitation Center	**2319 WEST SEVENTH STREET , SAINT PAUL, Minnesota, 55116**

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F0657 SS = D	Continued from page 6 A facility policy titled Care Plan, Comprehensive Person-Centered with a revision date of 10/2025 indicated: 1. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 2. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 3. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 4. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. 5. The resident has the right to refuse to participate in the development of their care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.	F0657		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the	F0727	Director of Nursing form submitted on 1/5/2026. A new Director of Nursing was hired and orientation started 1/19/2026. There were no adverse effects experienced by residents during this transition. For future departures of Administrator, Director of Nursing, President Governing Board, Board Members, Managing Agent, the Minnesota Department of Health will be notified via mail or email. VP of Clinical Services is responsible for compliance. Audits on employee departures in the above job classifications will be audited 1x week for 2 weeks then monthly to ensure compliance.	02/06/2026

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F0727 SS = F	Continued from page 7 services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to designate a registered nurse to serve as the director of nursing (DON) on a full-time basis following the exit of the former DON. This practice had the potential to affect all 54 residents who resided at the facility. Findings include: Upon entrance interview on 12/29/25 at 9:39 a.m. licensed practical nurse, (LPN)-B stated she was the only administration staff on duty and had been acting as the DON for the last two weeks. The former DON's human resource file indicated she was let go of her duties on 12/17/25. Upon interview on 12/30/25 at 9:17 a.m. the Director of Human Resources stated he was not certain who was acting as the DON currently. He stated that he was not involved in the hiring process of a new DON as the corporate office had been taking care of new DON applications and interviews.	F0727	Continued from page 7 Audit results will be reviewed by the Administrator or designee, and the Administrator or designee will take audit results to QAPI for review and recommendation. Compliance: 02/6/2026	

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F0727 SS = F	Continued from page 8 Upon interview on 12/30/25 at 3:46 p.m. the Administrator stated the facility did not have a DON. The facility was using a team effort with the ADON, nursing staff and the Vice President of Clinical Services to cover the open role. She was not certain where corporate was in the process of a new hire. Upon interview on 12/30/25 at 4:25 p.m. the Vice President of Clinical Services stated the facility was working without a DON and she was not able to assume the role on a full-time basis. A facility policy regarding required nursing services was requested however none received.	F0727		

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20000	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 12/29/25 – 12/30/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

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20000	Continued from page 1 The following complaints were reviewed. H50282240C /MN2701141 & 2701246 with orders issued at ST20570 & ST20720 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 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.	20000		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other	20570		02/06/2026

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20570	Continued from page 2 appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to revise R1's care plan after a change occurred for 1 of 3 residents reviewed for care plan development and implementation. R1's care plan was not revised to include increased needs in cares for home exercise program dated 9/11/25 by physical therapy (PT), for R1's comprehensive assessment dated 9/21/25 for maximum assistance in some of her ADL's, and to restart therapy on 11/18/25. Findings include: R1's care plan dated 4/28/25 indicated R1's functional status required: · Dressing supervision and set-up only. · Eating – independent, no set-up or physical help. · Personal hygiene – independent, no set-up or physical help. · Toilet use – independent, no set-up or physical help. · Transfers - independent, no set-up or physical help. R1's Admission Minimum Data Set (MDS) dated 5/1/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 had no limited ROM in her upper extremities or lower extremities. She was independent in eating, oral hygiene, upper body dressing, personal hygiene, rolling in bed, lying to sitting on the side of the bed, sitting to standing and toilet transfer. Ambulation and showering were not assessed. She used a manual wheelchair and was dependent to wheel at least 50 feet and make two turns. R1's pertinent diagnoses were metabolic encephalopathy (a brain dysfunction from a chemical imbalance due to a systemic illness), hypothyroidism, obesity, alcohol use, opioid dependence, paroxysmal atrial fibrillation (irregular heart rate that starts and stops on its own), aphasia	20570		

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20570	Continued from page 3 following cerebral infarction (difficulty swallowing following a stroke), depression, anxiety, and heart failure. R1's PT discharge summary note dated 9/11/24 indicated R1 had a home exercise program for lower extremity strength and range of motion (ROM). This order did not indicate the frequency or staff involvement for R1. R1's progress note dated 8/18/25 indicated R1 was being sent to the hospital to evaluate severe back and hip pain not resolved with opioids. R1 stated she had a fall the previous day and did not tell anyone. R1's Hospital Encounter dated 8/18/25 indicated R1 was admitted with a urinary tract infection and falls, discharging on 8/20/25 with antibiotics. R1's Hospital service date 8/27/25 indicated R1 admitted on 8/27/25 with acute respiratory failure with hypercapnia, acute metabolic encephalopathy, congestive heart failure, chronic obstructive pulmonary disease hypercarbic encephalopathy. R1's progress noted dated 9/1/25 indicated R1 admitted back to the facility using a wheelchair, resident was bedfast most of the time. R1's re-admission MDS dated 9/21/25 indicated R1 required maximum assistance with toileting hygiene, rolling from left to right in bed, sitting to lying and lying to sitting, sitting to standing and chair to bed and bed to chair transferring. Ambulation was not assessed. R1's progress note dated 10/25/25 indicated R1 was sent to the hospital due to a fall and confusion. Hospital discharge dated 10/28/25 indicated R1 admitted with acute metabolic encephalopathy after a fall and was currently on Macrobid for a urinary tract infection. R1 had a history of morbid obesity, hypercapnic respiratory failure, heart failure with preserved ejection fraction. R1 believed to be back at baseline cognitively and has gotten up and ambulated with the help of staff. Her hospital course acute	20570		

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20570	Continued from page 4 metabolic encephalopathy, resolved, urinary tract infection, acute kidney injury improving, right leg pain, history of falls, bilateral neuropathy, essential tremor is new. R1's neuropathy is likely contributing to frequency of falls, R1 was recommended for home physical therapy, neurology referral for neuropathy and follow-up with primary care physician. R1's quarterly Minimum Data Set (MDS) dated 11/1/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene, bathing, and lower body dressing. She required maximum assistance with upper body dressing and needed set-up with personal hygiene which included hair coming, shaving, applying make-up, washing and/drying face and hands. R1 was independent with rolling in bed, sitting to lying, sitting to standing and refused to transfer from the bed to the chair. R1's provider nursing home visit note dated 11/18/25 at 3:02 p.m. indicated R1's assessment indicated R1 had functional decompensation related to, deconditioning, decreased endurance, activity of daily Living (ADL's) impairment, abnormality of gait, muscle weakness, decreased activity tolerance, deep vein thrombosis risk due to decreased mobility, constipation risk due to decreased mobility and pain medication, skin breakdown risk due to decreased mobility. R1's plan was to continue with current medication regimen with the plan to increase gabapentin in two weeks if she was still having pain. R1 was ordered to participate in rehabilitation with services PT/OT/Rehab nursing. Evaluation and treatment of deficits in ADL's including patient and caregiver education, ROM/stretching, strengthening, neuromuscular re-education, modalities. This order was never processed. R1's goals were Goals being set forth as determined from the therapy evaluations. Attain/maintain patient's highest level of function and quality-of-life and reduce disability to maximize physical, mental, and social well-being. Opiate/Narcotic Management: Goal ls to minimize high doses and long-term usage with safe pain control plan while Improving patient function and quality of life. The goals were not added to the care plan. R1's care plan review on 12/29/25 indicated R1's functional status was not revised since her admission on 4/28/25.	20570		

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20570	Continued from page 5 Upon interview on 12/29/25 at 1:38 p.m. via phone from the hospital R1 stated the hospital used a ceiling lift to transfer her from the bed to her chair or the toilet. She stated she was not certain how the facility was supposed to have transferred her as some of the staff would use a mechanical lift, other staff would get her up using two staff members and some staff would tell her she could get out of bed on her own. R1 believed staff was to assist her meal set-up and personal hygiene since she could not complete on her own due to hand tremors and shoulder pain. She stated did not recall a home exercise program or orders to restart therapy on 11/18/25. Upon interview on 12/29/25 at 2:02 p.m. nursing assistant (NA)-A stated when R1 was first admitted in the spring of 2025 she could walk on her own. NA-A had worked with her once in the past few weeks and believed R1 required a mechanical lift as there was a sling for the lift in her room. NA-A did not get R1 out of bed. Upon interview on 12/29/25 at 2:40 p.m. NA-B stated R1 required the use of the mechanical lift for the past 2-3 months, from approximately 9/2020 – 12/2025. NA-B stated prior to September R1 was independent and would walk around the facility. R1 could not get out of bed herself or comb her own hair or brush her teeth without assistance since approximately September. R1 had a “a lot” of urinary tract infections and then became confused and could not do any of her cares herself. Upon interview on 12/29/25 at 3:16 p.m. registered nurse (RN)-A stated in the summer of 2025 R1 was able to walk as she would see her walking to the smoking unit. She stated R1 had been admitted to the Transitional Care Unit (TCU) and then transferred to Long Term Care (LTC) and at that point required assistance to get up. RN-A was not certain how the staff got her up or what cares they assisted her with. Upon interview on 12/30/25 at 8:30 a.m. NA-C stated when he cared for R1 he got her up from her bed to her chair with the assistance of another staff. He did not transfer R1 often, because she refused to get out of bed on most days. He was not certain of what cares the staff assisted R1 with as her care plan indicated she was independent with her ADL’s. Upon interview on 12/30/25 at 9:08 a.m. R1’s current	20570		

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20570	Continued from page 6 Medical Provider stated he had not met R1 yet and he was not the provider who wrote the orders to restart therapies. His expectations were if a provider writes an order that the facility follows the order and if there was a concern with an order to reach out and have a discussion with the provider. Upon interview on 12/30/25 at 12:36 p.m. licensed practical nurse (LPN)-A the RAI coordinator stated she did complete R1's MDS on 11/1/25 however did not update the care plan. She stated she was new to her job and recently had started updating care plans when MDS's are completed and have any changes. Upon interview on 12/30/25 at 2:22 p.m. the assistant director of nursing, licensed practical nurse (LPN)-B stated she had worked at the facility for three months and she was not aware that upon admission R1 was able to walk around the facility. R1 was noncompliant and no matter how much education she completed with R1 she would refuse to get out of bed. She stated she did not document the education and attempts to get R1 up. Documentation was something all the nurses at the facility were currently working on. She denied reaching out to therapy, the NP, the Pain clinic, or psychiatric services with R1's noncompliance and deconditioning. She stated the intradisciplinary team (IDT) converses about R1 often and the NP is in the room. LPN-B believed the NP was aware that R1 was not getting up and should have offer inventions since she heard them team talk about R1 in the meetings. LPN-B stated R1's current transfer status was via a mechanical lift. She denied awareness of R1 having home therapy orders following her therapy sessions in September and stated the facility must have missed the providers order on 11/18/25 because they were not initiated. Upon interview on 12/30/25 at 3:46 p.m. the Administrator stated her expectation was when a change was made to the comprehensive assessment the care plan would be updated at the same time. A facility policy titled Care Plan, Comprehensive Person-Centered with a revision date of 10/2025 indicated: 1. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.	20570		

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20570	Continued from page 7 2. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 3. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 4. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. 5. The resident has the right to refuse to participate in the development of their care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20570		
20720	Director of Nursing Services; full time CFR(s): MN Rule 4658.0500 Subp. 2 Subp. 2. Requirement of full-time employment. A director of nursing services must be employed full time, no less than 35 hours per week, and be assigned full time to the nursing services of the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to designate a registered nurse to serve as the director of nursing (DON) on a full-time basis	20720		02/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health And Rehabilitation Center	**2319 WEST SEVENTH STREET , SAINT PAUL, Minnesota, 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
20720	Continued from page 8 following the exit of the former DON. This practice had the potential to affect all 54 residents who resided at the facility. Findings include: Upon entrance interview on 12/29/25 at 9:39 a.m. licensed practical nurse, (LPN)-B stated she was the only administration staff on duty and had been acting as the DON for the last two weeks. The former DON's human resource file indicated she was let go of her duties on 12/17/25. Upon interview on 12/30/25 at 9:17 a.m. the Director of Human Resources stated he was not certain who was acting as the DON currently. He stated that he was not involved in the hiring process of a new DON as the corporate office had been taking care of new DON applications and interviews. Upon interview on 12/30/25 at 3:46 p.m. the Administrator stated the facility did not have a DON. The facility was using a team effort with the ADON, nursing staff and the Vice President of Clinical Services to cover the open role. She was not certain where corporate was in the process of a new hire. Upon interview on 12/30/25 at 4:25 p.m. the Vice President of Clinical Services stated the facility was working without a DON and she was not able to assume the role on a full-time basis. A facility policy regarding required nursing services was requested however none received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20720		