



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 24, 2024

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

RE: CCN: 245028
Cycle Start Date: June 27, 2024

Dear Administrator:

On July 22, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2024

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

Re: Reinspection Results
Event ID: CDEZ12

Dear Administrator:

On July 22, 2024 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 June 27, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 5, 2024

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

RE: CCN: 245028
Cycle Start Date: June 27, 2024

Dear Administrator:

On June 27, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 20, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 20, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 20, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$12,924; 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 July 20, 2024, 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 And Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 20, 2024. 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 27, 2024 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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

Highland Chateau Health And Rehabilitation Center

July 5, 2024

Page 5

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://forms.web.health.state.mn.us/form/NHDisputeResolution>

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 5, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: CDEZ11

Dear Administrator:

The above facility was surveyed on June 26, 2024 through June 27, 2024 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

*****PLEASE DISREGARD LETTER ORIGINALLY POSTED ON 7/5/24. ENFORCEMENT REMEDIES HAVE NOW BEEN UPDATED.*****

Electronically delivered
July 17, 2024

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

RE: CCN: 245028
Cycle Start Date: June 27, 2024

Dear Administrator:

On June 27, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 September 27, 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 December 27, 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/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,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 07/22/2024
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 06/27/2024
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 6/26/24 through 6/27/24, 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 complaint was reviewed H50284947C (MN00104359), with a deficiency cited at F684, F695. 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed assess and determine safety for 1 of 1 resident (R3) reviewed for self-administration of medication. Findings include:	F 554	R 3 had a new self-administration assessment completed and the resident does not desire to administer their medication. R3 will have a risk management incident completed and the MD notified that the resident medication		7/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2024

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.

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 06/27/2024
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 554	Continued From page 1 R3's care plan initiated 6/8/24, included the resident had a swallowing problem. Interventions included the resident would have small bites alternated with sips of fluid and use a teaspoon for eating. The resident was to eat only with supervision and was to be instructed to eat in an upright position. R3's electronic medical record (EMR) included a nursing note dated 6/9/24 which included the resident was on a dysphagia diet with thick nectar liquids. Medication was to be given whole in a spoonful of puree or applesauce. R3's Self Administration of medications assessment dated 6/8/24, indicated the resident did not want to self-administer medications. R3's EMR was failed to include an order for self-administration of medications. R3's medication administration record (MAR) for June included an order for Metoprolol Tartrate (a medication to lower blood pressure) Oral Tablet 25 mg, give ½ a tab twice a day by mouth. Parameters were included indicating to hold the medication if R3's blood pressure had a systolic (the top number on a blood pressure) reading below 100 or a diastolic (the bottom number on a blood pressure) reading below 60. The blood pressure reading for the June 27th blood pressure reading was marked "NA" or not applicable. The metoprolol tartrate was marked as being given. During interview on 6/27/24 at 11:45 a.m., R3 stated he assumed his blood pressure pill was mixed in with his morning medications. R3 did	F 554	was given without blood pressure assessment. MD response will be recorded in the resident electronic medical record. All current resident self-administration assessments were reviewed, and physician orders and care plans were reviewed and updated as needed. Future residents who desire to self-administer medications will be assessed and the IDT team along with the physician will review for appropriateness per facility policy. Facility nurses will be in-serviced on the Self-Administration of Medication Policy with focus on item #3 that if a resident is safe to self-administer their medication, it will be documented in the medical record, the order will indicate self-administration and it will be recorded in the resident care plan. Director of Nursing and/or designee is responsible for compliance. Audits on self-administration of medication assessment completion, self-administration physician orders marked for self-administration and self-administration care plan creation will begin 2x week for 2 weeks, weekly x 1 week then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/15/2024		

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

PRINTED: 07/22/2024
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 06/27/2024	
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 554	Continued From page 2 not remember staff taking his blood pressure prior to giving his morning medications. During interview on 6/27/24 at 12:00 p.m., licensed practical nurse (LPN)-A stated she left R3's pills in his room the morning of June 27th to retrieve a pain medication he requested. The medications were gone when she returned to the room. LPN-A stated an assessment should be in the chart if a resident could self-administer medications. LPN-A stated there was not an order which stated R3 could self-administer medications. LPN-A stated she should have stayed with R3 while he was taking his medications. During interview on 6/27/24 at 12:18 p.m., nurse practitioner (NP)-A confirmed the resident would need to be assessed prior to being allowed to self-administer medications and would need an order to self-administer. NP-A confirmed R3 did not have a self-administration order and would not have been appropriate for one because of his dysphagia (difficulty swallowing). During interview on 6/27/24 at 3:24 p.m., director of nursing (DON) stated if a medication was left in a resident's room and was taken without supervision, it was self-administered. DON stated an assessment by an interdisciplinary team (IDT) would be needed to assess the resident's safety and ability and an order from the resident's provider would be needed prior to any self-administration of medications. The DON confirmed R3 did not have an order to self-administer medications. The DON stated this was important to ensure resident safety. A facility policy titled Administering Medications			F 554			

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F 554	Continued From page 3	F 554			
F 655 SS=D	dated 12/13/21, included "Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely." Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655			7/15/24

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F 655	Continued From page 4 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a baseline care plan for 2 of 3 residents (R1, R3) reviewed for wounds, pain, and respiratory concerns. Findings include: R1's Nurse Admission/Readmission assessment dated 6/9/24, included under the respiratory status section, R1 was short of breath while lying, with exertion, and he received oxygen with a concentrator or liquid oxygen via a nasal cannula. Under the pain section, R1's pain was listed at 8/10, described as chronic pain. Ice, pain medication and rest were marked for alleviating factors to reduce R1's pain. The admission summary included "Resident had knee [pain] prior to total knee replacement. Continues to have pain, post op." R1's MDS Pain Assessment V5 dated 6/10/24, R1 rated his pain frequency in the past 5 days as "almost constantly." R1 answered pain effects his sleep "frequently", interference with therapy	F 655	R 1 has since been discharged from the facility. R 3 entire care plan was reviewed to include resident immediate and current needs are addressed. Residents admitted from survey exit until now, their baseline care plans were reviewed and updated as needed to ensure immediate care needs were addressed. Future resident admissions, the baseline care plan will be created and implemented with resident immediate needs within 48 hours per facility policy. Facility nurses and IDT team will be in-serviced on the Baseline Care Plans with emphasis on completing the baseline care plan upon admission and presenting the care plan to the resident/resident representative Director of Nursing and/or designee will be responsible for compliance. Audits on new admission baseline care plan initiation with resident focus need areas identified and timeliness of baseline care plan will begin weekly x 2 weeks then		

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F 655	Continued From page 5 activities "occasionally." R1 rated his pain as a 10 on a 1-10 pain scale, with 10 being the worst pain you can imagine. R1's hospital after discharge orders dated 6/9/24, included respiratory medications of Albuterol HFA inhaler (a fast acting medication to relax the muscles around the airway to make it easier to breath), levalbuterol nebulizer solution (a medication to prevent wheezing, shortness of breath and coughing), roflumilast (a medication to prevent bronchospasms), and Trelegy Ellipta inhaler (a long lasting medication to treat breathing problems) to treat chronic obstructive pulmonary disease (COPD). R1's discharge medications included acetaminophen, ibuprofen, and hydromorphone to treat pain for total knee arthroplasty (replacement) and osteoarthritis (inflammation in a joint). Provider visit note dated 6/10/24, included R1 was limited by post-surgical pain, his right knee incision was covered with a dressing, had nebulizers four times a day, and was on oxygen via nasal cannula. R1's care plan closed 6/21/24, included an identified focus of acute pain related to recent knee replacement. Care plan interventions that addressed how pain was alleviated was incomplete. Care plan failed to address respiratory needs including continuous oxygen, nebulizers and inhalers. Care plan failed to address surgical incision. R3's electronic medical record (EMR) included an admission summary note dated 6/8/24 at 12:03 p.m., included R3 complained of pain to his right lower abdomen where drain tube was located and	F 655	monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/15/2024		

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F 655	Continued From page 6 his low back where a tube was removed. R3's Order Summary Report printed 6/27/24, included an order placed 6/8/24 to change dressing around cholecystostomy tube (a tube placed to drain excess bile from the gallbladder after surgery) every evening and to empty bag as needed. R3's new patient provider visit note dated 6/10/24, included under the plan and order section to flush cholecystostomy tube daily, refer to pain management for [cholecystostomy] tube pain, and to refer to general surgery for follow up in regard to cholecystostomy tube. R3's care plan intervention for skin integrity dated 6/8/24 noted an actual skin impairment. Care Plan interventions failed to include specifics on cholecystostomy tube, wound care, monitoring, and risk for infection. During in interview on 6/27/24 at 10:40 a.m., registered nurse (RN)-I stated the managers normally completed the care plans. She would expect to find wound care to be identified on the care plan. During interview on 6/27/24 at 11:00 a.m., licensed practical nurse (LPN)-B stated she would have expected to find information about a wound and wound care to be identified on the resident's care plan. During an interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated all care plans were in Point Click Care, the facility electronic medical record charting system. She stated the care plan should be updated as concerns were	F 655			

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F 655	Continued From page 7 identified. The DON stated for R1, additional clarification should have been included for his skin integrity since he was admitted with a surgical wound. R1's pain intervention should include how his pain was relieved, both pharmacologically and non-pharmacological measures. R1's should have had a respiratory problem identified which included his oxygen, nebulizers, and diagnosis of heart failure and COPD. The DON confirmed R3's care plan did not address his old chest tube site nor his cholecystostomy site. The DON stated she did not feel these were complete and individualized care plans and the identified issues should have been added within the first 48 hours.	F 655			
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 observation, interview and document	F 684			7/15/24
			R 1 has since been discharged from the		

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F 684	Continued From page 8 review, the facility failed to assess and monitor 2 of 3 residents (R1, R3) reviewed for monitoring. Findings include: R1's Nurse Admission/Readmission assessment dated 6/9/24, included under the respiratory status section, R1 was short of breath while lying and with exertion, and received oxygen with a concentrator or liquid oxygen via a nasal cannula. The skin integrity section listed the resident's skin was intact and the resident had "right total knee." The admission summary included "Resident had knee [pain] prior to total knee replacement. Continues to have pain, post op." The assessment failed to document any skin impairments or surgical incisions. R1's New Patient provider visit note dated 6/10/24, included under the "skin" section; R1 had a right knee incision covered with dressing. R1's electronic medical record (EMR) indicated admission date of 6/9/24. However, the record lacked a comprehensive skin assessment or formal wound observation/assessment or documentation. R1's oxygen saturation was documented in R1's EMR on two occasions during his stay: 6/9/24 at 12:55 p.m. at 97% at 2 liters per minute via nasal cannula, 6/10/24 at 3:30 a.m. at 93% at 2 liters per minute via nasal cannula. R1's pulse was documented twice during his stay: 6/9/24 at 12:55 p.m. at 97.7 degrees Fahrenheit, 6/10/24 at 3:30 a.m. at 97.7 degrees Fahrenheit. R1's pulse rate was also only documented on two occasions during his stay: 6/9/24 at 12:55 p.m. at 99 beats per minutes, 6/10/24 at 3:30 a.m. at 90 beats per minute.			F 684	facility. R 3 will have a complete skin assessment, review of all physician orders and current care plan to ensure care needs have been addressed. R 3's MD will be made aware that the wound orders and skin assessments for 6/19 and 6/26 were not fully completed. The MD response will be recorded in the resident chart. All current residents wound, and physician order parameters were reviewed and updated as needed. Future residents who admit to the facility their physician orders will be followed per facility policy. Licensed nurses were in-serviced on the Acute change in Condition Policy and Standing Orders Policy with emphasis on assessing resident skin, performing proper wound care, notifying physician on any changes in resident condition and refusals. Director of Nursing and/or designee is responsible for compliance. Audits on weekly wound treatment procedure, weekly skin audit documentation and resident skin assessment completion will begin 2x week for 4 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/15/2024		

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F 684	Continued From page 9 R1's progress notes dated 6/12/24 at 10:05 a.m., indicated "the right knee is erythematous (red) and hot to the touch. The skin is so warm that it melted the ice packs put on just an hour before." Nursing progress note at 11:32 a.m. included "re-assessed knee, which remains erythematous, hot, and painful." The progress notes lacked any documentation prior to 6/12/24 acknowledging surgical incision. R3's nurse practitioner visit note dated 6/24/24, included monitor BP closely for two days and check vital signs every 4 hours for 48 hours for a diagnosis of hypotension (low blood pressure). R3's order summary report printed 6/27/24, included an order for vital signs every 4 hours for 48 hours for hypotension with a start date of 6/24/24 and an end date of 6/26/24. Active order for Metoprolol Tartrate 25 mg, give ½ tab twice a day with the parameters to hold if systolic blood pressure is less than 100 and diastolic blood pressure is less than 60. R3's medication administration record (MAR) for June had an entry of "NA" for blood pressure on 6/27/24. MAR indicated Metoprolol Tartrate was given on 6/27/24. R3's EMR included an order for vital signs every 4 hours for 48 hours which was marked off on 6/24/24. EMR includes the following vital blood pressure readings from 6/24/24 to 6/26/24: 6/24/24 at 4:57 p.m. 104/76 mmHg 6/25/24 at 8:29 a.m. 97/71 mmHg 6/25/24 at 6:49 p.m. 111/64 mmHg 6/26/24 at 9:07 p.m. 112/73 mmHg No reading for temperature, pulse, respiration	F 684			

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F 684	Continued From page 10 rate or oxygen saturation recorded after 6/24/24. R3's nurse progress note dated 6/24/24, included vital signs stable during the shift, however did not include specific vital sign readings. R3's nurse practitioner visit note from 6/27/24, included vital signs were ordered every 4 hours for 48 hours to start on Monday (6/24/24), however no vitals were documented in Point Click Care (the facility EMR system). During interview on 6/27/24 at 9:52 a.m., nurse practitioner (NP)-A stated R1 had a non-removable surgical dressing in place on 6/10/24 during NP visit. NP-A described slight shadowing (darker area caused by bleeding or drainage on a dressing), but not enough that she was concerned. NP-A stated she expected to see typical shift documentation were abnormalities, like shadowing, increased pain, redness, swelling) to be noted. NP-A expected daily oxygen monitoring with the rest of the vitals for residents receiving oxygen therapy. Further, NP-A stated R3 was hypotensive with mild tachycardia (fast heart rate) on Monday. NP-A ordered vital signs every 4 hours for 48 hours to confirm if R3 continued to be hypotensive. A complete set of vitals would include blood pressure, heart rate, pulse, oxygen saturation, respiratory rate, and temperature. NP-A stated the facility had missed an opportunity to identify a change in condition. During interview on 6/27/24 at 10:40 a.m., registered nurse (RN)-I stated a full set of vitals included blood pressure, temperature, respirations, pulse, oxygen and pain. A full set should be taken weekly for long term residents,	F 684			

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F 684	Continued From page 11 and daily or every shift for residents on the transitional care unit (TCU). RN-I stated the MAR directed how often vitals were ordered. RN-I stated there were certain medications that required specific vital signs to be checked prior to giving the medication. During interview on 6/27/24 at 11:00 a.m., licensed practical nurse (LPN)-A stated vital sign frequency would be in a resident's physician orders. LPN-A stated she liked to check vital signs once a day or more if needed, like if a resident was non-verbal or receiving certain medications. LPN-A stated vital signs were documented in the MAR and included temperature, pain, heart rate, blood pressure, and respirations. During interview on 6/27/24 at 10:35 a.m., assistant director of nursing (ADON) stated if someone came in with a surgical wound, there should have been documentation every shift or at least once a day that the wound was assessed. ADON stated she expected to see documentation on the type of dressing in place, what the surrounding skin looked like and the type of wound. During interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated a full set of vitals should be completed every shift for TCU residents for the first 3 days. Staff should complete any specific provider order for vitals, such as every 4 hour for 48 hours. A full set of vitals included blood pressure, pulse, oxygen, temperature, respirations, and pain. The DON confirmed a full set of vitals was not completed as expected for R1. The DON confirmed the order for R3 to have a full set of vitals ever 4 hours for 48 hours was	F 684			

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F 684	Continued From page 12 not completed. She stated this would be important to establish a baseline and to monitor for change in condition. During interview on 6/27/24 at 3:23 p.m., DON stated it was important to have baseline assessment on skin and wounds so nursing could monitor for changes. DON confirmed R1 did not have a baseline assessment and progress notes failed to describe wound. R3's admission summary note dated 6/8/24 at 12:03 p.m., which included R3 complained of pain to his right lower abdomen where drain tube was located and his low back where a tube was removed. R3's Order Summary Report printed 6/27/24, included an order placed 6/8/24 to change dressing around cholecystostomy tube (a tube placed to drain excess bile from the gallbladder after surgery) every evening and to empty bag as needed. R3's new patient provider visit note dated 6/10/24, included order to flush cholecystostomy tube daily, refer to pain management for [cholecystostomy] tube pain, and to refer to general surgery for follow up in regard to cholecystostomy tube. Wound Care progress note dated 6/19/24, included measurements of tube site on lower right back and treatment instructions to use wound cleanser and protect with a small foam dressing which should be changed daily. R3's EMR lacked an order for wound care from 6/19/24 wound care visit.	F 684			

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F 684	Continued From page 13 R3's Skin and Wound Evaluation dated 6/26/24, failed to include assessment of periwound (skin surrounding wound). Pain section and treatment section of evaluation were not complete. During interview on 6/27/24 at 10:40 a.m., RN-I stated wound care information was located in the MAR and progress notes. RN-I stated skin assessments were completed weekly and the admission assessment should have documented any skin impairment. Wound documentation should have included wound size, drainage, how the wound looked and any odor present. During interview on 6/27/24 at 11:00 a.m., LPN-A stated orders for wound have care and dressing changes were on the MAR. Skin was evaluated on bath days and a progress note added with any findings. During interview on 6/27/24 at 11:45 a.m., R3 stated he had a wound on his right side and believed there should be a dressing over it. R3 believed the nurses only changed his dressing twice since he had been admitted and believed it was the wound nurse who completed the dressing change. During interview on 6/27/24 at 3:23 p.m., DON confirmed wound care orders were placed on 6/19/24 for daily dressing change for R3. DON confirmed there was no documentation of wound care being completed and therefore could not say it was done as ordered. DON stated it was important to complete wound care as ordered to prevent infection and to promote healing. Facility provided policy titled Acute Condition	F 684			

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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 06/27/2024
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 684	Continued From page 14 Changes - Clinical Protocol dated 11/30/21, included the nurse should have assessed and documented the following baseline information: vital signs, current pain level and any recent changes, onset, duration and severity, all active diagnoses.	F 684			
F 695 SS=D	Facility provided policy titled Standing Orders for Skilled Nursing Facilities revised 2023, included for vital signs to be obtained weekly for four weeks and then monthly thereafter unless otherwise directed for long term care residents. For transitional care or TCU residents, daily vitals should be completed unless otherwise directed. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to properly assess and obtain orders for 1 of 1 residents (R1) receiving oxygen therapy. Findings include: R1's admission record dated 6/27/24, include diagnosis of chronic congestive heart failure (a serious condition where the heart cannot	F 695			7/15/24
			R 1 has since been discharged from the facility. All current residents who receive oxygen will have their oxygen orders and care plans updated and reviewed as ordered. Future residents who utilize oxygen will have oxygen orders, oxygen tubing change orders and care plans created per facility policy. Licensed nurses were in-serviced on the Oxygen Administration Policy and		

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F 695	Continued From page 15 effectively pump blood to meet the body's needs) and emphysema (a condition where there is damage to the air sacs in the lungs making it difficult to breathe). R1's hospital discharge orders dated 6/9/24, failed to include orders for oxygen. R1's hospital records prior to admission to facility reviewed. A nursing shift care plan summary note from 6/8/24 at 6:33 p.m. included R1 wears 2 liters of oxygen via nasal cannula. A Nursing Shift Care Plan Summary Note from 6/9/24 at 6:30 a.m., included R1 was on 2 liters of oxygen via nasal cannula, which was his baseline. R1's electronic medical record (EMR) included a nursing note dated 6/9/24 at 12:15 p.m., included resident arrived with oxygen on via nasal cannula at 2.5 liters. An oxygen concentrator was set up in his room. R1's Occupational Therapy evaluation dated 6/10/24, included R1 has chronic obstructive pulmonary disease (COPD) and was chronically on 2.5 liters of oxygen. R1's nurse admission/readmission assessment dated 6/9/24, included R1's oxygen saturation was 97% on oxygen via nasal cannula. The respiratory status section of the assessment included R1 was on an O2 concentrator or liquid oxygen. R1's care plan reviewed and failed to address oxygen use or respiratory problems. R1's provider visit note dated 6/10/24, included vital sign review of oxygen saturation which listed	F 695	Procedure with emphasis on item #1 that there must be an order present for the administration of oxygen. Director of Nursing and/or designee will be responsible for compliance. Audits on oxygen orders, cannula changes and oxygen care plans will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/15/2024		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 695	Continued From page 16 it at 93% on room air. Provider note failed to include orders or indication for use of oxygen. During interview on 6/27/24 at 9:52 a.m., nurse practitioner (NP)-A stated administration of oxygen was a medication and would need a prescription. During interview on 6/27/24 at 10:40 a.m., registered nurse (RN)-I stated an order for oxygen was needed and if someone was admitted from the hospital with oxygen, she would have called the hospital provider for clarification if there was not an order on the paperwork. RN-I stated it was not within her scope to order oxygen. During an interview on 6/27/24 at 11:00 a.m., licensed practical nurse (LPN)-A stated the facility had standing orders for 2 liters of oxygen for "pretty much everyone," but the provider would have needed to be updated if oxygen was used. LPN-A stated if someone was admitted with oxygen, they should have come with an order. If they did not, she would call the hospital to obtain one. LPN-A stated she would not feel comfortable keeping a resident on oxygen without an order. During interview on 6/27/24 at 1:05 p.m., LPN-B stated she remembered R1 being on continuous oxygen. LPN-B stated the admitting nurse was responsible for ensuring proper orders for oxygen were in the chart. During interview on 6/27/24 at 6/27/24, director of nursing (DON) confirmed oxygen was a medication and an order would need to be obtained to administer it. DON confirmed she did	F 695			

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F 695	Continued From page 17 not see an order for oxygen in R1's EMR. It was her expectation that staff followed up with either the hospital or the new primary provider to obtain an order. The DON stated it was important because there are resident's who should not be on oxygen, and it should be evaluated by the provider. Facility policy titled Oxygen Administration dated 11/1/21, listed staff should have verified that there is a physician order for administration as the first step in preparation to administer oxygen. Step two would have been to review the resident's care plan to assess for any special needs of the patient.	F 695			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately obtain blood pressure reading prior to administering blood pressure medication per provider orders for 1 of 1 resident (R3) reviewed for medication administration in accordance with physician instructions. Findings include: R3's medication administration record (MAR) for June 2024, included an order for Metoprolol Tartrate (a medication to lower blood pressure) Oral Tablet 25 mg, give ½ a tab twice a day by mouth. Parameters were included indicating to	F 760	R3 will have a risk management incident completed and the MD notified that the resident medication was given without blood pressure assessment. MD response will be recorded in the resident electronic medical record. All current residents on hypertensive medications and other medication parameters physician orders and care plans were reviewed and updated as needed. Future residents who receive medications with order parameters will have medication administered per physician order. Facility nurses will be in-serviced on the Administering Medication Policy with		7/15/24

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F 760	Continued From page 18 hold the medication if R3's blood pressure had a systolic (the top number on a blood pressure) reading below 100 or a diastolic (the bottom number on a blood pressure) reading below 60. The blood pressure reading for the 6/27/24 was marked "NA" or not applicable. The metoprolol tartrate was marked as being given. During interview on 6/27/24 at 11:45 a.m., R3 stated he assumed his blood pressure pill was mixed in with his morning medications. R3 did not remember staff taking his blood pressure prior to giving his morning medications. R3 stated he worked with physical therapy for about an hour after taking his medications. He started to feel sweaty and got dizzy after sitting down. R3 stated he attempted to go to his room because it was "ice cold" and he wanted to lay on the bed and let the air blow on him, but he fell over outside of the elevator. During interview on 6/27/24 at 12:00 p.m., licensed practical nurse (LPN)-A stated R3 took Metoprolol and there were parameters for holding the medication if his blood pressure was below a specific reading. LPN-A confirmed R3's blood pressure should have been taken prior to him taking his blood pressure medication, however, she did not take it that morning prior to giving him his blood pressure medication. LPN-A confirmed she also did not take R3's blood pressure after he took his medication. LPN-A stated she did not check R3's blood pressure prior to administering the medication because she left his medication in his room in a medication cup when she went to get a saline flush and pain medication. LPN-A stated R3 took his medications while she was out of the room prior to her being able to check his blood pressure.	F 760	emphasis on item #11 that prior to administering medications, allergies and any additional vital sign assessment must be reviewed prior to administering medications. Director of Nursing and/or designee is responsible for compliance. Audits on visual medication administration with emphasis on checking for vital signs and allergy checks prior to medication administration will begin daily x 7 days, 2x week x 3 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/15/2024		

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F 760	Continued From page 19 During interview on 6/27/24 at 11:29 a.m., nurse practitioner (NP)-A confirmed R3 had parameters for his blood pressure medication and his blood pressure was not documented prior to has medication being given the morning of 6/27/24. NP-A stated the facility checked R3's blood pressure after he fell and his systolic blood pressure was 77. When the blood pressure was rechecked it was 81/59 mmHg. During observation and interview on 6/27/24 at 11:43 a.m., R3 was sitting in wheelchair next to medication cart in the common room with blood pressure cuff on arm and reading on the blood pressure machine of 78/51 mmHg with a heart rate of 95 beats per minute. NP-A approached R3 and informed him she was going to send R3 to the hospital. NP-A stated she thinks the low blood pressure was related to the metoprolol he was given in the morning. During interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated R3 was a fall risk due to his hypotension. DON confirmed R3 was taking blood thinners which did increase the risk of injury from a fall due to an increased risk of bleeding. The DON confirmed R3 took Metoprolol and he was supposed to have his blood pressure checked prior to administering his blood pressure medication. The DON stated failure to follow this order include R3 falling. The DON does count this as a medication error as it was given incorrectly, and a medication error report was completed. Facility policy titled Administering Medications dated 12/13/21, included medication were to be administered in accordance with prescriber	F 760			

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F 760	Continued From page 20 orders. Vital signs and allergies were to be checked and verified for each resident prior to administering medication if necessary.	F 760			

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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 6/26/24 to 6/27/24, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

07/08/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H50284947C (MN00104359) with a licensing order issued at 1545 and 1565. 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.	2 000			

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2 000	Continued From page 2	2 000			
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545			7/15/24

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21545	Continued From page 3 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately obtain blood pressure reading prior to administering blood pressure medication per provider orders for 1 of 1 resident (R3) reviewed for medication administration in accordance with physician instructions. Findings include: R3's medication administration record (MAR) for June 2024, included an order for Metoprolol Tartrate (a medication to lower blood pressure) Oral Tablet 25 mg, give ½ a tab twice a day by mouth. Parameters were included indicating to hold the medication if R3's blood pressure had a systolic (the top number on a blood pressure) reading below 100 or a diastolic (the bottom number on a blood pressure) reading below 60. The blood pressure reading for the 6/27/24 was marked "NA" or not applicable. The metoprolol tartrate was marked as being given.	21545	Corrected		

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21545	Continued From page 4 During interview on 6/27/24 at 11:45 a.m., R3 stated he assumed his blood pressure pill was mixed in with his morning medications. R3 did not remember staff taking his blood pressure prior to giving his morning medications. R3 stated he worked with physical therapy for about an hour after taking his medications. He started to feel sweaty and got dizzy after sitting down. R3 stated he attempted to go to his room because it was "ice cold" and he wanted to lay on the bed and let the air blow on him, but he fell over outside of the elevator. During interview on 6/27/24 at 12:00 p.m., licensed practical nurse (LPN)-A stated R3 took Metoprolol and there were parameters for holding the medication if his blood pressure was below a specific reading. LPN-A confirmed R3's blood pressure should have been taken prior to him taking his blood pressure medication, however, she did not take it that morning prior to giving him his blood pressure medication. LPN-A confirmed she also did not take R3's blood pressure after he took his medication. LPN-A stated she did not check R3's blood pressure prior to administering the medication because she left his medication in his room in a medication cup when she went to get a saline flush and pain medication. LPN-A stated R3 took his medications while she was out of the room prior to her being able to check his blood pressure. During interview on 6/27/24 at 11:29 a.m., nurse practitioner (NP)-A confirmed R3 had parameters for his blood pressure medication and his blood pressure was not documented prior to his medication being given the morning of 6/27/24. NP-A stated the facility checked R3's blood pressure after he fell and his systolic blood pressure was 77. When the blood pressure was	21545			

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21545	Continued From page 5 rechecked it was 81/59 mmHg. During observation and interview on 6/27/24 at 11:43 a.m., R3 was sitting in wheelchair next to medication cart in the common room with blood pressure cuff on arm and reading on the blood pressure machine of 78/51 mmHg with a heart rate of 95 beats per minute. NP-A approached R3 and informed him she was going to send R3 to the hospital. NP-A stated she thinks the low blood pressure was related to the metoprolol he was given in the morning. During interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated R3 was a fall risk due to his hypotension. DON confirmed R3 was taking blood thinners which did increase the risk of injury from a fall due to an increased risk of bleeding. The DON confirmed R3 took Metoprolol and he was supposed to have his blood pressure checked prior to administering his blood pressure medication. The DON stated failure to follow this order include R3 falling. The DON does count this as a medication error as it was given incorrectly, and a medication error report was completed. Facility policy titled Administering Medications dated 12/13/21, included medication were to be administered in accordance with prescriber orders. Vital signs and allergies were to be checked and verified for each resident prior to administering medication if necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure	21545			

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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 06/27/2024
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION			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) COMPLETE DATE	
21545	Continued From page 6 medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed assess and determine safety for 1 of 1 resident (R3) reviewed for self-administration of medication. Findings include: R3's care plan initiated 6/8/24, included the resident had a swallowing problem. Interventions included the resident would have small bites alternated with sips of fluid and use a teaspoon for eating. The resident was to eat only with supervision and was to be instructed to eat in an upright position. R3's electronic medical record (EMR) included a nursing note dated 6/9/24 which included the resident was on a dysphagia diet with thick nectar liquids. Medication was to be given whole in a spoonful of puree or applesauce.	21565	Corrected	7/15/24	

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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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21565	Continued From page 7 R3's Self Administration of medications assessment dated 6/8/24, indicated the resident did not want to self-administer medications. R3's EMR was failed to include an order for self-administration of medications. R3's medication administration record (MAR) for June included an order for Metoprolol Tartrate (a medication to lower blood pressure) Oral Tablet 25 mg, give ½ a tab twice a day by mouth. Parameters were included indicating to hold the medication if R3's blood pressure had a systolic (the top number on a blood pressure) reading below 100 or a diastolic (the bottom number on a blood pressure) reading below 60. The blood pressure reading for the June 27th blood pressure reading was marked "NA" or not applicable. The metoprolol tartrate was marked as being given. During interview on 6/27/24 at 11:45 a.m., R3 stated he assumed his blood pressure pill was mixed in with his morning medications. R3 did not remember staff taking his blood pressure prior to giving his morning medications. During interview on 6/27/24 at 12:00 p.m., licensed practical nurse (LPN)-A stated she left R3's pills in his room the morning of June 27th to retrieve a pain medication he requested. The medications were gone when she returned to the room. LPN-A stated an assessment should be in the chart if a resident could self-administer medications. LPN-A stated there was not an order which stated R3 could self-administer medications. LPN-A stated she should have stayed with R3 while he was taking his medications.	21565			

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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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21565	Continued From page 8 During interview on 6/27/24 at 12:18 p.m., nurse practitioner (NP)-A confirmed the resident would need to be assessed prior to being allowed to self-administer medications and would need an order to self-administer. NP-A confirmed R3 did not have a self-administration order and would not have been appropriate for one because of his dysphagia (difficulty swallowing). During interview on 6/27/24 at 3:24 p.m., director of nursing (DON) stated if a medication was left in a resident's room and was taken without supervision, it was self-administered. DON stated an assessment by an interdisciplinary team (IDT) would be needed to assess the resident's safety and ability and an order from the resident's provider would be needed prior to any self-administration of medications. The DON confirmed R3 did not have an order to self-administer medications. The DON stated this was important to ensure resident safety. A facility policy titled Administering Medications dated 12/13/21, included "Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a	21565			

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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) COMPLETE DATE
21565	Continued From page 9 resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565			