Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2024

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

RE: CCN: 245028
Cycle Start Date: January 25, 2024

Dear Administrator:

On January 25, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On January 25, 2024, the situation of immediate jeopardy to potential health and safety cited at F805 was removed.

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:

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

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 $11,995; 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 January 25, 2024. 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.

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/24/24 through 1/25/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H50289106C (MN00100216) and a deficiency was issued at F805 for PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 805 SS=J	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow dietary orders for a resident who was NPO (nothing by mouth) for 1 of 3 residents (R1) reviewed for diet modifications. This resulted in an immediate jeopardy (IJ) when R1 received a regular textured meal on 1/23/24, which caused R1 to choke, lose consciousness, require the Heimlich maneuver, cardiopulmonary resuscitation (CPR), and resulted in death. The	F 805	Past noncompliance: no plan of correction required.	

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

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

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F 805	Continued From page 1 facility immediately implemented corrective action so the deficient practice was issued at past non-compliance. The IJ began on 1/23/24, when R1 received a regular textured meal, which caused R1 to choke, lose consciousness, require the Heimlich maneuver, CPR, and died as a result of choking. The administrator was notified of the past non-compliance IJ on 1/25/24, at 1:29 p.m. The facility implemented immediate corrective action on 1/24/24, prior to the start of the survey and was issued as past non-compliance. Findings include: R1's Face Sheet dated 1/22/24 indicated R1 had a diagnosis of dysphagia (difficulty in swallowing food or liquid). R1's care plan dated 1/22/24 indicated R1 was NPO, and required all nutrition through tube feeding due to dysphagia. R1's Provider Orders dated 1/22/24 indicated R1 was NPO, and received nutrition through his gastrostomy (G)- tube. R1's Occupational Therapy (OT) note dated 1/22/24 indicated R1 was on strict NPO, had limited insight into the NPO status, and was uncertain of outcomes. On 1/23/24 at 11:15 a.m., a progress note written by licensed practical nurse (LPN)-A indicated around 8:40 a.m. LPN-A was checking diabetic patients' blood sugars, and saw nursing assistant (NA)-A passing meal trays. LPN-A heard someone coughing or trying to cough from R1's	F 805		

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F 805	Continued From page 2 room. She opened the door and saw a meal tray in front of R1, and R1 trying to cough. LPN-A documented it came to her that R1 was NPO, and a meal tray should not have been in his room. She encouraged R1 to keep coughing to get whatever was blocking his airway out. R1 coughed a little, and LPN-A heard no more coughing. R1 was in obvious distress, and placed both hands around his neck. LPN-A called out for the trained medical assistant (TMA) who was in the hallway and told her someone was choking. LPN-A got behind R1 and started doing the Heimlich maneuver. No food was dislodged, and after a couple of thrusts, R1 started turning blue and sliding down. LPN-A's arms were still around R1, so she assisted R1 to the floor. LPN-A checked for a pulse and there was none, and she started CPR. LPN-A told TMA to call 911 and to get help. Nurse Practitioner (NP)-A took over CPR from LPN-A, and LPN-A applied the automated external defibrillator (AED). On 1/23/24 at 12:18 p.m. a progress note written by LPN-A indicated R1 had passed away. On 1/25/24 at 8:14 a.m., cook-A (C)-A stated he worked on 1/23/24 and he did not make a plate of food for R1 as there was no meal ticket or communication form regarding R1's meals. C-A stated staff from one east (not R1's unit) did call the kitchen and stated they were missing a tray for a resident. C-A stated the kitchen wouldn't provide any food to residents without a communication form or a meal ticket. On 1/25/24 at 8:33 a.m., LPN-A stated she heard someone coughing and opened R1's door, R1 was sitting in his room with a tray of food. LPN-A stated she knew R1 was NPO, so she got R1	F 805		

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F 805	Continued From page 3 standing and encouraged him to keep coughing. R1 stopped coughing and grabbed his throat. LPN-A stated she started doing the Heimlich maneuver, and yelled for help. She lowered R1 to the floor as he was turning blue. LPN-A stated she checked for a pulse and there was not one, so she told staff to call 911 and get help. She then started CPR. The assistant director of nursing (ADON), director of nursing (DON), and the nurse practitioner (NP)-A entered the room with a crash cart. NP-A took over CPR. LPN-A placed the AED on R1. LPN-A stated it looked like a hard-boiled egg was lodged in R1's throat, and there was one hard boiled egg on the plate. LPN-A stated staff should know what diet a resident has by looking at the chart. LPN-A stated she felt if R1 had not gotten the tray of food he would be alive right now. On 1/25/24 at 9:05 a.m., NP-A stated on 1/23/24, at around 8:30 a.m. she went into R1's room and saw LPN-A giving CPR to R1. NP-A stated R1 was pulseless and cyanotic on the floor. Emergency medical services (EMS) arrived and took over CPR, so she went to the hall and started looking at R1's chart. NP-A stated R1 had recently admitted, and she was supposed to see him that day. NP-A stated R1 had severe dysphagia and was not supposed to have anything by mouth. EMS staff then pronounced R1's death at around 9:25 a.m. NP-A stated R1 getting a meal tray contributed to his death, and if that tray was not given to him he would be alive today. On 1/25/24 at 9:13 a.m., NA-A stated she was the only one passing trays on 1/23/24. NA-A stated she thought there was a piece of paper with R1's name on it and his room number on R1's tray.	F 805		

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F 805	Continued From page 4 NA-A stated she put the meal on the side table in R1's room, and told him she would be back as she was going to look for clothes for him to wear. Once she got back to R1's room staff where in his room doing CPR. NA-A stated she was told he swallowed an egg and choked. NA-A stated she was unaware of R1's diet, and she didn't check the computer or ask the nurse what R1's diet was. NA-A stated if staff doesn't know a resident diet, they were supposed to look in the computer or ask the nurse. On 1/25/24 at 9:19 a.m., the DON stated LPN-A told her that R1 was choking on 1/23/24. She stated she ran to grab the crash cart and then started placing oxygen on R1. NP-A then took over CPR, they continued to do compressions and placed the AED on R1 until EMS arrived. EMS staff called R1's death at around 9:25 a.m. The DON stated staff should look at the meal tickets and make sure the meal is for the correct resident. The DON stated she believed this step did not happen as there was no meal ticket for R1 because he was NPO. On 1/25/25 at 9:29 a.m., the administrator stated NA-A told her she had provided R1 with the meal tray on 1/23/24. The administrator stated she talked with a dietary staff member, and was told a tray for another resident was accidentally placed on the wrong cart. The administrator stated the kitchen received a call from one east unit informing them they were missing a tray for a resident who had a regular diet. That tray was accidentally placed on the unit cart where R1 resided and it was believed it was the meal tray R1 received. The staff from the kitchen stated they did not make a meal tray for R1. The administrator stated staff passing meals were	F 805		

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F 805	Continued From page 5 expected to look at the meal ticket and make sure they are passing the correct tray to the correct resident. The administrator stated this was not completed for R1. On 1/25/24 at 10:10 a.m., the dietitian (D)-A stated the kitchen staff would not give meals out to anyone unless they had a communication form which has the provider information on it for each resident diet. The facility Dining Room Service policy revised 12/23/21, directed staff should check individual name and diet on the meal identification card/ticket to verify that the meal is served to the correct person. The past noncompliance IJ began on 1/23/24. The IJ was removed, and the deficient practice corrected by 1/24/24, after the facility implemented a systemic plan that included the following actions: -The facility re-educated all staff who pass meal trays on reading meal tickets. Re-educated nursing staff and dietary staff on diet changes and communication forms on diets. Education was completed 1/23/24 through 1/24/24. -Dietary staff reviewed and revised their plating process, now the meal tickets are checked by three kitchen staff prior to going to the unit. - The facility completed a full house audit on diet orders in point click care (PCC) and ensured the nursing care sheets and care plans matched the order and the meal ticket for all residents. -No other residents residing in the facility are currently NPO. -Interdisciplinary team members will be on the floors at mealtimes to assist with meal trays as needed.	F 805		

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F 805	Continued From page 6 - Audits initiated on 1/23/24, to ensure staff are checking meal tickets to make sure residents are receiving the correct meal tray and diet. This was completed on 1/24/24 prior to the survey. Verification of corrective action was confirmed by observation, interview, and document review on 1/24/24, from 2:35 p.m. to 4:30 p.m. and 1/25/24, from 7:00 a.m. to 1:30 p.m. Kitchen staff were observed during plating of meals and three staff where checking to ensure the diet order was correct on the meal tray. Nursing staff were observed during meal service to verify the meal tickets matched the meals on the trays, and the resident they were bring the meal to. Nursing and kitchen staff interviewed confirmed education was provided regarding checking meal tickets to ensure the right diet and right resident was getting the correct meal tray. Sign-in sheets for reading a meal ticket education confirmed education began on 1/23/24. Meal ticket and tray audits reviewed and confirmed appropriate interventions initiated and deficient practice corrected on 1/24/24, therefore this was cited at past non-compliance.	F 805		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2024

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

Re: Event ID: QXOV11

Dear Administrator:

The above facility survey was completed on January 25, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

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	00494	A. BUILDING: _____ B. WING _____	C 01/25/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/24/24 through 1/25/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was reviewed during the	2 000		

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2 000	Continued From page 1 survey: H50289106C (MN00100216) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		