



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2025

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

RE: CCN: 245028
Cycle Start Date: March 5, 2025

Dear Administrator:

On March 14, 2025, we notified you a remedy was imposed. On March 25, 2025 the Minnesota Department of Health 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 March 25, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 29, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 14, 2025, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa 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

April 1, 2025

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

Re: Reinspection Results
Event ID: Y8FU12 and EO6T12

Dear Administrator:

On March 25, 2025 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 surveys completed on March 5, 2025 and March 7, 2025. 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 'Melissa 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 Submitted
March 14, 2025

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

RE: CCN: 245028
Cycle Start Date: March 5, 2025

Dear Administrator:

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

On March 5, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 3, 2025, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 March 29, 2025.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 29, 2025 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 29, 2025, (42 CFR 488.417 (b)).

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.

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 \$13,343; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective . This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to

an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Highland Chateau Health And Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective . This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2025
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 03/05/2025
--	---	--	---

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	<p>INITIAL COMMENTS</p> <p>On 2/28/25 - 3/5/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed. H50288301C / MN110871, H50288181C / MN110832, H50287702C / MN110686 with a deficiency issued at F600</p> <p>Deficient practice was identified related to incidental finding at F600, F656, F677, F679, F684, F700, F838 & F841</p> <p>The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to provide care, comfort, and safety. This resulted in mental anguish and emotional distress when care and services were not provided to three-of-three residents to get out of bed who were dependent on staff. The IJ began on 2/28/25 at 12:42 p.m., and the immediacy was removed on 3/3/25 at 4:10.</p> <p>The above findings constituted substandard quality of care, and an extended survey was conducted from (3/3/25) to (3/5/25).</p> <p>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.</p>	F 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/22/2025
---	-------	--------------------------------

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.

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

PRINTED: 03/24/2025
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 03/05/2025
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	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to protect the residents' rights to be free from neglect when the facility did not provide care, comfort, and safety. This resulted in immediate jeopardy (IJ) for 3 of 4 residents (R1, R2, R3) who experience mental anguish, and emotional distress when care and services were not provided to assist these dependent residents to get out of bed. In addition, the facility failed to provide care and services for R5 who was dependent on staff to get out of bed. The immediate jeopardy began on 2/28/25, when	F 600	R1 and R2 met with social service designee on 2/28/2025 and again on 3/3/2025 by social services to ensure there were no ill effects experienced by this deficient practice. A new BIMS and PHQ9 were completed for R1 and R2 and grievances, if any, will be recorded per the grievance policy. For R1 and R2, VP Clinical met with R1 and R2 and both residents and they both report that all their needs have been met. This includes the appropriate lift equipment, wheelchairs, transportation and beds. All current residents have been reviewed and there	3/25/25

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 2</p> <p>the facility failed to provide care, comfort, and safety. This resulted in mental anguish, and emotional distress when care and services were not provided to R1, R2, and R3 to get out of bed. These residents were dependent on staff for bed mobility. The Chief Operating Officer, the Vice President of Clinical, the Director of Nursing, and Administrator were notified of the IJ on 2/28/25 12:42 p.m. and the immediacy was removed on 3/3/25 at 4:10 p.m. However noncompliance remained at the lower scope and severity level 2 (D isolated.) which indicated no actual harm with potential for more than minimal harm</p> <p>Findings include:</p> <p>R1's nursing progress note dated 12/12/24, taken from a hospital encounter on 12/10/24, indicated R1's podiatrist recommended R1 to be non-weight bearing and to use a wheelchair or a foot scooter.</p> <p>R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.).</p> <p>R1's care plan dated 1/2/25, indicated R1 was a</p>	F 600	<p>currently are no residents identified who are unable to get out of bed. R3 has since been discharged from the facility. Before admitting to the facility, the admission coordinator, Director of Nursing and VP of Clinical will review bariatric residents to ensure needs can and will be met. Any changes in condition/mood or behavior, the MD will be contacted for further orders. All like residents were reviewed and their PHQ9, BIMS scores and mood care plans were reviewed and updated as needed. Future residents who admit will be treated with Dignity per facility policy.</p> <p>Facility social service designee and facility staff will be in-serviced on the Quality of Life <input type="checkbox"/> Dignity Policy along with Change in Resident Condition Policy with emphasis on alerting the nurse that a change in mental health condition status and that residents are to be free from abuse and be free to choose how their care should be rendered.</p> <p>The Facility Social Service department and/or designee will be responsible for compliance.</p> <p>Audits on BIMS and PHQ9 score changes and acute changes in condition MD notification, mood and behavior care plans for appropriate interventions will be completed weekly x 3 weeks, then monthly to ensure sustained compliance. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation.</p> <p>Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 3</p> <p>total assistance of two staff and the use of a full body lift for transfers. The care plan did not identify what lift to use or the sling size to be used.</p> <p>R1's care plan dated 1/4/25, indicated staff were to assist R1 with ambulation and transfers, and utilize therapy recommendation. The care plan did not indicate what the therapy recommendations were.</p> <p>Upon interview with R1 on 2/26/25 at 2:12 p.m., R1 began crying stating he needed help; he had not gotten out of bed since December. R1 stated when he first came to the facility, the staff tried to get him out of bed, but the machine did not work, and no one has tried since. R1 was told he was non-weight bearing and had made two appointments with his doctor to find out why and if he could get cleared to bear weight. On both occasion the facility was not able to get him to his appointment because there was something wrong with transportation due to his size. R1 did not think he had any skin impairments. R1 continued to cry throughout the interview. R1 stated the only activity he has been provided is the television in his room and on occasion the facility will offer bingo or a group activity, but he is unable to get there since they can't get him out of bed. R1's wife brought him a handheld game device and a book. R1 expressed the need to be outside with access to fresh air.</p> <p>Upon observation and interview on 2/27/25 at 10:12 a.m., R1 put on his call light and requested to sit in his wheelchair. Nursing assistant (NA)-A told R1 she was not sure how to get him up and left to get the nurse. NA-A and registered nurse, (RN)-A returned to R1's room telling R1 they</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 4</p> <p>needed more assistance and the mechanical lift. t. NA-A, NA-B, RN-A and the certified occupational therapist (OTA)-A returned with a different mechanical lift, rolled the resident from side to side placing the sling for the mechanical lift under R1. When the staff connected the sling to the mechanical lift, the mechanical lift base would not fit under the bed frame. Staff again left, returned with the director of nursing (DON) who directed staff to use a different mechanical lift to see if the base of that lift would fit under R1's bed. Staff returned with a different mechanical lift, connected the sling to the lift, and were able to begin lifting R1. R1 screamed in pain "stop, stop, my legs are being pinched" R1 was laid flat in bed, staff placed towels between R1's upper thighs and the sling and retried the lift. R1 told staff that is not helping, the sling is too small. Staff laid R1 back in bed and said they were not able to transfer him out of bed because the sling was too small. The sling size was XXXL, which is the largest size the facility had. After the failed attempt to lift R1 out of bed, R1 began crying again stating he did not feel safe at the facility. If there was an emergency, he would not be able to get out.</p> <p>The director of nursing on 2/27/25 at 3:10 p.m. stated she was not aware R1 had not been transferred out of bed since admission in December 2024. The facility would need a new mechanical lift and a sling size that fit R1 to move him from his bed. If there was an emergency or a fire the facility would not be able to transfer or move R1, the facility would need to call 911 for assistance.</p> <p>Upon interview on 2/27/25 at 12:07 p.m., the physician assistant (PA) stated the beginning of</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 5</p> <p>2/2025 was the first time he saw R1 and was aware staff hadn't been walking him. Instead of having R1 leave the facility to see Podiatry he ordered an in-house x-ray of R1's foot to ensure there were no fractures. R1's order was changed from a non-weight bearing status to "ok to bear weight." The PA was not aware staff had not been getting R1 out of bed at all. There was no reason he could not have gotten up to his wheelchair, even with a non-bearing order. PA stated "The facility should not admit a bariatric resident if they can't take care of them."</p> <p>Upon interview on 2/28/25 at 9:35 a.m., R1 stated after the staff attempted to get him out of bed on 2/27/25 he panicked and lost sleep due to feelings of anger and anxiety that he should have been getting out of bed to his wheelchair daily despite being told he could not due to a non-weight bearing status. He had been having thoughts of self-harm over the past month due to feeling isolated and being in bed. The self-harm thoughts increased after the attempt to get him out of bed on 2/27/25.</p> <p>Upon interview on 2/28/25 at 10:27 a.m. the Social Worker designee (SW) stated R1 had always maintained a happy and positive attitude until "about a week ago" he expressed feelings struggling that he hadn't gotten out of bed since December. He didn't mention suicidal ideation to the SW, she did not ask him specifically if he was suicidal.</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. MDS did</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 6</p> <p>not indicate R2's functional mobility. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid severe obesity due to excess calories, reduced mobility, chronic pain and pre-diabetes. R2's weight was 435 lbs.</p> <p>Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was an obese lady dressed in a hospital gown in bed who had just finished lunch. She stated the only time she had been out of bed was when she was transferred to the hospital in early February. She stated she feels the reason is because of her obesity. Staff cannot handle her because at times it takes four staff members just to assist her to wash up. She cried during the visit stating the only thing she had in her room is her bible. She wanted to at least see the facility she is living in and get some fresh air.</p> <p>Upon observation and interview on 2/27/25 at 11:26 a.m., R2 pressed her call light and requested to licensed practical nurse (LPN)-A answered the call light and R2 requested to get her out of bed. LPN-A explained to R2, she was unable to get her out of bed until she spoke with the therapy department. Also, R2 didn't have a wheelchair to sit in, and LPN-A didn't know what size sling, for the mechanical lift, to use on R2.</p> <p>Upon interview on 2/27/25 at 12:07 p.m., the PA stated there was no reason R2 should not be getting out of her bed daily.</p> <p>Upon interview with R2 on 2/26/27 at 12:12 p.m., R2 stated she has not gotten out of her bed since admission until she had to go to the hospital for respiratory distress. Staff attempted to use the mechanical lift once and set her back down on the bed because the lift was not stable. R2 stated</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 7</p> <p>she worked with physical therapy upon admission, they were able to sit her up in bed, which she said, "felt wonderful". Staff have not gotten her out of bed since that one time on early admission. R2 stated she put on her call light to request getting out of bed, the staff turn off her call light, tell her they are going to get staff, then never come back. R2 stated she wanted to return to physical therapy and be able to get out of bed. R2 became tearful stating she lived in fear because the only time she was out of bed was when the paramedics took her to the hospital. PT stopped working with R2 due to her getting to her optimum level and when her arm strength was good enough PT would see her again</p> <p>R3</p> <p>R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not identify what type of lift or what size sling to be used on R3.</p> <p>R3's quarterly MDS dated 1/13/25, indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified.</p> <p>Upon interview on 2/27/25 2:18 p.m., R3 stated he hadn't been out of his bed since 12/2024. He stated he would like to get up, but he is transferring out of the facility soon and was tired of arguing with staff every day. R3 pointed to a small wheelchair and stated he couldn't get up if he wanted to because he didn't fit in the chair. R3 began to cry and stated it was a daily fight with</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 8</p> <p>the staff to even ask to sit in his chair and if discharge to an assisted living facility does not happen soon, "he will throw himself to the floor and crawl out naked." R3 stated he did not feel safe, in the event of an emergency he would be on his own and have to crawl out to safety.</p> <p>Upon interview with the 2/27/25 at 12:07 p.m. the P.A. was concerned with R3 being in bed all the time and wrote orders for a prophylaxis antibiotic for concerns of returning cellulitis, a pressure relieving mattress, and every other day bathing since he found out R3 had not had a bath or shower in over three months.</p> <p>Upon observation and interview on 2/28/25 at 10:15 a.m., R3 was in bed in hospital gown, five urinals were on a garbage can next to his bed, three of them had urine in them, there was an odor of urine in the room. R3's hair appeared greasy. He stated he felt like a, "beast in a cage losing health every day." He stated in the fall of 2024 he was standing and able to ambulate a few steps and that was the last time he ambulated. He believed staff had gotten him out of bed in December of 2024, but could not recall a specific date. Currently his legs could not hold him and required the use of a mechanical lift.</p> <p>Upon interview on 2/26/25 at 4:08 p.m., the director of nursing (DON) stated she was aware that in 12/2024 R1 had difficulty with the full body lift rated to lift 500 lbs., so she instructed the staff to use the full body lift rated to lift 600 lbs. She hadn't heard anything since she instructed the staff to use the lift rated for use at a higher weight. DON was not aware they had not gotten R1 out of bed. The DON also stated she wasn't aware that R2 wasn't getting out of bed, and she</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 9</p> <p>wasn't certain of the status of R3, if he was a full body lift or if he was transferring on his own. Staff had not reported any concerns to her about R1, R2 or R3. Her expectation was staff would report an inability to get residents out of bed and/or equipment concerns to her immediately.</p> <p>R5</p> <p>R5's admission MDS dated 1/26/25, indicated a BIMs score was nine indicating moderate cognitive impairment. R5 was dependent on two or more staff for toileting hygiene, shower/bathing, and upper body dressing and all transfer activity. Lower body dressing was not attempted. R5's pertinent diagnoses were morbid obesity and heart failure. R5's weight was 377 lbs.</p> <p>R5's nursing progress note dated 2/17/25 at 12:29 p.m., indicated R5 was sent to the hospital for confusion, extreme fatigue, and pulse oximeter saturation of 80% (normal 92-100%).</p> <p>Upon interview on 2/28/25, R5's family member (FM)-A stated R5 left the facility due to a stroke and would not be returning to the facility because the entire time she was at the facility she did not get dressed or out of her bed. When FM-A visited in the late morning or afternoon R5 would not be dressed and was still in bed. R5 was a joyful happy person, but the isolation at the facility made her depressed. FM-A would call the facility and attempt to speak with staff but would not be able to speak with anyone. Her reason for calling was to find out if R5 had gotten up for the day, but never received an answer.</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600	<p>Continued From page 10</p> <p>Upon a telephone interview on 2/28/25 at 4:42 p.m., R5 stated she never got out of bed while at the facility. She felt the staff couldn't handle a "bigger gal". She refused to go back to the facility after her hospital stay because she recalled crying everyday at the facility.</p> <p>Upon interview on 3/3/25 at 9:05 a.m., nursing assistant NA-B stated he didn't recall R5 getting out of bed, and she was a full body lift resident. He couldn't recall the reason. He stated, he didn't know if it was a therapy concern, if she refused or if they didn't have a sling for her.</p> <p>Upon interview on 3/3/25 at 4:05 p.m., the OTA, therapy manager stated R5 required the use of full body mechanical lift. She was not certain if staff was getting R5 up or not. She stated she didn't feel the facility should have admitted such heavy residents if staff can't get all the residents out of bed in a given day. The residents should be getting up daily unless they have a special circumstance such as an illness.</p> <p>-On 1/17/25 at 3:40 p.m. the immediate jeopardy was removed when the facility: -Had Physical therapy reassess R1, R2 and R3 on their transfer status -Updated R1, R2, and R3's care plans. -Educated staff about the need to follow the care plan. -Ensured the facility had the proper equipment in working order.</p> <p>A facility policy titled Abuse and Neglect - Clinical Protocol indicated neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are</p>	F 600		

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

PRINTED: 03/24/2025
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 03/05/2025
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 600 F 656 SS=D	Continued From page 11 necessary to avoid physical harm, pain, mental anguish or emotional distress. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 600 F 656		3/25/25

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

PRINTED: 03/24/2025
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 03/05/2025
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 656	<p>Continued From page 12</p> <p>community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan. The care plans for 3 of 3 residents (R1, R2, and R3) failed to indicate specifically which mechanical lift and sling was to be used during transfers. In addition R3 had conflicting information on his care plan of how he was to transfer out of his bed.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 12/16/24 indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis</p>	F 656	<p>R1, R2 and R3 had a new lift mobility assessment completed and the care plan for lift mobility, bed mobility and transfer status were reviewed and updated to include which mechanical lift and sling size as needed. All other current residents who require a mechanical lift, their lift assessments, bed mobility and care plans were reviewed and/or updated as needed. A facility audit for all lifts and slings were completed on 3/13/2025 and 3/14/2025 and additional lift slings were ordered. Future residents who require a mechanical lift, the lift and sling will be present before residents admit to the facility and their care plan will be initiated to include the resident bed transfer status and mechanical lift/sling needed during transfers.</p> <p>Licensed nurses, nurse aides and the IDT team will be in-serviced on the Assistive Devices and Equipment Policy that Devices that emphasize equipment that is needed to assist with resident mobility, safety and independence are provided for residents. Licensed nurses and nurse</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 656	<p>Continued From page 13</p> <p>(death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.).</p> <p>R1's care plan dated 1/2/25 indicated R1 was a total assistance of two staff and the use of a full body lift. The care plan did not indicate what weight limit on the lift was to be used or which sling was to be used.</p> <p>Upon interview on 2/28/25 at 8:52 a.m. nursing assistant (NA)-B stated he worked with R1 almost daily. He stated he didn't know what lift to use, however R1 was not getting out of bed because he believed R1 was a non-bearing status and not getting up. He stated he would use the 600 lb. lift as he could visually see R1 was heavy. In regard to the sling each resident has their own sling left in their room. There is a color code chart on each lift that identified which sling to use if the NA knows the residents weight.</p> <p>Upon observation on 2/28/25 at 3:40 p.m. each lift did have a color-coded chart for which sling to use.</p> <p>R2</p> <p>R2's care plan dated 1/21/25, indicated R2's bed mobility was two-person total assistance. R2 required the use of a full body lift for transfers. The care plan did not indicate what weight limit on the lift to use or the sling size.</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid,</p>	F 656	<p>aides will also be in-serviced on the Safe Lift Policy with emphasis on item #3 that staff will document the lift and transfer status into the resident care plan and the nurse aides will report any changes to the licensed nurse.</p> <p>Director of Nursing and/or designee is responsible for compliance.</p> <p>Audits on resident bed mobility, transfer status and mechanical lift with sling will be completed weekly x 3 weeks, then monthly to ensure sustained compliance. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation.</p> <p>Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 656	<p>Continued From page 14</p> <p>severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs.</p> <p>Upon observation on 2/26/24 at 12:56 p.m., R2 did not have a sling in her room. A lift with 500 lb. limit was outside her room. R2 stated she didn't know what lift or what sling was to be used because the facility hadn't only attempted to get her up once, shortly after admission.</p> <p>Upon observation and interview on 2/27/25 at 11:26 a.m., licensed practical nurse (LPN)-A, confirmed R2's care plan did not indicate what weight limit on the lift or sling size was to be used. She stated staff weren't getting R2 up anyway because R2 didn't have a large enough wheelchair for R2 to be transferred to. LPN-A stated she wasn't certain what size sling to use on R2 as the facility wasn't able to get R2's weight.</p> <p>R3</p> <p>R3's quarterly MDS dated 1/13/25, indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's was dependent in toilet, showering/bathing. Upper and lower body dressing and bed mobility was not assessed.</p> <p>R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not indicate what weight limit on the lift was to be used or sling size to be used.</p> <p>R3's care plan dated 7/28/24, indicated R3 was to be transferred using a stand pivot transfer to</p>	F 656		

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

PRINTED: 03/24/2025
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 03/05/2025
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 656	Continued From page 15 wheelchair with assistance of one staff member. Upon interview on 2/27/25 at 2:18 p.m., R3 stated he used a mechanical lift as he would not feel comfortable without a mechanical lift. He stated since he hadn't gotten out of bed since 12/2024 he wasn't certain which sling the staff would be using. He wasn't certain what his care plan indicated for transferring Upon interview on 3/3/25 at 9:05 a.m., NA-B stated R3 would be a mechanical lift however he had not gotten him out of bed. He stated he would ask the supervisor before using a lift to find out which lift and which sling to use. Upon interview on 3/3/25 at 2:32 p.m. the director of nursing stated she was aware the care plan didn't indicate which lift was to be used or the color of the sling to be used on each resident. She added that information to R1, R2, R3 as part of the abatement plan from the immediate jeopardy of the survey. A comprehensive care plan policy was requested however none obtained.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to carry out activities for 1 of 3 (R3) dependent residents reviewed for assistance with	F 677	R3 has been discharged from facility. All other current dependent residents who can specify their preferences and resident	3/25/25

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

PRINTED: 03/24/2025
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 03/05/2025
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 677	<p>Continued From page 16 activities of daily living (ADLs).</p> <p>Findings include:</p> <p>R3's provider order dated 2/25/25, indicated R3 was to be assisted with bathing every other day.</p> <p>R3's eMAR dated 2/1/25 - 2/28/25, indicated R3 was to be assisted with bathing every other day. No document was obtained to indicate R3 received assistance with bathing.</p> <p>Upon observation and interview on 2/28/25 at 2:18 p.m., R3 was in bed, in a hospital gown. R3 had shoulder length, thick greasy hair and a full beard. R3 stated he complained to the Physician Assistant (PA) he hadn't had his hair washed since he was in the hospital in 12/2024. He stated he hadn't been in the actual shower ever at the facility and maybe got a bed bath weekly without his hair being washed.</p> <p>Upon interview on 2/28/25 at 3:09 p.m., PA stated R3 complained to him about not getting cleaned-up at the facility and not having his hair washed since had been in the hospital in 12/2024. The PA wrote an order on 2/25/28, for R3 to be get assistance with bathing every other day.</p> <p>R3's care plan dated 3/4/24, indicated R3 was totally dependent on one staff member to provide bath or shower. The plan did not indicate the frequency of every other day bathing order from 2/25/25.</p> <p>R3's eMAR dated 3/1/25 - 3/4/25, indicated R3 was supposed to receive assistance with bathing every other day. No document was obtained that</p>	F 677	<p>representatives were contacted for those who aren't able to express their preferences, their weekly bathing schedule and care plans were reviewed and updated as needed. The resident/representative response for personal care was recorded in the resident EMR. Resident refusals will be documented. For future residents, their bathing preference, weekly bath audit and care plan will be initiated per resident preference and facility policy. Facility clinical leadership (DON, ADON) will in-service all nurses and nurse aides on the ADL Support Policy with emphasis on item #2 that residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance the staff will ensure assistance will be provided. In addition, nurse aides were in-serviced on reporting refusals and the nurse will reapproach and document acceptance or refusals. Director of Nursing and/or designee is responsible for compliance. Audits on resident preference documentation, weekly bath audits and bathing assistance care plan audits will be completed weekly x 3 weeks, then monthly to ensure sustained compliance. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 677	Continued From page 17 R3 received assistance with bathing. Upon interview on 3/4/25 at 2:32 p.m., the director of nursing (DON) stated she was not aware R3 was not getting assistance with bathing as ordered by PA. DON confirmed R3 had complained about his hygiene and had a specialized provider order for every other day bathing.	F 677		
F 679 SS=D	No policy on activities of daily living in reference to bathing was obtained upon request. Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to support the facility-sponsored and individual activities for residents preference to support their physical, mental and psychosocial well-being for 3 of 3 residents (R1, R2, & R3) who were dependent on staff for activities. Findings include:	F 679	R1 and R2 will have their resident preference assessment for activities reviewed and updated as needed. R1 and R2 will be offered an activity calendar and will be assisted by staff to facility events as needed and per resident preferences. R3 discharged from the facility on 3/19/2025. All current and future residents will be offered facility activities, a calendar will be provided and assistance to	3/25/25

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

PRINTED: 03/24/2025
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 03/05/2025
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 679	<p>Continued From page 18</p> <p>R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.).</p> <p>R1's progress notes dated 12/11/24 at 3:40 p.m., indicated it was very important to have books, magazines and newspapers to read. It was very important to be around animals such as pets and it was somewhat important to do things with groups of people. It was very important to go outside to get fresh air based on an activity assessment.</p> <p>R1's care plan dated 12/16/24 indicated R1 did well with one-on-one activities and was working on coming out to other activities.</p> <p>R1's progress note dated 1/6/25 at 12:00 p.m. R1 had stated "I just want someone to talk to."</p> <p>R1's activity Point of Care (POC) response history dated 1/26/25, indicated R1 did not participate in any activities over the past 30 days.</p> <p>Upon observation and interview on 2/26/25 at 2:12 p.m., R1 was laying in bed, in a hospital gown. He started weeping at the beginning of the</p>	F 679	<p>activities coordinated per facility policy. The Activity department was in-serviced on the Activity Program Policy with emphasis on item #2 that activities are based on the comprehensive assessment and resident preferences and the Activity department along with nursing will also be in-serviced on the Group Programs Policy that calendars are posted at height level throughout the facility and that smaller monthly activity calendars are placed in each resident room and to encourage and assist residents to the scheduled activity. The Activity Director and/or designee is responsible for compliance. Audits on activity calendar delivery to all residents, resident preference care plan interventions and resident participation per resident preference will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 679	<p>Continued From page 19</p> <p>interview as he stated he hadn't been out of his bed since his admission on 12/11/24. He felt isolated and alone. R1 had not been given activities to keep him occupied except for the television in his room, a handheld video game and a book his wife had brought for him. R1 recalled he had one one-to-one activity with the activity department early on in his admission. R1 would like to meet other residents, get outside for fresh air and attend group activities to help the time pass.</p> <p>Upon interview on 2/27/25 at 9:44 a.m., the director of activities stated she had completed a one-to-one activity with R1. She stated she could not recall the date and provided an undated form indicating she had completed a one-to-one and R1 would like to try to play bingo soon. The activity director believed this encounter had taken place around a "month and a half ago" and that was the last time she had complete a one-to-one with him. She stated she couldn't get residents to group activities if the nursing staff couldn't get the residents out of bed to attend the activities.</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses was morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes.</p> <p>R2's care plan dated 1/13/25 indicated R2 liked self-initiated activities such as reading spiritual books. No facility-initiated group activities</p>	F 679		

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

PRINTED: 03/24/2025
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 03/05/2025
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 679	<p>Continued From page 20 identified.</p> <p>Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was in her bed wearing a hospital gown. She had a bible on her tray table. R2 stated the only time she had been out of her bed was during a hospital stay on or about 2/10/25. She stated her days get confused as they are all the same. R2's only activity was her bible that she borrowed from her sister. R2 would have liked to play Bingo, see the rest of the facility, and go to a bible class that nursing assistant (NA) provides. R2 had never had an activity one-to-one visit.</p> <p>Upon interview on 2/27/25 at 9:44 a.m., the activity director stated she had not completed any one-on-one visits with R2, and nursing was unable to get R2 out of bed to attend any of the group activities.</p> <p>R3</p> <p>R3's care plan dated 3/5/24 indicated R3 needed one-to-one bedside-in-room visits and activities to if he is unable to attend out of room events. Staff was to invite/encourage R3's family members to attend activities with residents in order to support participation.</p> <p>R3's quarterly MDS dated 1/13/25 indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified.</p> <p>Upon observation and interview on 2/27/25 at 2:18 p.m., R3 was in his bed dressed in a hospital</p>	F 679		

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

PRINTED: 03/24/2025
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 03/05/2025
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 679	Continued From page 21 gown. R3 stated he had not been out of his bed since 12/24. He had been at the facility for about a year and had created his own activities because the facility had not given him any. He would like to get into his wheelchair and go outside as he can hear others chatting outside from his room. "I sit here all day and waste away." R3 played video games with a family member remotely every evening and his family member visited on weekends, otherwise he "diddles" with his laptop all day. Upon interview on 2/27/25 at 2:30 p.m., the activity director stated R3 spends his time on his laptop all day. He is unable to get out of bed and can not get to group activities. He had been offered books or magazines but declined. The activity director did not have an assist. Upon interview on 3/4/25 at 2:32 p.m., the Administrator stated all residents are to receive group or individual activities. She stated the activity director documents the activities. Any staff can perform activities, and her expectation was for staff to assist dependent residents with activities. She was not aware that staff was not getting R1, R2, or R3 out of bed to attend activities. A facility policy titled Activity Programs with a revision date of 1/20/25 indicated all activities are documented in the resident's medical record. The activities program is ongoing and included facility-organized group activities, independent individual activities and assisted individual activities.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684			3/25/25

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 03/05/2025
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	<p>Continued From page 22</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to weigh residents per their standing order guidelines for 2 of 3 residents (R1 and R2) reviewed for weekly weights.</p> <p>Findings include:</p> <p>R1's standing orders dated 12/10/24, indicated R1 was to have weekly weights taken.</p> <p>R1's care plan dated 12/16/24, indicated R1 was to be weighed per facility protocol.</p> <p>R1's electronic medication administration record (eMAR) dated 12/1/24 - 12/31/24, indicated R1 was to be weighed every seven days on 12/11/24, 12/18/24, and 12/25/24. The record indicated on 12/11/24, a chart code of drug refused was entered and no weight was documented. On 12/18/24, a weight of 548 lbs. was documented. On 12/25/24, a chart code indicated to other / progress notes. No weight documented.</p> <p>R1's electronic medication administration record (eMAR) dated 1/1/25 - 1/31/25, indicated R1 was to be weighed weekly on 1/8/25, 1/15/25, 1/22/25 and 1/29/25. On 1/15/25 the record indicated R1</p>	F 684	<p>R1 and R 2 were weighed on 3/6/2025. Their weights were recorded in the resident EMR. R1 and R2 Attending Physician was notified that weekly weights were not obtained. Attending Physician response will be recorded in the resident EMR. Any weight inaccuracies will be reviewed by the DON and Dietitian for resolution and documented in resident record. A weight scale was rented on 3/6/2025 to obtain resident weight and the facility lift with weight scale was serviced on 3/11/2025. All current resident weights were obtained on 3/16/2025. The facility dietitian was notified of completion of monthly weights for review. Any dietary recommendations will be implemented. Future residents who admit their weights will be obtained per physician order. The licensed nurses and nurse aides will be in-serviced on the Weight Assessment policy with emphasis on monitoring for undesirable or unintended weight loss or gain, obtaining the resident weight as ordered, recording the weight and documenting resident refusals. Director of Nursing and/or designee is</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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	<p>Continued From page 23</p> <p>weighed 548 lbs. On 1/8/25, 1/22/25 and 1/29/25 the record indicated a chart code of other / see progress notes and no weights were documented.</p> <p>R1's eMAR dated 2/1/25 - 2/28/25, indicated R1 was to be weighed every week on 2/6/25, 2/11/25, 2/19/25 and 2/26/25. On 2/6/25, the record indicated a chart code other /see progress notes, no weight was documented. On 2/12/25 and 2/19/25, a chart code indicated drug refused, no weight was documented. On 2/26/25, a chart code indicated non-applicable, no weight was documented.</p> <p>Upon interview on 2/26/25 at 2:12 p.m., R1 stated the had not gotten out of bed since his admission date of 12/11/25. He stated the staff had attempted to get him up with a mechanical lift with a weight limit of 500 lbs. in 12/2024, but it didn't work. He stated he wasn't certain if he was too heavy for the lift as he thought he weighted around 550 lbs. but hadn't been weighed at the facility.</p> <p>Upon interview on 2/28/25 at 8:52 a.m., nursing assistant (NA)-B stated he worked with R1 almost daily and had not weighed him or witnessed him being weighed. He stated he wasn't certain how R1 would be weighed since he was not able to get up and the bed didn't have a scale.</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and</p>	F 684	<p>responsible for compliance.</p> <p>Audits on weekly weight completion per MD order, dietitian notification for fluctuations and any resident education provided will be completed weekly x 3 weeks, then monthly to ensure sustained compliance.</p> <p>Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation.</p> <p>Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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	<p>Continued From page 24</p> <p>bladder. R2's pertinent diagnoses included morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes.</p> <p>R2's standard order sheet dated 2/7/25, indicated R2 was to be weighed weekly.</p> <p>R2's care plan dated 1/14/25, indicated to obtain R2's weight per facility policy.</p> <p>R2's eMAR dated 1/1/25 - 1/31/25, indicated R2 was to have weekly weights on 1/10/25, 1/17/25, 1/24/25 and 1/31/24. On 1/10/25, no weight was documented. The weight for 1/17/25, chart code indicated as other/ see nursing note with no weight documented. The weight for 1/24/25, was documented as 435 lbs. and the weight for 1/31/25 indicated R2 was hospitalized.</p> <p>Upon interview on 2/26/25 at 12:56 p.m., R2 stated she had never been weighed and the facility, she felt she had lost some weight and would like to know her current weight.</p> <p>Upon interview on 2/27/25 at 8:15 a.m., licensed practical nurse (LPN-A) stated she had not weighed R2 and if the note says she did it must have been an error. She stated all residents on the transitional care unit (TCU) were to be weighed weekly.</p> <p>Upon observation on 3/3/25 at 1:30 p.m., R2 was lifted out of bed with a mechanical lift. The weight limit indicated on the mechanical lift was 600 lbs. R2 asked the staff what she weighed and was informed the lift she was required to use did not have a scale on it.</p> <p>A facility Policy titled Weight Assessment and</p>	F 684		

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

PRINTED: 03/24/2025
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 03/05/2025
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 25 Intervention indicated resident weights are monitored for undesirable or unintended weight loss or gain.	F 684		
F 700 SS=E	<p>Bedrails CFR(s): 483.25(n)(1)-(4)</p> <p>§483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to attempt to try alternative devices before using bedrails on resident's beds for 5 of 5 residents (R1, R2, R3, R6, & R7) when the facility failed to accurately assess the resident for risk of entrapment by assessing residents' medical diagnoses, height and weight, cognition, communication, mobility,</p>	F 700	<p>R1, R2, R6 and R7 were reassessed by therapy for use of bed rails. Alternative devices will be trialed and successfully implemented if needed. If alternative devices are unsuccessful, the resident will be provided with bed rail safety information, a risk vs benefit along with documented alternatives attempted and</p>	3/25/25

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 26</p> <p>and risk of falling. In addition, the facility failed to provide ongoing assessments to assure the bedrail was used to meet the resident's needs.</p> <p>Findings include:</p> <p>Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated October 2023 indicated a physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident.</p> <p>R1's Bed Rail/Assist bar evaluation dated 12/11/24 at 4:35 p.m., was blank, no questions were answered.</p>	F 700	<p>electronic signature obtained. R3 discharged from the facility on 3/19/2025. An impaired mobility care plan will be initiated, and positioning aid will be entered into the intervention, implemented and reviewed quarterly and as needed. All existing and future residents <input type="checkbox"/> functional status for Bed Rail usage will be documented and residents who require use of bed rail, the facility will follow Bed Rail policy and procedures. Licensed nurses, facility therapy department employees and the IDT team will be in-serviced on the Bed Safety and Bed Rail on the entire policy with emphasis on assessment, care planning and ongoing review. Director of Nursing and Director of Rehab is responsible for compliance. Audits on risk vs benefit signed consent, bed rail assessment, care plan initiation and documented alternative device attempt will be completed weekly x 3 weeks, then monthly to ensure sustained compliance. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 27</p> <p>R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively impaired. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.). R1's bed rail was not indicated.</p> <p>R1's care plan dated 12/16/24 - 3/3/25, did not indicated the use of bedrails. R1's bed mobility was extensive assistance/one person physical assist.</p> <p>Upon observation and interview on 2/26/25 at 2:12 p.m., R1 had bilateral 1/4 upper bed rails. The bed rails were permantly affixed to the bed and could be lowered. R1 stated he would hold the rails when staff was turning him with cares. He did not use the rails to independently reposition himself in bed. He did not recall a formal assessment completed for the use of the bed rails. R1 could not remove the bed rails on his own.</p> <p>R2</p> <p>R2's Bed rail/Assist Bar evaluation dated 1/21/25 at 9:29 p.m., was blank, no questions were answered.</p>	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 28</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses wee morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs. R2's bed rail was not indicated.</p> <p>R2's care plan dated 1/21/25 - 3/3/25, did not indicate the use of bedrails. R2's bed mobility was a two person total assistance.</p> <p>Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was laying in bed. She had an upper 1/4 bed rail on the left side of her bed. The rail was permanently affixed to the bed, but could be lowered. She stated she had two bed rails, but the right one was removed when she went to the hospital and hadn't been replaced. R2 stated she needed the right bed rail put back on her bed to assist her with bed mobility. She had been asking staff; however, the bed rail had not been replaced. She was not able to remove or lower the rail on her own.</p> <p>R3</p> <p>R3's Bed rail/Assist Bar evaluation dated 5/15/24, indicated R3 had a bed rail to assist with bed mobility and safety. R3 expressed the desire to have the rail, had no fluctuations in level of consciousness or a cognitive deficit. R3 was able to follow directions and he had a history of falls. He did not have poor balance, trunk control or hypotension (low blood pressure). The bedrail</p>	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 29</p> <p>did help R1 to rise from a supine (lying) position to a standing position and R3 was not able to climb over the bar and had no medications that would require safety precautions. The form was not signed by the resident or the physician.</p> <p>Review of R3's medical record lacked indication if further bedrail evaluations had been completed since 5/15/24.</p> <p>R3's quarterly MDS dated 1/13/25 indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's was dependent in toilet, showering/bathing. Upper and lower body dressing and bed mobility was not assessed.</p> <p>R3's nursing progress note dated 3/4/24 at 8:25 p.m., indicated R3's bed rail/assist evaluation had been completed, based on the evaluation, the bed rail or assist bar is indicated and will serve as an enabler to promote independence.</p> <p>R3's care plan dated 3/4/24 - 3/3/25, did not indicate the use of bedrails. R3 required limited assistance of one staff to turn and reposition in bed.</p> <p>Upon observation and interview on 2/27/25 at 2:18 p.m., R3 stated when he had gotten out of bed using a gait belt and staff assistance, he used the bed rail to assist himself to a standing position. He used the bed rails to reposition himself in bed. R3 did not recall a formal staff assessment for the bed rails or any measuring of them. R3's bed rails were bilateral 1/4 rails permanently affixed by the head of his bed. He could not lower or remove the bedrails on his</p>	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 30 own.</p> <p>R6</p> <p>R6's Bed rail/Assist Bar evaluation dated 10/23/24 at 11:59 a.m., did not indicate what type of rail was being used, interventions and care plan updated or a signature from resident or the physician. The evaluation did indicate R6 did not desire to have bed rails/assist bar when in bed for safety or comfort and based on the summary a bed rail or assist bar was not indicate at that time.</p> <p>Review of R6's record lacked indication if further bed rail evaluations had been completed since 10/23/24.</p> <p>R6's admission MDS dated 10/22/24, indicated R3 had a BIMs of 15 indicating she was cognitively intact. R6 was independent with toileting hygiene, dressing and mobility. R6's pertinent diagnoses were bipolar disorder, paranoid personality disorder, lack of coordination, and adult failure to thrive. R6's bed rail was not indicated.</p> <p>R6's unsigned clinical physician orders dated 10/22/24 - 3/3/25, did not indicate the use of bed rails.</p> <p>R6's care plan dated 10/22/24 - 3/3/25, did not indicate the use of bed rails. R6 was independent with bed mobility.</p> <p>Upon observation and interview on 2/28/25 at 1:08 p.m., R6's bed rails were bilateral 1/4 rails permanently affixed by the head of his bed. She could not lower or remove the bedrails on his own She stated she didn't use them as she was</p>	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 31</p> <p>independent. She thought the rails were there to keep her from falling out bed when she slept. She didn't mind the rails as they made her feel safe while sleeping. R6 did not recall any formal assessments by the staff for the rails.</p> <p>R7</p> <p>R7's Bed rail/Assist bar evaluation dated 8/9/24 at 8:32 p.m., indicated R7 had not requested and did not have bed rail in use.</p> <p>R7's annual MDS dated 8/9/24, indicated R7's BIMs score was 15, indicating he was cognitively intact. R7's pertinent diagnoses were chronic congestive heart failure, acquired absence of left leg below the knee. R7's bed rails were not identified.</p> <p>R7's unsigned clinical physician order dated 4/9/24 - 3/3/25, did not indicate the use of bed rails.</p> <p>R7's care plan dated 4/9/24 - 3/3/25, did not indicate the use of bed rails. R7 was indendent with bed mobility.</p> <p>Upon observation and interview on 2/28/25 at 1:19 p.m., R7's bed rails were bilateral 1/4 rails permanently affixed by the head of his bed. He could not lower or remove the bedrails on his own, He stated he uses them to get up and could not get up without them. He was not certain how staff assessed the bed rails.</p> <p>Upon interview on 2/28/25 at 12:07 p.m., the physician assistant, PA stated he believed the provider had to signed orders for all bed rails and/or grab bars.</p>	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 32</p> <p>Upon interview on 3/4/25 at 2:32 p.m., the Administrator stated that bed rails could only be used for mobility purposes. She was not aware that the facility assessments had not been completed.</p> <p>A facility policy titled Bed Safety and Bed Rails dated 10/18/22 indicated:</p> <ol style="list-style-type: none"> 1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. 3. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. 4. Bed dimensions are appropriate for the resident's size. 5. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. 6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. 7. The maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee. 8. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications. 	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 33</p> <p>9. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.).</p> <p>10. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.).</p> <p>11. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment.</p> <p>Use of Bed Rails</p> <p>1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. For the purpose of this policy "bed rails" include:</p> <ul style="list-style-type: none"> a. side rails; b. safety rails; and c. grab/assist bars. <p>2. Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.</p> <ul style="list-style-type: none"> a. The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could 	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 34</p> <p>be considered a restraint.</p> <p>3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.</p> <p>4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include:</p> <ul style="list-style-type: none"> a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling off the bed. <p>5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes:</p> <ul style="list-style-type: none"> a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative; and d. consultation with the attending physician. <p>6. The resident assessment to determine risk of entrapment includes, but is not limited to:</p> <ul style="list-style-type: none"> a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight; c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; 	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	<p>Continued From page 35</p> <p>i. cognition; j. communication; k. mobility (in and out of bed); and l. risk of falling.</p> <p>7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following:</p> <p>a. Accident hazards:</p> <p>(1) The resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or</p> <p>(2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress.</p> <p>b. Restricted mobility:</p> <p>(1) Hinders residents from independently getting out of bed thereby confining them to their beds;</p> <p>(2) Creates a barrier to performing routine activities such as going to the bathroom or retrieving items in his/her room, eating, hydration and/or walking;</p> <p>(3) Decline in resident function, such as muscle functioning/balance; and/or</p> <p>(4) Skin integrity issues.</p> <p>c. Psychosocial outcomes:</p> <p>(1) Creates an undignified self-image and alters the resident's self-esteem;</p> <p>(2) Contributes to feelings of isolation; and/or</p> <p>(3) Induces agitation or anxiety.</p> <p>8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:</p> <p>a. The assessed medical needs that will be addressed with the use of bed rails;</p>	F 700		

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

PRINTED: 03/24/2025
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 03/05/2025
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 700	Continued From page 36 b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons. 9. The staff shall report to the director of nursing and administrator any accidents or incidents associated with a bed or related equipment including the bed frame, side or bed rails, and mattresses. The administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.	F 700			
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's	F 838		3/25/25	

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

PRINTED: 03/24/2025
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 03/05/2025
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 838	<p>Continued From page 37</p> <p>resident capacity;</p> <p>(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;</p> <p>(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;</p> <p>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</p> <p>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.</p> <p>§483.71(a)(2) The facility's resources, including but not limited to the following:</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both</p>	F 838		

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

PRINTED: 03/24/2025
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 03/05/2025
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 838	<p>Continued From page 38</p> <p>normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).</p> <p>§ 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>§483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).</p> <p>§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident</p>	F 838		

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

PRINTED: 03/24/2025
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 03/05/2025
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 838	<p>Continued From page 39 population.</p> <p>§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.</p> <p>§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.</p> <p>§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update their facility assessment when they no longer provided restorative nursing (continuous specialized approach in nursing care to maintain and improve physical and emotional wellbeing of individuals who have experienced a decline in function abilities) at the facility. Two of two residents (R1 and R2) had the potential to benefit from restorative nursing. This failure had the potential to affect all 56 residents who resided at the facility.</p> <p>Findings include:</p> <p>The facility assessment dated 9/20/24, indicated under the category of activities of daily living, the specific care of practices of residents needs indicated restorative nurse was offered at the facility.</p>	F 838	<p>R1 was cleared to bear weight on 2/1/2005 and is currently receiving PT and OT therapy services as of 2/27/2025. R2 is currently receiving PT and OT services as of 2/28/2025. R 1 and R 2 ADL care plans were reviewed and updated as needed. As of this writing, there are no recommendations for restorative services from therapy. Future residents who have recommendations from therapy for restorative services, the restorative service plan will be implemented by the facility policy. Facility nurses, therapist and Administrator will be in-serviced on the Restorative Maintenance Program with emphasis on the entire maintenance program policy and procedure. The Administrator will be in-serviced on the</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 838	<p>Continued From page 40</p> <p>R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.).</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs.</p> <p>Upon interview on 2/27/25 at 2:47 p.m., the physical therapist (PT) stated he worked with R1 and R2. R1 had reached his goals in becoming independent in bed. Therapy was going to re-admit R1 when he was able to bear weight and gain upper body strength. R2 had the same scenario where she met her goals of being independent in bed, however her arms were too weak to move further with therapy at that point. PT confirmed Both R1 and R2 would have benefited from restorative nursing, however the facility didn't offer it anymore. PT could not recall</p>	F 838	<p>Facility Assessment Policy with emphasis on item #3 that the facility assessment includes a detailed review of the population along with factors that affect the overall acuity of the facility. The Administrator and/or designee is responsible for compliance. Audits on updates to the facility assessment will be completed weekly x 1 week then monthly to ensure sustained compliance. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 838	<p>Continued From page 41</p> <p>how long it had been since the facility had been without restorative nursing.</p> <p>Upon interview on 2/27/25 at 3:15 p.m. the physician assistant stated he was not aware the facility did not have restorative nursing however believed R1, R2 and "many others" could benefit from restorative nursing especially when therapy ends. Restorative nurse would reduce the risk for deterioration of the residents when therapy is no longer able to work with them. It also can strengthen and make better outcomes for residents.</p> <p>Upon interview on 2/27/25 p.m. at 4:01 p.m. the director of nursing (DON) stated the facility did not have restorative nursing. The DON wasn't certain when restorative nursing stopped.</p> <p>Upon interview on 3/3/25 at 4:26 p.m. the Medical Director (MD) stated the facility needed to follow whatever is on their facility assessment. He wasn't certain if the facility had restorative nursing in place or not.</p> <p>Upon interview on 3/4/25 at 2:32 p.m. the Administrator stated the facility did not have a restorative nursing program, however had a function maintenance program. She did not provide any documented information on that program. The functional maintenance program had the nursing assistants continuing care with residents following therapy. The facility did not have any residents utilizing the program and no documented was provided regarding the program when requested. The Administrator was not certain when restorative nursing was stopped or if residents and family were notified as she could not recall if the change was made when she</p>	F 838		

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

PRINTED: 03/24/2025
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 03/05/2025
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 838	Continued From page 42 was the Administrator.	F 838		
F 841 SS=F	<p>Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2)</p> <p>§483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director.</p> <p>§483.70(g)(2) The medical director is responsible for-</p> <p>(i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure the Medical Director (MD) assisted in the implementation and guidance of resident care policies, coordination, and admission of three bariatric residents (body weight greater than 100 pounds (lbs.) of ideal body weight) residents (R1, R2 and R3). The facility was unable to safely manage these residents due to lack of guidance upon admission and provided cares received at the facility. This had the potential to affect all 56 residents who resided at the facility.</p> <p>Findings include: R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate</p>	F 841	<p>The corporate team, COO and CEO reviewed the Facility Assessment Policy, Medical Director Policy and Admission Criteria policy. There were no updates to the Medical Director Policy. For the Facility Assessment and Admission Criteria policy, areas that reference bariatric care, both the admission criteria policy and the facility assessment were updated to include verbiage that before bariatric residents are admitted, a clinical review must be conducted. The Medical Director and physician group were also updated on this policy change. The Admission Criteria policy items #6 and 7 will be expanded to include diagnosis and facility clinical capabilities. The IDT team, Medical Director and physician group will be in-serviced on the</p>	3/25/25

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

PRINTED: 03/24/2025
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 03/05/2025
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 841	<p>Continued From page 43</p> <p>assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 lbs.</p> <p>R1's care plan dated 1/2/25, indicated R1 was a total assistance of two staff and the use of a full body lift. The care plan did not indicate what type of lift was to be used or sling size.</p> <p>R1's care plan dated 1/4/25, indicated staff were to assist R1 with ambulation and transfers, utilization of therapy recommendation. The care plan did not indicate what the therapy recommendations were.</p> <p>R1's nursing progress notes dated 12/11/24 - 3/3/25, did not indicate R1 had gotten out of bed while at the facility or why he had not gotten out of bed.</p> <p>Upon observation and interview on 2/26/25 at 2:12 p.m., R1 was laying in bed, in a hospital gown. He started weeping at the beginning of the interview as he hadn't been out of his bed since his admission on 12/11/24. R1 was waiting for the facility to have him see a podiatrist so he could bear weight. R1 did not understand why he wasn't getting out of bed to a seated position in his wheelchair since that didn't require him to weight bear.</p> <p>Upon observation and interview on 2/27/25 at</p>	F 841	<p>Admission Policy item #8, that certain conditions may require authorization from the physician group, Medical Director, Director of Nursing and/or the Administrator.</p> <p>The facility Administrator and/or designee will be responsible for compliance.</p> <p>Audits on Facility Assessment, Admission Criteria and Medical Director policy will be reviewed yearly and as needed.</p> <p>Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation.</p> <p>Compliance: 03/25/2025</p>	

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

PRINTED: 03/24/2025
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 03/05/2025
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 841	<p>Continued From page 44</p> <p>10:21 a.m., R1 requested to be transferred from his bed to his wheelchair. Nursing assistant (NA)-A stated she couldn't get R1 up because she had never gotten him up before and wanted assistance from the therapy team.</p> <p>Upon observation and interview on 2/27/25 at 10:21 a.m., occupational therapy assistant (OTA) stated R1 had some "issues" with his orders, so nobody worked with him. She stated at an unknown date in 12/2024 the staff tried to get him up with a 600 lbs. mechanical lift and he had to be laid back down in bed, so his transferring was at a standstill. She did not know what the facility would do in an emergency to safely get R1 out of his room.</p> <p>Upon observation and interview on 2/27/25 at 11:12 a.m., five staff members attempted to transfer R1 from his bed to a wheelchair with a 600 lb. lift that uses a sling and lifts residents up and sits them down without having to stand. R1 was lifted approximately 4 inches off his bed, and he started screaming that his legs were being pinched. He was placed back down on his bed and the staff attempted to place towels between his legs and the stand and lift again. Again he screamed his legs were being pinched. He was laid back down on his bed. The OTA stated the facility would need to get a larger sling for R1 therefore there was not a way to get him out of bed. R1 began to cry and stated he did not feel safe at the facility knowing the staff did not have the capability to remove him from his bed.</p> <p>Upon interview on 2/27/25 at 12:07 p.m., the physician assistant (PA) stated the beginning of 2/2025 was the first time he saw R1 and was aware staff hadn't been walking him. Instead of</p>	F 841		

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

PRINTED: 03/24/2025
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 03/05/2025
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 841	<p>Continued From page 45</p> <p>having R1 leave the facility to see Podiatry he ordered an inhouse x-ray of R1's foot and there were no fractures. R1's order was changed from a non-weight bearing status to "o.k. to bear weight". PA was not aware staff had not been getting R1 out of bed at all. There was no reason he could not have gotten up to his wheelchair with a non-bearing order. "The facility should not admit a bariatric resident if they can't take care of them."</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs.</p> <p>R2's nursing progress notes dated 1/11/25 - 3/3/25, did not indicate R2 had gotten out of her bed or why she hadn't gotten out of bed.</p> <p>R2's care plan dated 1/21/25 - 3/3/25, did not indicate the use of bedrails. R2's bed mobility was a two person total assistance. R2 required the use of a fully body lift for transfers. The care plan did not indicate what type of lift of sling size required.</p> <p>Upon observation and interview on 2/27/25 at 11:26 a.m., R2 pressed her call light and requested to get out of her bed to licensed practical nurse (LPN)-A. LPN-A told R2 that she was unable to get her out of bed until she spoke</p>	F 841		

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

PRINTED: 03/24/2025
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 03/05/2025
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 841	<p>Continued From page 46</p> <p>with the therapy department and R2 didn't have a wheelchair to sit in. LPN-A did not know what size sling to use for R2's transfer.</p> <p>Upon interview on 2/27/25 at 12:07 p.m., PA stated there was no reason R2 should not be getting of her bed daily.</p> <p>R3</p> <p>R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not indicate what type of lift was to be used, or the size of the sling.</p> <p>R3's quarterly MDS dated 1/13/25, indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified.</p> <p>Upon interview on 2/27/25 2:18 p.m., R3 stated he hadn't been out of his bed since 12/2024. He stated he would like to get up, but he is transferring out the facility soon and was tired of arguing with staff every day. R3 pointed to a small wheelchair and stated he couldn't get up if he wanted to because he didn't fit in the chair.</p> <p>Upon interview on 2/27/25 at 3:39 p.m., PA stated R3 had deconditioned in the facility. In the fall of 2/2024 R3 had been walking around his room and now the staff would need to use a lift with him. He was worried about R3's skin condition and loss of muscle mass.</p> <p>Upon interview on 3/3/25 at 4:26 p.m., Medical Director (MD) stated he was aware there was an</p>	F 841		

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

PRINTED: 03/24/2025
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 03/05/2025
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 841	<p>Continued From page 47</p> <p>immediate jeopardy called at the facility on 2/28/25 at 12:42 p.m., due to one resident not getting out of bed. He was not aware that the immediate jeopardy was for the neglect of three residents. He stated he was not involved in admission of the residents to the facility. MD stated the facility needed to follow their facility assessment for admission and cares. MD did not know the exact criteria for admitting bariatric residents and denied the facility requesting recommendations regarding R1, R2 and R3 prior to admission, the facility did not have proper equipment and the ability or inability to fully care for the residents following admission.</p> <p>Upon interview on 3/4/25 at 1:15 p.m. PA stated he had not had any correspondence with MD. "I don't even know his name."</p> <p>Upon interview on 3/4/25 at 2:32 p.m. the administrator stated MD was very responsive to text messages or phone calls. He was told everything about the immediate jeopardy and how the facility got the abatement. She stated the MD attends QAPI and would come to the facility if asked. Administrator stated the MD doesn't have involvement in the facility admissions. If the facility has concerns about whether the facility can accommodate a resident or not, they reached out to the corporate nurse not the MD. The facility did not reach out to the MD when they found out the residents were not getting out of bed.</p> <p>A policy titled Medical Director dated 3/2/25 indicated the Medical Director is responsible for all aspects of medical oversight of the facility.</p>	F 841		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: Y8FU11

Dear Administrator:

The above facility was surveyed on February 28, 2025 through March 5, 2025 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.

Highland Chateau Health And Rehabilitation Center

March 14, 2025

Page 2

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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
--------------------	--	---------------	---	--------------------

2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 2/28/25 - 3/5/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/22/25
---	-------	------------------------------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
--------------------	--	---------------	---	--------------------

2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaints were reviewed. H50288301C / MN110871, H50288181C/ MN110832 & H50287702C MN110686 the following order were written ST0875, ST0920, ST1230, ST1435</p> <p>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.</p> <p>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</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 875	MN Rule 4658.0520 Subp. 2 Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to weigh residents per their standing order guidelines for 2 of 3 residents (R1 and R2) reviewed for weekly weights. Findings include: R1's standing orders dated 12/10/24, indicated R1 was to have weekly weights taken. R1's care plan dated 12/16/24, indicated R1 was to be weighed per facility protocol. R1's electronic medication administration record (eMAR) dated 12/1/24 - 12/31/24, indicated R1	2 875	Corrected	3/25/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
2 875	<p>Continued From page 3</p> <p>was to be weighed every seven days on 12/11/24, 12/18/24, and 12/25/24. The record indicated on 12/11/24, a chart code of drug refused was entered and no weight was documented. On 12/18/24, a weight of 548 lbs. was documented. On 12/25/24, a chart code indicated to other / progress notes. No weight documented.</p> <p>R1's electronic medication administration record (eMAR) dated 1/1/25 - 1/31/25, indicated R1 was to be weighed weekly on 1/8/25, 1/15/25, 1/22/25 and 1/29/25. On 1/15/25 the record indicated R1 weighed 548 lbs. On 1/8/25, 1/22/25 and 1/29/25 the record indicated a chart code of other / see progress notes and no weights were documented.</p> <p>R1's eMAR dated 2/1/25 - 2/28/25, indicated R1 was to be weighed every week on 2/6/25, 2/11/25, 2/19/25 and 2/26/25. On 2/6/25, the record indicated a chart code other /see progress notes, no weight was documented. On 2/12/25 and 2/19/25, a chart code indicated drug refused, no weight was documented. On 2/26/25, a chart code indicated non-applicable, no weight was documented.</p> <p>Upon interview on 2/26/25 at 2:12 p.m., R1 stated the had not gotten out of bed since his admission date of 12/11/25. He stated the staff had attempted to get him up with a mechanical lift with a weight limit of 500 lbs. in 12/2024, but it didn't work. He stated he wasn't certain if he was too heavy for the lift as he thought he weighted around 550 lbs. but hadn't been weighed at the facility.</p> <p>Upon interview on 2/28/25 at 8:52 a.m., nursing assistant (NA)-B stated he worked with R1 almost daily and had not weighed him or witnessed him</p>	2 875		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
--------------------	--	---------------	---	--------------------

2 875	<p>Continued From page 4</p> <p>being weighed. He stated he wasn't certain how R1 would be weighed since he was not able to get up and the bed didn't have a scale.</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses included morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes.</p> <p>R2's standard order sheet dated 2/7/25, indicated R2 was to be weighed weekly.</p> <p>R2's care plan dated 1/14/25, indicated to obtain R2's weight per facility policy.</p> <p>R2's eMAR dated 1/1/25 - 1/31/25, indicated R2 was to have weekly weights on 1/10/25, 1/17/25, 1/24/25 and 1/31/24. On 1/10/25, no weight was documented. The weight for 1/17/25, chart code indicated as other/ see nursing note with no weight documented. The weight for 1/24/25, was documented as 435 lbs. and the weight for 1/31/25 indicated R2 was hospitalized.</p> <p>Upon interview on 2/26/25 at 12:56 p.m., R2 stated she had never been weighed and the facility, she felt she had lost some weight and would like to know her current weight.</p> <p>Upon interview on 2/27/25 at 8:15 a.m., licensed practical nurse (LPN-A) stated she had not weighed R2 and if the note says she did it must have been an error. She stated all residents on the transitional care unit (TCU) were to be</p>	2 875		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
2 875	<p>Continued From page 5</p> <p>weighed weekly.</p> <p>Upon observation on 3/3/25 at 1:30 p.m., R2 was lifted out of bed with a mechanical lift. The weight limit indicated on the mechanical lift was 600 lbs. R2 asked the staff what she weighed and was informed the lift she was required to use did not have a scale on it.</p> <p>Upon interview on 3/4/25 at 2:32 p.m., the director of nursing (DON) stated the residents in the TCU get weighed weekly per standing orders and she was not aware that R1 and R2 had not been weighed. She was not aware that the residents did not get weighed. They should have been weighed using the mechanical lifts.</p> <p>A facility Policy titled Weight Assessment and Intervention indicated resident weights are monitored for undesirable or unintended weight loss or gain.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review facility policy and procedures on frequency of taking residents' weights. The DON or designee could provide education on these policies and procedures to all nursing staff. The DON or designee could conduct audits of resident weights, and report the results of these audits to the Quality Assurance committee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 875		
2 920	<p>MN Rule 4658.0525 Subp. 6 B Rehab - ADLs</p> <p>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing</p>	2 920		3/25/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
--------------------	--	---------------	---	--------------------

2 920	<p>Continued From page 6</p> <p>home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review the facility failed to carry out activities for 1 of 3 (R3) dependent residents reviewed for assistance with activities of daily living (ADLs).</p> <p>Findings include:</p> <p>R3's provider order dated 2/25/25, indicated R3 was to be assisted with bathing every other day.</p> <p>R3's eMAR dated 2/1/25 - 2/28/25, indicated R3 was to be assisted with bathing every other day. No document was obtained to indicate R3 received assistance with bathing.</p> <p>Upon observation and interview on 2/28/25 at 2:18 p.m., R3 was in bed, in a hospital gown. R3 had shoulder length, thick greasy hair and a full beard. R3 stated he complained to the Physician Assistant (PA) he hadn't had his hair washed since he was in the hospital in 12/2024. He stated he hadn't been in the actual shower ever at the facility and maybe got a bed bath weekly without his hair being washed.</p> <p>Upon interview on 2/28/25 at 3:09 p.m., PA stated R3 complained to him about not getting cleaned-up at the facility and not having his hair washed since had been in the hospital in 12/2024. The PA wrote an order on 2/25/28, for R3 to be get assistance with bathing every other</p>	2 920	Corrected	
-------	---	-------	-----------	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
2 920	<p>Continued From page 7</p> <p>day.</p> <p>R3's care plan dated 3/4/24, indicated R3 was totally dependent on one staff member to provide bath or shower. The plan did not indicate the frequency of every other day bathing order from 2/25/25.</p> <p>R3's eMAR dated 3/1/25 - 3/4/25, indicated R3 was supposed to receive assistance with bathing every other day. No document was obtained that R3 received assistance with bathing.</p> <p>Upon interview on 3/4/25 at 2:32 p.m., the director of nursing (DON) stated she was not aware R3 had not been receiving assistance with baths as ordered by PA. DON confirmed R3 had complained about his hygiene and had a specialized provider order for every other day bathing.</p> <p>No policy on activities of daily living in reference to bathing was obtained upon request.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing could monitor for compliance with all direct care staff in providing resident assessed need for bathing.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days.</p>	2 920		
21230	<p>MN Rule 4658.0700 Subp. 2 B Medical Director; Implement ResCare Policies</p> <p>Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for:</p>	21230		3/25/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21230	<p>Continued From page 8</p> <p>B. implementation of resident care policies;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Medical Director (MD) assisted in the implementation and guidance of resident care policies, coordination, and admission of three bariatric residents (body weight greater than 100 pounds (lbs.) of ideal body weight) residents (R1, R2 and R3). The facility was unable to safely manage these residents due to lack of guidance upon admission and provided cares received at the facility. This had the potential to affect all 56 residents who resided at the facility.</p> <p>Findings include: R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 lbs.</p> <p>R1's care plan dated 1/2/25, indicated R1 was a total assistance of two staff and the use of a full body lift. The care plan did not indicate what type of lift was to be used or sling size.</p>	21230	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21230	<p>Continued From page 9</p> <p>R1's care plan dated 1/4/25, indicated staff were to assist R1 with ambulation and transfers, utilization of therapy recommendation. The care plan did not indicate what the therapy recommendations were.</p> <p>R1's nursing progress notes dated 12/11/24 - 3/3/25, did not indicate R1 had gotten out of bed while at the facility or why he had not gotten out of bed.</p> <p>Upon observation and interview on 2/26/25 at 2:12 p.m., R1 was laying in bed, in a hospital gown. He started weeping at the beginning of the interview as he hadn't been out of his bed since his admission on 12/11/24. R1 was waiting for the facility to have him see a podiatrist so he could bear weight. R1 did not understand why he wasn't getting out of bed to a seated position in his wheelchair since that didn't require him to weight bear.</p> <p>Upon observation and interview on 2/27/25 at 10:21 a.m., R1 requested to be transferred from his bed to his wheelchair. Nursing assistant (NA)-A stated she couldn't get R1 up because she had never gotten him up before and wanted assistance from the therapy team.</p> <p>Upon observation and interview on 2/27/25 at 10:21 a.m., occupational therapy assistant (OTA) stated R1 had some "issues" with his orders, so nobody worked with him. She stated at an unknown date in 12/2024 the staff tried to get him up with a 600 lbs. mechanical lift and he had to be laid back down in bed, so his transferring was at a standstill. She did not know what the facility would do in an emergency to safely get R1 out of his room.</p>	21230		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21230	<p>Continued From page 10</p> <p>Upon observation and interview on 2/27/25 at 11:12 a.m., five staff members attempted to transfer R1 from his bed to a wheelchair with a 600 lb. lift that uses a sling and lifts residents up and sits them down without having to stand. R1 was lifted approximately 4 inches off his bed, and he started screaming that his legs were being pinched. He was placed back down on his bed and the staff attempted to place towels between his legs and the stand and lift again. Again he screamed his legs were being pinched. He was laid back down on his bed. The OTA stated the facility would need to get a larger sling for R1 therefore there was not a way to get him out of bed. R1 began to cry and stated he did not feel safe at the facility knowing the staff did not have the capability to remove him from his bed.</p> <p>Upon interview on 2/27/25 at 12:07 p.m., the physician assistant (PA) stated the beginning of 2/2025 was the first time he saw R1 and was aware staff hadn't been walking him. Instead of having R1 leave the facility to see Podiatry he ordered an inhouse x-ray of R1's foot and there were no fractures. R1's order was changed from a non-weight bearing status to "o.k. to bear weight". PA was not aware staff had not been getting R1 out of bed at all. There was no reason he could not have gotten up to his wheelchair with a non-bearing order. "The facility should not admit a bariatric resident if they can't take care of them."</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and</p>	21230		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21230	<p>Continued From page 11</p> <p>bladder. R2's pertinent diagnoses were morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs.</p> <p>R2's nursing progress notes dated 1/11/25 - 3/3/25, did not indicate R2 had gotten out of her bed or why she hadn't gotten out of bed.</p> <p>R2's care plan dated 1/21/25 - 3/3/25, did not indicate the use of bedrails. R2's bed mobility was a two person total assistance. R2 required the use of a fully body lift for transfers. The care plan did not indicate what type of lift or sling size required.</p> <p>Upon observation and interview on 2/27/25 at 11:26 a.m., R2 pressed her call light and requested to get out of her bed to licensed practical nurse (LPN)-A. LPN-A told R2 that she was unable to get her out of bed until she spoke with the therapy department and R2 didn't have a wheelchair to sit in. LPN-A did not know what size sling to use for R2's transfer.</p> <p>Upon interview on 2/27/25 at 12:07 p.m., PA stated there was no reason R2 should not be getting out of her bed daily.</p> <p>R3</p> <p>R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not indicate what type of lift was to be used, or the size of the sling.</p> <p>R3's quarterly MDS dated 1/13/25, indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and</p>	21230		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
--------------------	--	---------------	---	--------------------

21230	<p>Continued From page 12</p> <p>morbid obesity. R3's activities of daily living were not identified.</p> <p>Upon interview on 2/27/25 2:18 p.m., R3 stated he hadn't been out of his bed since 12/2024. He stated he would like to get up, but he is transferring out the facility soon and was tired of arguing with staff every day. R3 pointed to a small wheelchair and stated he couldn't get up if he wanted to because he didn't fit in the chair.</p> <p>Upon interview on 2/27/25 at 3:39 p.m., PA stated R3 had deconditioned in the facility. In the fall of 2/2024 R3 had been walking around his room and now the staff would need to use a lift with him. He was worried about R3's skin condition and loss of muscle mass.</p> <p>Upon interview on 3/3/25 at 4:26 p.m., Medical Director (MD) stated he was aware there was an immediate jeopardy called at the facility on 2/28/25 at 12:42 p.m., due to one resident not getting out of bed. He was not aware that the immediate jeopardy was for the neglect of three residents. He stated he was not involved in admission of the residents to the facility. MD stated the facility needed to follow their facility assessment for admission and cares. MD did not know the exact criteria for admitting bariatric residents and denied the facility requesting recommendations regarding R1, R2 and R3 prior to admission, the facility did not have proper equipment and the ability or inability to fully care for the residents following admission.</p> <p>Upon interview on 3/4/25 at 1:15 p.m. PA stated he had not had any correspondence with MD. "I don't even know his name."</p> <p>Upon interview on 3/4/25 at 2:32 p.m. the</p>	21230		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21230	<p>Continued From page 13</p> <p>administrator stated MD was very responsive to text messages or phone calls. He was told everything about the immediate jeopardy and how the facility got the abatement. She stated the MD attends QAPI and would come to the facility if asked. Administrator stated the MD doesn't have involvement in the facility admissions. If the facility has concerns about whether the facility can accommodate a resident or not, they reached out to the corporate nurse not the MD. The facility did not reach out to the MD when they found out the residents were not getting out of bed.</p> <p>A policy titled Medical Director dated 3/2/25 indicated the Medical Director is responsible for all aspects of medical oversight of the facility.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator (ADM) could review the role of the medical director and the corresponding contract. The ADM could revise any corresponding systems to ensure appropriate Medical Director involvement in the admission process, implementation and guidance of policies. The ADM could include the interdisciplinary team in that review. The ADM could develop an auditing system to ensure the MD is involved in the admissions and the implementation and guidance of the care policies. The ADM could report those results to the quality assurance group for further recommendations.</p> <p>TIME PERIOD FOR CORRECTION: Twenty one (21) days.</p>	21230		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435		3/25/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
--------------------	--	---------------	---	--------------------

21435	<p>Continued From page 14</p> <p>Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to support the facility-sponsored and individual activities for residents preference to support their physical, mental and psychosocial well-being for 3 of 3 residents (R1, R2, & R3) who were dependent on staff for activities.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 12/16/24, indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis</p>	21435	Corrected	
-------	---	-------	-----------	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21435	<p>Continued From page 15</p> <p>(death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.).</p> <p>R1's progress notes dated 12/11/24 at 3:40 p.m., indicated it was very important to have books, magazines and newspapers to read. It was very important to be around animals such as pets and it was somewhat important to do things with groups of people. It was very important to go outside to get fresh air based on an activity assessment.</p> <p>R1's care plan dated 12/16/24 indicated R1 did well with one-on-one activities and was working on coming out to other activities.</p> <p>R1's progress note dated 1/6/25 at 12:00 p.m. R1 had stated "I just want someone to talk to."</p> <p>R1's activity Point of Care (POC) response history dated 1/26/25, indicated R1 did not participate in any activities over the past 30 days.</p> <p>Upon observation and interview on 2/26/25 at 2:12 p.m., R1 was laying in bed, in a hospital gown. He started weeping at the beginning of the interview as he stated he hadn't been out of his bed since his admission on 12/11/24. He felt isolated and alone. R1 had not been given activities to keep him occupied except for the television in his room, a handheld video game and a book his wife had brought for him. R1 recalled he had one one-to-one activity with the activity department early on in his admission. R1 would like to meet other residents, get outside for fresh air and attend group activities to help the time pass.</p> <p>Upon interview on 2/27/25 at 9:44 a.m., the director of activities stated she had completed a</p>	21435		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21435	<p>Continued From page 16</p> <p>one-to-one activity with R1. She stated she could not recall the date and provided an undated form indicating she had completed a one-to-one and R1 would like to try to play bingo soon. The activity director believed this encounter had taken place around a "month and a half ago" and that was the last time she had complete a one-to-one with him. She stated she couldn't get residents to group activities if the nursing staff couldn't get the residents out of bed to attend the activities.</p> <p>R2</p> <p>R2's re-admission MDS dated 2/13/25, indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses was morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes.</p> <p>R2's care plan dated 1/13/25 indicated R2 liked self-initiated activities such as reading spiritual books. No facility-initiated group activities identified.</p> <p>Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was in her bed wearing a hospital gown. She had a bible on her tray table. R2 stated the only time she had been out of her bed was during a hospital stay on or about 2/10/25. She stated her days get confused as they are all the same. R2's only activity was her bible that she borrowed from her sister. R2 would have liked to play Bingo, see the rest of the facility, and go to a bible class that nursing assistant (NA) provides. R2 had never had an activity one-to-one visit.</p>	21435		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21435	<p>Continued From page 17</p> <p>Upon interview on 2/27/25 at 9:44 a.m., the activity director stated she had not completed any one-on-one visits with R2, and nursing was unable to get R2 out of bed to attend any of the group activities.</p> <p>R3</p> <p>R3's care plan dated 3/5/24 indicated R3 needed one-to-one bedside-in-room visits and activities to if he is unable to attend out of room events. Staff was to invite/encourage R3's family members to attend activities with residents in order to support participation.</p> <p>R3's quarterly MDS dated 1/13/25 indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified.</p> <p>Upon observation and interview on 2/27/25 at 2:18 p.m., R3 was in his bed dressed in a hospital gown. R3 stated he had not been out of his bed since 12/24. He had been at the facility for about a year and had created his own activities because the facility had not given him any. He would like to get into his wheelchair and go outside as he can hear others chatting outside from his room. "I sit here all day and waste away." R3 played video games with a family member remotely every evening and his family member visited on weekends, otherwise he "diddles" with his laptop all day.</p> <p>Upon interview on 2/27/25 at 2:30 p.m., the activity director stated R3 spends his time on his laptop all day. He is unable to get out of bed and can not get to group activities. He had been</p>	21435		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
--	--	---	---

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
21435	<p>Continued From page 18</p> <p>offered books or magazines but declined. The activity director did not have an assist.</p> <p>Upon interview on 3/4/25 at 2:32 p.m., the Administrator stated all residents are to receive group or individual activities. She stated the activity director documents the activities. Any staff can perform activities, and her expectation was for staff to assist dependent residents with activities. She was not aware that staff was not getting R1, R2, or R3 out of bed to attend activities.</p> <p>A facility policy titled Activity Programs with a revision date of 1/20/25 indicated all activities are documented in the resident's medical record. The activities program is ongoing and included facility-organized group activities, independent individual activities and assisted individual activities.</p> <p>SUGGESTED METHOD FOR CORRECTION: The activity director and/or designee could review/revise policy and provide education for staff regarding resident one-to-one activities. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	21435		