Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2024

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

RE: CCN: 245028
Cycle Start Date: February 2, 2024

Dear Administrator:

On February 26, 2024, we informed you of imposed enforcement remedies.

On February 27, 2024, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 2, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 2, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 2, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $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.

If you have not achieved substantial compliance by May 2, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Chateau Health And Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 2, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care

deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 2, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 15, 2024

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

RE: CCN: 245028
Cycle Start Date: February 2, 2024

Dear Administrator:

On February 2, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 2, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 2, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 15, 2024

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

Re: Event ID: I4TI11

Dear Administrator:

The above facility survey was completed on February 2, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: ______ B. WING ______	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH AND REHABILITATION	**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	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 1/30/24 to 2/2/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 02/20/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: ______ B. WING ______	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH AND REHABILITATION	**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 1 H50289253C(MN00095490), H50289254C(MN00096649), H50289256C (MN00098642), H50289255C (MN00093125) and H50289647C (MN0098584) with no licensing order issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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 02/02/2024

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 1/30/24 to 2/2/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H50289253C (MN00095490), H50289254C(MN00096649),H50289256C (MN00098642), H50289255C (MN00093125) The following complaints were reviewe. H50289647C (MN0098584) with a deficiency issued at F740 and F741 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health	F 740		2/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/20/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING ______ B. WING ______	C 02/02/2024

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 740	Continued From page 1 encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan with appropriate services, treatments, and prevention interventions and reevaluation of intervention effectiveness for substance use disorders for 1 of 1 resident (R5) reviewed for behavioral health needs. R5's care plan lacked person-centered planning identifying mental health stressors, an interdisciplinary approach to care, and meaningful activities to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. In addition, R5 had falls related to alcohol use while in the facility. Findings include: During observation and interview on 1/31/24 at 12:18 p.m. R5 speech appeared slurred, cheeks appeared red, and R5's behavior in conversation appeared to be variable from agitated to making jokes in a quick time frame. R5 noted to have an open and consumed 1.75-liter bottle of Windsor next to his bed as well as a coffee cup R5 was drinking from. Multiple other 1.75-liter bottles of Windsor within plan site during conversation at bedside. R5 reporting drinking Windsor occasionally and was able to have it in his room and access it on his own without issue. R5 reports walking up to the liquor store up the street every few days and brings it back to the facility. During observation and interview on 1/31/24 at 12:21 p.m., licensed practical nurse (LPN)-A	F 740	F 740 R 5 care plan was reviewed and updated to include a substance abuse focus care plan with goals and interventions. R 5s fall care plan focus was updated to include ETOH abuse and monitor and report changes in vital signs to MD as ordered. A new Chemical Dependency Assessment will be completed on 2/16/2024. All current residents were reviewed and their care plan for substance use abuse was updated as needed. Future residents who admit will be screened for chemical use, a chemical dependency assessment will be conducted, and a substance abuse care plan will be initiated, and interventions implemented. The facility IDT team will be in-serviced on the Behavioral Assessment with focus on the interdisciplinary team will develop individualized interventions and approaches to avoid the behavior to occur. In addition, the IDT team and licensed nurses will review the Alcoholic Beverage procedure with emphasis on item #9 that if a resident has been found intoxicated, the physician will be notified, the resident will be sent to the emergency department for evaluation and alcohol will be confiscated and disposed. Social services and/or designee is responsible for compliance.	

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 02/02/2024

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 740	Continued From page 2 confirmed R5 had alcohol in his room, however, was unaware of how much he consumes or how many bottles were in his room. During observation LPN-A confirmed 23 bottles of 1.75-liter Windsor with 19 empty, one full unopened, and one partially consumed. LPN-A reported to be surprised by the amount of alcohol identified. LPN-A stated R5 drinks in the facility and it is a pretty common thing for him to get drunk. LPN-A was not aware of an order for him to have alcohol, but reported the nurse practitioner was aware he drinks as LPN-A had reported concerns to NP related to drinking and falling. LPN-A was unaware of a policy for alcohol consumption in the facility. LPN-A reported for prevention and treatment A.A. had been offered before. LPN-A was unaware of how the facility was to be managing behaviors, triggers, or psychosocial component to alcohol abuse and other than reporting to NP to be unsure how to manage alcohol dependance. During observation and interview on 1/31/24 at 1:54 p.m. acting director of nursing (ADON)-B during observation of R5's room ADON-B reported to be shocked about the amount of alcohol in R5's room. ADON-B stated the alcohol was in plain sight and any staff member would be providing cares such as changing the bed or going up to R5's bed would be able to see alcohol bottles. ADON-B reported it was as if R5 was under the influence once entering his room due to on and off erratic mood and appearance. ADON stated R5 had a history of alcoholism, however, was unaware of him drinking in the facility. Facility staff had a concern of R5's potential to drink and were to be watchful of it and notify (ADON)-B or administrative staff if concerns arose. The prevention and treatment for substance use was	F 740	Audits on IDT team chemical dependency assessment and individualized substance abuse care plan development and interventions will begin 2x week for 2 weeks, then monthly for sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will present audit results at QAPI for review and recommendation. Compliance: 2/21/2024	

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 02/02/2024

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

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to be watchful of R5's behaviors. ADON-B was not made aware of any report of R5 drinking. Upon review of care plan the nursing staff were responsible for goal of R5's goal of drinking less daily. ADON-B was unaware of how the goal was being managed. ADON-B reported its the social worker's responsibility to manage psychosocial needs and community resources.

R5's face sheet printed 2/5/24 identified R5 admitted to the facility on 4/28/23 with a diagnosis that included alcohol abuse and other psychoactive substance abuse, in remission.

R5's therapeutic recreation/activity evaluation dated 4/29/23 identified R5 to have recreation interests to include groups, one to one, day/activity room and inside and out of the facility. R5 was interested in active activities and prefers morning time. R5 enjoys watching TV and requires cues/reminders for participation. Overall activity summery identified for staff to encourage, remind, and involve to group activity of choice.

R5's social service admission record dated 5/1/23 identified R5 had past or present chemical/addiction use health issues, R5 had completed an outpatient chemical dependency/addiction program and had seen a psychologist in the past year. R5 had drinks containing alcohol in the past year 2-3 times a week and R5 smoked. Date of last treatment, number of times resident had received treatment and the amount of drinks containing alcohol in a typical day were not completed.

R5's admission MDS dated 5/5/23 identified R5 admitted to the facility 4/28/23 and had moderate cognitive impairment and behaviors were not

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present. It was very important for R5 to listen to music, to be around animals such as pets, somewhat important to do things with groups of people, somewhat important to do favorite activities and very important to get fresh air when the weather is good.

R5's care plan dated 7/21/23 identified R5 was independent for meeting emotional, intellectual, physical, and social needs. R5's goal was to attend/participate in activities of choice twice weekly by next review date. Staff are to invite the resident to activities, to provide the resident materials for individual activities as desired and provide with activity calendar and notify R5 of any changes to the activities.

R5's care plan dated 8/2/23 identified R5 had substance abuse/dependence of alcohol as evidenced by residents drinking. Goal was to drink less daily. Staff are to provide with information regarding community resources for ongoing support services and treatment options prior to discharge.

R5's progress note dated 8/4/23 identified social service talked to resident about alcoholics anonymous (AA) and other treatment options. Resident declined.

R5's incident report dated 10/11/23 indicated R5 had an unwitnessed fall and R5 smelt of alcohol and was slurring words and unable to get up from the ground. Nurse practitioner (NP) was updated and orders to send to the hospital for detox and at 9:45 p.m. R5 was escorted via stretcher to hospital.

R5's care plan dated 10/26/23, included R5 had a

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F 740	Continued From page 5 risk for safety and there was a potential for abuse due to the use of medications, alcohol. Staff were to remove R5 from potentially dangerous situations. R5's encounter note dated 11/17/23 identifies R5 was seen by medical doctor (MD) and staff are to continue current meds for alcohol abuse and other psychoactive substance abuse. Staff are to encourage patient to engage in healthy lifestyle behaviors such as engaging in social activities, exercising (PT/OT), eating well, and following care plan. Will continue to monitor patient and work with nursing staff collaboratively to work towards positive patient outcomes. R5's Chemical Dependence Health assessment dated 1/11/24 identified R5 required the assessment to be completed for determination of chemical health services need. R5 substance use was alcohol with 2-4 drinks a day every day for 30 years. R5 had no withdrawal experience in the last 30 days, unknown circumstance of relapse and specific problems or behaviors exhibited include falling and the concerns were being addressed by a health care professional. R5 did not recognize the need for substance use and was not willing follow treatment recommendations, was able to understand written treatment materials and based off the assessment and information from collateral sources the facility will implement the following: a room search to be conducted per facility policy and the facility will hold medications per MD order. The concerns need to be referred to an appropriate health care professional was not completed. R5's progress note dated 1/9/24 identified R5 had	F 740		

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an incident of a fall and alcohol could be smelled from patient breath, however R5 denied drinking. Director of nursing (DON), nurse practitioner (NP) and emergency contact was notified.

R5's therapeutic recreation activities assessment dated 1/15/24 indicated its very important for R5 to have a family or close friend involved in discussion about his care. It is somewhat important for R5 to do things with groups of people, it is very important to do his favorite activities and its very important to go outside to get fresh air when the weather was good.

R5's progress noted dated 1/10/24 identified at 7:30 staff found patient pouring alcohol from big brown bottle into coffee mug, patient stated "it's never too early to drink." PM nurse updated.

R5's progress noted dated 1/11/24 identified staff observed R5 wobbling and almost fall to the ground but did not. R5 appeared drunk. Staff assisted back to bed and advised R5 to call for help when wanting to get out of bed and call light within reach.

R5's progress note dated 1/12/24 indicated R5 continues to drink alcohol and could not sit up form laying to sitting in the bed without falling back down. R5 continues to deny consuming any alcohol even though writer saw him.

R5's progress note dated 1/31/24 identified R5 was seen drunk, and staff found multiple empty bottles of alcohol. Staff took away all the bottles from room when R5 was outside. R5 went to the nurse's station to ask for the bottles. Provider was updated. Order to monitor and check vitals was given. R5 refused vital checks. Will continue to

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monitor and update status.

During interview on 1/31/24 at 1:34 p.m. nursing assistant (NA)-A stated R5 prefers to stay in his room and watch TV and goes out in the community and outside to smoke for activities. NA-A was unaware of R5's history of drinking or if R5 consumed alcohol in the facility and was unaware of R5's history, trauma, or any concerns with triggers.

During interview on 1/31/24 at 4:45 p.m. activities director (AD)-A stated to be new to the facility and her role in the facility is to coordinating work and engage residents to promote life enrichment and generalized positive wellbeing. AD-A reports participating in completing assessments for routines and activities and individualizes this based off the residents needs and desires. AD-A reports being notified if any changes or triggered events have happened where activities may be beneficial to promote wellbeing. AD-A was not aware of hearing about anything related to R5 and had not met him or engaged with him with activities.

During interview on 2/2/24 at 9:37 a.m., registered nurse RN-A reported R5's activities and preferences are to mostly stay in his room and go out to smoke. RN-A was unaware of what R5 enjoys doing for mental health other than drinking and smoking. RN-A was unaware of trauma history or R5's military background. RN-A reported a facility activities director, however, was unaware if R5 participated in activities. RN-A was unaware how to manage residents who have alcohol dependency.

During interview on 1/31/24 at 3:42 p.m. R5

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reported being upset that the facility staff came in and took all the alcohol that was in his room when he was outside and did not talk to him about it. R5 reported he had been drinking in his room for months and staff have never had an issue with it before. R5 reported drinking a 1.75-liter Windsor bottle ever three days for years and he had been consuming the same amount in the facility. R5 reported liking to golf, however, was unable to anymore due to his family selling all his belongings while in the hospital. R5 reported the situation made him feel depressed and like "horseshit". R5 declined participating in activities at the facility and leaves his room to go outside to smoke or go to the liquor store.

During interview on 2/2/24 at 8:10 a.m. social worker (SW)-A stated R5 was admitted to the facility due to drinking and was found unresponsive and was admitted to the hospital, additionally family had concerns related to failure to thrive and inability to care for himself. R5 participated in therapy and was not drinking in the facility at the time of admission. R5 became independent with mobility in July of 2023. SW-A stated to be aware of R5's alcohol use at time of admission by reports from family and the social service admission assessment dated 5/1/23. SW-A reported there was no documented evidence of how the facility addressed the chemical dependency/addiction identified in the assessment. SW-A reported the action of addressing stressors and triggers related to alcohol consumption was having a conversation on 8/4/23 and nothing at that time was identified. During the conversation AA was offered as well as other treatment options and R5 declined. SW-A stated there may have been something in the facility which triggered the conversation,

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F 740	Continued From page 9 however unsure what or why the conversation was initiated. SW-A stated nothing was done to maintain R5's sobriety, additionally following reported occurrences of R5 drinking in the facility there was not ongoing support to services documented. The first documented occurrence for R5 being under the influence was a progress note dated 10/11/23 R5 smelt like alcohol. SW-A declined the care plan being review and revised when it was identified R5 was drinking in the facility or at the change of condition when R5 was sober to consuming alcohol. SW-A declined completing any trauma assessments for R5, however was aware he had a military background. R5's care plan did not identify alcohol or substance abuse until 8/2/23 and was based off the fact he had been sober; however, it was not individualized or comprehensive. SW-A reported verbally offering R5 ACP (associated clinic of psychology) services, however R5 declined. Psychosocial wellbeing and mental health were being addressed by the facility posting activity calendars R5 could attend, however it did not meet the individualized needs for someone with a background of alcohol abuse. During interview on 2/1/24 at 9:42 a.m. acting director of nursing (ADON)-A stated the chemical dependency health assessment was new to the facility and was not implemented until November or December of 2023. ADON-A stated something should have been done to address the chemical dependency identified in the admission assessment. ADON-A stated R5 should have been more closely monitored related to alcohol dependency. During interview on 1/31/24 at 2:19 p.m. Administrator, SW-A and ADON-A stated to be	F 740		

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F 740	Continued From page 10 aware of R5's history of alcohol abuse and there had not been any issues or awareness with R5 drinking in the facility. After reviewing R5's consumption in the facility staff confirmed the care plan was not appropriate or individualized to meet R5's needs. AA was offered, however a lack of behavioral health plan to attain or maintain psychosocial wellbeing. Additionally, there were no interventions placed following the occurrences of R5 drinking in the facility. The facility policy and procedure titled Behavioral Assessment, Intervention and Observing policy dated 10/18/21 indicated staff are responsible for the following components behavioral symptoms, behavioral health services, minimal resident complications, and the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. And, included assessment, cause identification, management/interdisciplinary team, resident and/or family/representative involvement, interventions individualized. Interventions and approaches will be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior, precipitating factors, or situations. Policy titled Alcoholic Beverages dated 10/24/23 indicated the purpose of this procedure is to establish uniform guidelines concerning the administration of alcoholic beverages. 1. A physician ' s order must be received before any alcoholic beverage may be administered to a resident. 2. Should such an order be received, the Nurse Supervisor receiving the order must contact the	F 740		

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F 740	Continued From page 11 pharmacist to determine if any of the resident ' s current medications would interact with alcohol. 3. Should there be a medication that would interact with the alcohol, the Nurse Supervisor must inform the physician of such medication. 4. Record and follow the physician ' s instructions. 6. The Nurse Supervisor receiving the alcoholic beverage must label the bottle. 7. The label must contain: a. The resident ' s name and room number. b. The exact dosage to be administered. c. The time(s) each dose is to be administered. d. The name of the physician. 8. Alcoholic beverages must be treated as medication and stored in the medicine room. 9. Any resident found intoxicated, the nurse will notify the physician and request medication hold parameters. The resident will be monitored every 15 minutes until the provider responds with frequency order. A risk management incident will be created, and the resident care plan must be reviewed and adjusted as needed. 10. Alcohol that is brought into the facility that is not authorized by the physician will be confiscated and disposed of.	F 740		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 741		2/21/24

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accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
[as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].

§483.40(a)(2) Implementing non-pharmacological interventions.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure staff were trained to appropriately to respond to a residents need of an active substance use disorder and to address a history of trauma for 1 of 1 resident (R5) reviewed for behavioral health needs. The facility assessment identified the ability to serve residents with mental health disorders and staff did not have appropriate competencies and skills sets to ensure residents attain or maintain the highest practicable physical, mental, and psychosocial wellbeing.

Findings include:

The Facility Assessment Tool reviewed 1/2024 identified the resident population to have individuals with behavioral health need, active or current substance use disorders, and psychiatric

F 741

F 741
R 5 will have a Trauma Informed Care Assessment completed and a trauma care plan initiated. R 5 care plan was reviewed and updated to include a substance abuse focus care plan with goals and interventions. All current residents will have their trauma care assessment reviewed and their trauma care plan reviewed and updated as needed. Future residents will have a Trauma Informed Care Assessment completed and a care plan initiated and individualized interventions implemented. The IDT team, licensed nurses and nurse aides were in-serviced on the Alcoholic Beverage procedure with emphasis on item #9 that if a resident has been found intoxicated, the physician will be notified,

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F 741	Continued From page 13 and mood disorders. Staff training education and competencies identified it is necessary to provide the level and types of support and care needed for the resident population. Including staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies and to consider the following competencies that are not on the inclusive list such as caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder and implementing nonpharmacological interventions as identified in the State Operations Manual, Appendix PP at Nursing Services § 483.35 and Behavioral Health Services § 483.40(a). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: 483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e). R5's face sheet printed 2/5/24 identified R5 admitted to the facility on 4/28/23 with a diagnosis that included alcohol abuse and other psychoactive substance abuse, in remission. R5's social service admission record dated 5/1/23 identified R5 had past or present chemical/addiction use health issues, R5 had completed an outpatient chemical dependency/addiction program and had seen a psychologist in the past year. R5 had drinks containing alcohol in the past year 2-3 times a week and R5 smoked. Date of last treatment,	F 741	the resident will be sent to the emergency department for evaluation and alcohol will be confiscated and disposed. The IDT team will also be in-serviced on the Behavioral Assessment, Intervention and Observation policy and procedure that emphasizes approaches from a detailed assessment and underlying causes. The facility will also complete education on Behavioral Management in SNF with competency. Social Services and/or designee responsible for compliance. Audits on IDT team chemical dependency assessment and individualized substance abuse care plan development and interventions and Behavioral Health Management education completion will begin 2x week for 2 weeks, then monthly for sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will present audit results at QAPI for review and recommendation. Compliance: 2/21/2024	

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number of times resident had received treatment and the amount of drinks containing alcohol in a typical day were not completed.

R5's care plan dated 8/2/23 identified R5 had substance abuse/dependence of alcohol as evidenced by residents drinking. Goal was to drink less daily. Staff are to provide with information regarding community resources for ongoing support services and treatment options prior to discharge.

R5's care plan dated 10/26/23, included R5 had a risk for safety and there was a potential for abuse due to the use of medications, alcohol. Staff were to remove R5 from potentially dangerous situations.

R5's encounter note dated 11/17/23 identifies R5 was seen by medical doctor (MD) and staff are to continue current meds for alcohol abuse and other psychoactive substance abuse. Staff are to encourage patient to engage in healthy lifestyle behaviors such as engaging in social activities, exercising (PT/OT), eating well, and following care plan. Will continue to monitor patient and work with nursing staff collaboratively to work towards positive patient outcomes.

Email communication from 1/31/24 from 2:56 p.m. to 4:18 p.m. from ADON-A to NP indicated:
-ADON: The surveyor is here asking about R5 and his alcohol consumption. He has 23 bottles of alcohol with two of them with liquor in them. I am having the nursing team assess him now. Is there anything else you would like for us to do?
-NP: Can we legally remove the liquor? I have gotten conflicting info from the previous DON. We should monitor for withdrawal and notify the

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provider immediately.
-ADON: Yes, we can remove the liquor if the resident allows. He allowed us to remove it from his room.
-NP: Thank you!

R5's progress note dated 1/31/24 identified R5 was seen drunk, and staff found multiple empty bottles of alcohol. Staff took away all the bottles from room when R5 was outside. R5 went to the nurse's station to ask for the bottles. Provider was updated. Order to monitor and check vitals was given. R5 refused vital checks. Will continue to monitor and update status.

R5's order dated 1/31/24 directed staff to monitor for alcohol withdrawal symptoms of anger, headache, tremors, seizures, elevated heart rate and report this to the provider immediately. Staff are to monitor every shift for alcohol withdrawal related to alcohol abuse. R5's orders were updated 2/1/24 to monitor every four hours.

R5's order dated 2/1/24 directed staff to use Ativan 1 milligram (ml) tablets, give 1/2 tablet by mouth with any withdrawal symptoms every 2 hours as needed.

During an interview on 1/31/24 at 12:21 p.m., licensed practical nurse (LPN)-A stated R5 drinks in the facility and it is a common for R5 to get drunk in the facility. LPN-A confirmed he had alcohol in his room, however, was unaware of how much he consumes or how many bottles were in his room. LPN-A was not aware of an order for him to have alcohol. R5 was unaware of the facility drug and alcohol policy. LPN-A reported a time where the facility had removed the alcohol, however due to resident rights gave it

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F 741	Continued From page 16 back. LPN-A was aware there were medications which would have contraindications with alcohol, however, was not sure if there were any concerns with any medications R5 was on. LPN-A was not aware of behaviors related to alcohol abuse, triggers, psychosocial training, and no other training related to alcohol use or withdrawal. LPN-A was unaware of what was in place to assess and monitor consumption use. LPN-A stated residents who consume alcohol should have an order and without it, it would be against medical advice. LPN-A was unaware of clinical institute withdrawal assessment for alcohol (CIWA)12 protocol. During an interview on 1/31/24 at 1:34 p.m. nursing assistant (NA)-A stated to be unaware of R5's history of drinking or if R5 consumed alcohol in the facility and was unaware of R5's history, trauma, or any concerns with triggers. NA-A reported there to be some sort of training on behavior recently, however, was unable to relate it to a situation where a resident had an alcohol addiction. NA-A was unaware if there were any residents who consumed alcohol in the facility. During an interview on 1/31/24 at 5:09 p.m. registered nurse (RN)-B was unaware R5 had a diagnosis of alcohol abuse and was surprised to learn by the facility on this day and was instructed to monitor him due to facility staff finding alcohol in his room. Staff were to monitor R5 by following the order placed by the doctor. RN-B reported to be able to identify if someone had a substance abuse issue related to alcohol by smelling it, would typically see signs of tremoring and sweating. If you were to observe these things or increased agitation, you would call the provider. RN-B reported residents are allowed to drink but	F 741		

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F 741	Continued From page 17 needs to be held at the nurse's station and there needs to be an order by the provider. RN-B did not have training for residents with alcohol/drug dependency or trauma. RN-B was unaware of R5's preferences, triggers or if R5 engaged in activities. RN-B reported there was no medication on board at the time the alcohol was removed from the resident's room. RN-B was unaware of CIWA protocol. During interview on 1/31/24 at 4:00 NA-B was unaware of any training by the facility related to behavioral health or chemical dependency concerns or any issues or behaviors which may be related to the diagnosis of alcohol abuse. During interview on 1/31/24 at 416 p.m. NA-C did not have training related to behavioral management or alcohol dependency. NA-C reported sometimes residents get drunk, however they do outside of the facility. In that situation you let the nurse know. If you see alcohol, you call the DON and administrator, but they have to have proof to see they were drinking. During interview on 1/31/24 at 4:45 p.m. activities director (AD)-A stated the role of being an activities director was new to her, however, had done previous work with coordination of activities. AD-A was not aware of any training by the facility related to psychosocial wellbeing for a resident with an active substance use disorder, history of trauma and was unaware of residents who may have alcohol dependency. During interview on 2/2/24 at 8:10 a.m., worker (SW)-A expressed concerns related to training within the facility. SW-A started as a temporary support staff in June and hired on full time	F 741		

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F 741	Continued From page 18 10/20/23. SW-A reported she had no formal training with behavioral health or how to manage alcohol abuse care plans, interventions, or assessments. SW-A expressed concerns regarding a lack of experience, knowledge and background surrounding management of treatment. SW-A reported training was not initiated until December of 2023 when a new Chemical Dependence Health assessment was rolled out and still feels the training to be insufficient. During interview on 2/2/24 at 10:34 a.m. human resource representative (HR)-A was in charge of the general orientation, however, does not do competencies or floor training. General orientation includes a slideshow which identifies basic behavioral interventions. For agency staff the slide show either gets sent to them or printed in a folder and staff sign off on acknowledging reading the material. Staff orientation checklist process changed 12/29/23 for agency staff with a form titled "agency staff general orientation" the form identifies that list items must be reviewed prior to the start of the shift. Staff are to familiarize themselves with the policies and procedures within the facility electronic policy folder. Form identified chemical and substance abuse was addressed. Facility was unable to show completed and signed copies by agency staff. During interview on 2/1/24 at 10:25 a.m. nurse practitioner (NP) stated R5 was admitted to the facility due to adult failure to thrive and septic related to alcohol abuse. R5 had made remarkable progress with therapy and got to the point of being independent and was sustaining from alcohol. In October was the first occurrence	F 741		

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F 741	Continued From page 19 of being notified of R5's alcohol use in the facility and was getting intoxicated and falling. NP reported recently R5 continued to have alcohol in his room, however, was not aware of getting to the point of inebriation and was not having falls. NP was not aware of the rules when it came to alcohol and residents having it int the room but was told prior staff are not allowed to go into the room and remove it. Staff are to know how to manage alcohol withdrawal symptoms and the need of being transferred to a higher level of care by notifying NP if anything came up related to monitoring of the order placed and NP would give the direction of higher level of care. NP reported residents would typically be tapered with Ativan and initiate alcohol withdrawal assessment scoring guidelines (CIWA) protocol. NP explained the CIWA protocol was a clear objective scale which assesses the signs and symptoms of withdrawal. NP stated medical management of withdrawal was important and if it was not completed appropriately there was a risk of seizures. NP reported to be unaware if the alcohol was removed from room and was the reason Ativan was not initiated on 1/31/23 and CIWA protocol was not advised. NP was aware they were working on it, but not that it was completed. During interview on 2/1/24 at 9:42 a.m. ADON-A stated the orientation packet was not in depth and the behaviors are more related to Alzheimer's/dementia and not related to chemical dependency or alcohol abuse. ADON-A was in charge of on the floor training, competencies, and Relias online modules. ADON-A reported agency staff in the building would not be trained on how to comprehensively manage psychosocial wellbeing for a resident with an active substance	F 741		

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F 741	Continued From page 20 use disorder and was a concern as they would not know what to do. Staff are expected to notify the physician if they see a resident appear drunk. They would identify this if the resident smelt of alcohol, had slurred speech, wobbly gait, or erratic behavior. The physician was to put in an order to direct the staff on what to do. In this case the direction was "monitor for alcohol withdrawal symptoms such as anger, headache, tremors, seizures, elevated heart rate and report to the provider immediately. Every shift monitors for alcohol withdrawal". When and how the monitoring of resident safety was physician driven and dependent on the order. Vital signs should be all within normal range and staff are to contact the physician with changes. ADON-A reported there are standing orders for Narcan (medication for opioid overdose) if needed, however was not sure if facility staff have been trained on Narcan. Staff are to know if residents require a higher level of care such as the hospital, by the direction of the NP or if they are not coherent or have seizure like activity. The decision to remove the alcohol out of the room was directed by the NP via email communication with ADON-A. Additionally the direction to remove the alcohol and not taper was driven by the NP as well. ADON-A reported decision of removing the alcohol without R5's knowledge was inappropriate and against what the direction was by the NP. ADON-A reported R5's care should be under a licensed staff member who had appropriate education to provide care in the facility for alcohol withdrawal and chemical dependency and behavioral health. During subsequent interview with ADON-A on 2/2/24 at 11:50 a.m., reported the training for all staff was not comprehensive to meet the needs of residents with alcohol dependency. The training failed to address	F 741		

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F 741	Continued From page 21 specialized training related to withdrawal and signs and symptoms of alcohol abuse, additionally does not have any competencies or acknowledgement of completed training. Policy titled Behavioral Health services dated 10/18/21, the purpose is for residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 1. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. 2. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. 3. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder(s) will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. 4. Staff must promote dignity, autonomy, privacy, socialization, and safety as appropriate for each resident and are trained in ways to support residents in distress. 5. Staff training regarding behavioral health services includes, but is not limited to: a.recognizing changes in behavior that indicate psychological distress.b. implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to their needs; c. monitoring care plan interventions and reporting changes in condition; and d. protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post-traumatic stress disorder. 6. Behavioral	F 741		

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F 741	Continued From page 22 health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care. 7. Staff are scheduled in sufficient numbers to manage resident needs throughout the day, evening, and night.	F 741		