Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 2, 2026

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

RE: CCN: 245028
Cycle Start Date: February 20, 2026

Dear Administrator:

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

On February 20, 2026, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 May 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 20, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 2, 2026

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

Re: Event ID: 1E48BF-H1

Dear Administrator:

The above facility survey was completed on February 20, 2026 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,

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

May 21, 2026

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

RE: CCN: 245028
Cycle Start Date: February 20, 2026

Dear Administrator:

On March 25, 2026, we notified you a remedy was imposed. On May 5, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 9, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 9, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 25, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 9, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 9, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 2/19/26 through 2/20/26, 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: H50286440C (2745009) and H50285580C (2736486). Incidental findings were cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to assess and implement individualized	F0689	F689 R 1 remains at the facility. R 1 had a Therapy Safety Questionnaire performed and the resident safety care plan and interventions were initiated. All current residents who also access the community, their Safety Questionnaire was completed and care plan initiated. Future residents who desire to access the community will have a safety assessment completed and care plan initiated. The facility IDT team was in-serviced on the updated Resident Leave of Absence Policy (Updated 03/03/2026 and again on 3/6/2026) with emphasis on item #1 that explains that all current residents have the right to access their community. In the event a resident is assessed to be at risk, the IDT team will work with the resident to implement safeguards and safety interventions when the resident leaves the facility. These items will be care planned and interventions	03/09/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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Highland Chateau Health And Rehabilitation Center	**2319 WEST SEVENTH STREET , SAINT PAUL, Minnesota, 55116**

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F0689 SS = D	Continued from page 1 interventions to ensure safe independent community access for 1 of 3 residents (R1) who had expressive aphasia and cognitive impairment and went on community outings independently placing R1 at risk for inability to effectively communicate needs or obtain assistance while unsupervised in the community. Findings include: A vulnerable adult maltreatment report dated 2/14/26 indicated R1 had been out in the community independently without staff or family escort. R1 was unable to articulate clear responses to questions or needs, and information could not be obtained easily. R1's diagnoses list dated 2/20/26 included stroke, bipolar disorder, aphasia (a communication disorder resulting from brain damage), diabetes type II, anxiety disorder, other symptoms and signs involving cognitive functions and awareness, and encephalopathy. R1's admission Minimum Data Set dated 12/24/25 indicated R1 had moderate cognitive impairment, had no speech but could be understood by others (verbally and non-verbal). R1 did not have functional range of motion deficits and did not use assistive devices to ambulate. The MDS identified R1's ability to ambulate functional community distances, navigate uneven surfaces, manage curbs/steps, or perform car transfers were marked "Not assessed/no information." R1's care plan dated 12/19/25 indicated R1 was independent with all activities of daily living, transfers, and ambulation. R1's care plan included a focus of resident is a vulnerable adult due to communication impairment with an intervention of provide clear, simple instructions and a focus of risk for impaired communication evidenced by aphasia with intervention of incorporate visual prompting, cues or gestures. R1's nursing note dated 2/12/26 at 11:22 a.m., informed R1 had left for an outing at 10:45 a.m. to be back at 12:30 per R1. R1's nursing note dated 2/14/26 at 9:54 a.m. informed R1 had left for an outing and had received breakfast and morning medications. R1's nursing note dated 2/19/26 at 9:54 a.m. informed R1 had left the facility at 9:00 a.m. and was expected to return at 1:00 p.m.	F0689	Continued from page 1 implemented. In addition, the IDT team was in-serviced on the Resident Safety Procedure which includes protocol and criteria information to assist the IDT team to determine the safety of the resident and identify, and initiate interventions as needed. Residents who have diagnosis of Alzheimer's/Dementia, are unable to ambulate and/or propel self, who cannot complete the assessment with accurate responses will not be allowed to leave the facility independently and the appropriate interventions will be developed. Director of Nursing and/or designee is responsible for compliance. Audits on Therapy Safety Questionnaire completion, assessment results and care plan initiation will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 03/09/2026	

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F0689 SS = D	Continued from page 2 In review of R1's record between 12/19/25 through 2/19/26, there was no documentation of a completed assessment determining R1's ability to safely navigate community environments, manage emergencies, or obtain assistance while outside the facility. During an observation and interview on 2/19/2026 at 1:42 p.m., R1 was observed walking independently in his room. During interview, R1 was slow to respond with words. He used arm gestures to assist with communication. R1 indicated through hand gestures he had left the facility (pointed to himself in place of the word "me" and stated, "I can do everything." R1 would use his cell phone to call family if he needed help and demonstrated how to call two family members. R1's contact list did not contain a phone number and address for the facility. (R1 ended the interview before any other questions could be asked.) During an interview on 2/19/2026 at 4:13 p.m., nursing assistant (NA)-A stated if a resident could walk, was independent and did not wear a Wander guard (a device used to alert staff when a resident attempted leave the facility) the resident could leave the facility independently if they signed out. NA-A would alert the nurse if a resident wanted to leave the facility. NA-A did not know if there was a list of residents who were safe to go into the community independently. During an interview on 2/20/2026 at 10:30 a.m. NA-B stated he would look in a resident's care plan to learn if the resident was safe to leave the facility independently. NA-B did not find any information about leaving the facility in R1's care plan. NA-B would ask a nurse if R1 wanted to go out of the facility. During an interview on 2/19/2026 at 4:00 p.m. registered nurse (RN)-A stated a resident could leave the facility with a responsible person. RN-A did not know if there was an assessment used to determine if a resident was safe to go into the community independently. RN-A indicated R1 would be vulnerable in the community because R1 was difficult to understand and could get agitated quickly when other people did not understand what he was trying to say. If R1 wanted to go into the community, RN-A would ask him where he wanted to go, try to convince him to stay at the facility, and call R1's son.	F0689		

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F0689 SS = D	Continued from page 3 During an interview on 2/20/2026 at 9:11 a.m., RN-B stated she would look to see if a resident had a provider order to leave the facility. RN-B confirmed R1 did not have a provider order instructing R1 could leave the facility independently nor was there any information in his care plan. When a resident wanted to leave the facility, they needed to tell a nurse and sign out. R1 went out of the facility frequently. He was good at caring for himself but had trouble with speaking. R1 would get angry with staff when staff did not understand what R1 was saying. RN-B stated to assist with communication an information sheet could be created for R1 to take with him when he leaves the facility with R1's name, basic information like he has trouble speaking, family phone numbers and facility name and phone number. During an interview on 2/19/2026 at 4:21 p.m., speech therapist (ST-A) stated R1 had a form of expressive aphasia where the brain knew which word to say but the processing was not occurring in the brain to tell the mouth how to say the word. When provided with a short, written list of possible answers, R1 would point to the correct answer after thinking for a short time. ST-A had not been consulted regarding R1's ability to go into the community independently but ST-A would have concerns related to communication. ST-A stated a written list of words to point to might assist R1 with communication while in the community. During an interview on 2/20/2026 at 12:12 p.m., occupational therapist (OT-A) stated she had never been asked to assess a resident for safety in the community. During an interview on 2/20/2026 at 2:42 p.m. vice president of clinical services (VP) stated she looked at a resident's hospital history and physical, the elopement assessment and a resident's cognition to assess if a resident was safe to go into the community safely. VP would document in a resident's care plan if they were not safe to leave the facility safely by themselves. During an interview on 2/20/2026 at 3:50 p.m. nurse practitioner stated she would expect the facility to do an assessment including cognition, mobility, and ability to do things for themself like cross the street, get on a bus or use money before a resident goes out into the community independently.	F0689		

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F0689 SS = D	Continued from page 4 Facility policies did not address protocols and criteria for residents to leave the facility independently. The Resident Leave of Absence policy dated 1/13/2026 instructed a resident can choose to leave the facility for limited periods for therapeutic reasons. Residents leaving the facility must sign the designated leave of absence book with time leaving the facility, expected return time and purpose for the pass. Residents who have responsible parties will be contacted for approval. The Care Plans, Comprehensive Person-Centered policy dated 11/13/25 instructed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs must be developed and implemented for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.	F0689		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/19/26 through 2/20/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure. The following complaints were reviewed: H50286440C (2745009)	20000		

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/20/2026**

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20000	Continued from page 1 H50285580C (2736486). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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.	20000		