



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 17, 2024

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

RE: CCN: 245028
Cycle Start Date: April 8, 2024

Dear Administrator:

On May 10, 2024, the Minnesota Department 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2024

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

RE: CCN: 245028
Cycle Start Date: April 8, 2024

Dear Administrator:

On April 8 2024, a survey was completed at your facility by the Minnesota Department 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
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 July 8, 2024 (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 October 8, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_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.

Highland Chateau Health and Rehabilitation Center

April 19, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is written in a cursive, flowing style.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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Electronically delivered
April 19, 2024

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

Re: Event ID: F22Y11

Dear Administrator:

The above facility survey was completed on April 8, 2024, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 05/06/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/08/2024
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 4/8/24, 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. H50282672C (MN00102127) with a deficiency issued at F684. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 684	R1 physician order for the PRN	4/23/24	

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

TITLE

(X6) DATE

Electronically Signed

04/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	<p>Continued From page 1</p> <p>failed to ensure monitoring of hypertension for one of one resident (R1) reviewed for quality of care. R1 had a history of hypertension and an order for Hydralazine as needed for a systolic blood pressure 140 or greater but the facility failed to monitor R1's blood pressure.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on 5/24/23 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Additional diagnoses included chronic obstructive pulmonary disease, anxiety disorder, low back pain, type 1 diabetes mellitus with other circulatory complications, type 1 diabetes mellitus with hyperglycemia, attention-deficit hyperactivity disorder, essential (primary) hypertension (high blood pressure), cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery, acquired absence of right leg below the knee, and acquired absence of left leg below the knee.</p> <p>R1's physician progress note dated 7/20/23 stated R1's primary care provider had recommended adding Amlodipine. The note stated the facility provided agreed with the primary care provider's recommendations and ordered Amlodipine 5 milligrams (mg) by mouth in the morning.</p> <p>R1's discharge orders from M Health Fairview dated 8/19/23 indicated R1's cardiac markers was elevated possibly due to hypertension.</p> <p>R1's physician progress note dated 8/28/23 stated R1 had returned from the hospital where the physician's in the hospital had recommended</p>	F 684	<p>hypertensive medication was updated to include blood pressure monitoring before and after administration and the hypertension care plan was initiated. There were no ill effects from this deficient practice. All current residents who are prescribed hypertension medications, their orders and care plans were reviewed and updated as needed. Future residents who admit to the facility with hypertensive medications, blood pressure monitoring and care plan will be initiated per MD and facility policy. Licensed nurses and HIM director was in-serviced on the updated Medication Orders policy with emphasis on obtaining physician ordered parameters for both routine and PRN medications. The MDS coordinator was in-serviced on the Comprehensive Care Area assessment policy with emphasis on item #1 that the CAA process involves gathering data and implementing the appropriate interventions and monitoring results. Director of Nursing and/or designee is responsible for compliance. Audits on physician medication parameters orders and hypertension are plan initiation will begin 2x week for 2 weeks, weekly x 3 weeks, then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 4/23/2024</p>	

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F 684	<p>Continued From page 2</p> <p>R1 start on Hydralazine. The facility provided ordered Hydralazine 10mg by mouth once daily as needed for systolic blood pressure 140 or greater.</p> <p>R1's physician order dated 8/22/23 stated for staff to check R1's blood pressure every shift and to give hydralazine 10mg by mouth three times a day for blood pressure systolic greater than 140.</p> <p>R1's physician progress note dated 9/5/23 indicated R1 had recently elevated blood pressure and was still on metoprolol and lisinopril. The noted stated R1's physician ordered Amlodipine 5mg by mouth in the morning and Hydralazine 10mg by mouth once daily as needed for systolic blood pressure over 140.</p> <p>R1's physician order dated 9/5/23 indicated discontinuation of Amlodipine 5mg daily for hypertension and ordered for Amlodipine 10mg daily due to hypertension. The order also indicated for R1 to get a renal ultrasound done for hypertension.</p> <p>R1's brief interview for mental status (BIMS) assessment dated 1/4/24 indicated R1 had a score of 15 which indicated R1 was cognitively intact.</p> <p>R1's minimum data set (MDS) dated 1/4/24 indicated R1 had a diagnosis of hypertension.</p> <p>R1's physician order dated 1/9/24 indicated R1 was prescribed Metoprolol 150mg by mouth twice a day for hypertension.</p> <p>R1's blood pressure readings indicated R1's blood pressure was being measured several</p>	F 684		

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F 684	<p>Continued From page 3</p> <p>times a day from 5/24/23 through 2/15/24, but the last time the facility measured R1's blood pressure was on 2/15/24.</p> <p>R1's physician order dated 2/21/24 indicated R1 was prescribed Hydrochlorothiazide 12.5mg by mouth every morning. The primary diagnosis for R1 taking this medication is edema. Hydrochlorothiazide is also used to treat hypertension.</p> <p>R1's care plan dated 3/18/24 did not indicate R1 had hypertension or interventions related to R1's hypertension.</p> <p>R1's MAR dated 4/24 indicated R1 was on amlodipine 10mg by mouth one time a day due to hypertension, hydrochlorothiazide 12.5mg by mouth once a day, lisinopril 40mg by mouth once a day related to hypertension, metoprolol 150mg by mouth twice a day for cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery, and hydralazine 10mg by mouth every eight hours as needed for a systolic blood pressure over 140 related to hypertension.</p> <p>During an interview with the assistant director of nursing (ADON) on 4/8/24 at 2:38 p.m., the ADON stated the facility was not monitoring R1's blood pressure.</p> <p>The facility policy titled Medication and Treatment Orders did not indicate as needed medication administration.</p>	F 684		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 4/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during the survey.H50282672C (MN00102127)</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/19/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
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2 000	<p>Continued From page 1</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		