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,

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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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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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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 14, 2025, we informed you of imposed enforcement remedies.

On March 7, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) , as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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, will remain in effect.

This Department continues to recommend that CMS impose a 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.

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

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.

As we notified you in our letter of March 14, 2025, in accordance with Federal law, as specified in the Act at

Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2025.

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

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 - 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 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

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)

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.

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 03/07/2025

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 3/6/25 and 3/7/25, 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. The following complaints were reviewed: H50289221C (MN00111159), H50289463C (MN00111046), and H50289462C (MN00110939), with deficiencies cited at F656 and F677. 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 656 SS=D	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	F 656		3/25/25

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.

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F 656	Continued From page 1 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 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to include residents bathing preferences and bathing in the care plan	F 656	R 1 is currently in the hospital. Upon return, R1□s care plan will be comprehensively reviewed, and bathing	

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F 656 Continued From page 2

for 2 of the 3 residents (R1, R3).

Findings include:

R1

R1's face sheet dated 3/6/25, identified R1 had diagnoses of morbid obesity (extremely overweight) and weakness.

R1's admission Minimum Data Set (MDS) dated 1/15/25, identified R1 had no cognitive impairment. R1 required substantial/maximum assistance for bathing activities, dependent on staff for lower body dressing, and substantial/maximum assistance for upper body dressing.

R1's care plan dated 1/14/25, identified a focus of current functional performance. Interventions included total one person assist for dressing, extensive assist for bed mobility, transfers total assist of two people. R1's care plan did not identify R1's bathing preferences or level of assistance R1 required for bathing.

R3

R3's face sheet dated 3/6/25, identified R3 had diagnoses that included quadriplegia (paralysis that affects all four limbs of the torso), legal blindness, non-traumatic intracerebral hemorrhage (brain bleed).

R3's quarterly MDS dated 2/16/25, identified R3 could not make himself understood, could not communicate with others, R3 was blind, and had an inability to make cognitive decisions for self. R3's functional ability assessment was not

F 656

preference and assistance will be updated as needed. R3 discharged from the facility on 3/19/2025. Current residents care plans were reviewed for bathing preferences and bathing assistance and updated as needed. Future residents will have their bathing preferences and bathing assistance interventions implemented through the Personalized Care Plan and Current Functional Care Plan focus categories.
Licensed nurses will be in-serviced on the Comprehensive Person-Centered Care Plan with emphasis on developing interventions and timetables to meet the resident�s physical, psychological and functional needs. The IDT team will be in-serviced on the Care Planning Policy that emphasizes that the IDT team is responsible for the development of resident care plans based on the resident assessments.
Director of Nursing and/or designee will be responsible for compliance.
Audits on resident bathing assistance in the ADL care plan and bath preference care plan intervention 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

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F 656	Continued From page 3	F 656		

completed.

R3's care plan dated 2/5/25, identified R3 required two person physical assist for dressing, bed mobility, transfers, and toileting. R3's care plan did not identify bathing assistance or bathing preferences.

During an interview on 3/7/25 at 9:19 a.m., nursing assistant (NA)-B stated he would look in the care plan or kardex to direct the plan of care for the residents.

During an interview on 3/6/25 at 11:36 a.m., registered nurse (RN)-A stated the assistant director of nursing (ADON) and director of nursing (DON) created and updated the care plans for residents. ADON stated the care plan should include the assistance required for bathing and what the residents preference is for bathing.

During an interview on 3/7/25 at 12:50 p.m., DON stated it was her expectation that bathing preferences be included in the care plan along with the level of assistance required for bathing. DON stated it was a toss-up between the social worker and nurse manager (which would be DON or ADON) who is responsible for interventions being added to the care plans. The DON expected these interventions would be included in the care plan.

The facility Comprehensive Person-Centered care plan policy dated 1/20/2025, identified a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs would be developed and implemented for each resident. Assessments of

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F 656	Continued From page 4 residents are ongoing and care plans revised as information about the residents and the residents conditions change. The interdisciplinary team reviews and updates the care plan. The facility Care Planning Interdisciplinary Team policy dated 1/20/2025, identified the interdisciplinary team is responsible for the development of resident care plans. The care plans are based on the resident assessments.	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 observation, interview, and record review the facility failed to complete at a minimum, weekly baths/showers for residents for 2 of 3 residents (R1, R2) which resulted in the residents not being bathed for an extended time period. Findings include: R1 R1's face sheet dated 3/6/25, identified R1 had diagnoses of morbid obesity (extremely overweight) and weakness. R1's admission Minimum Data Set (MDS) dated 1/15/25, identified R1 had No cognitive impairment. Required substantial/maximum assistance for bathing activities. Dependent on	F 677	R 1 is currently in the hospital. Upon return, R 1 weekly bath/shower assessment will be scheduled for nurse completion weekly. R 2 will have a bath, and a weekly bath/shower assessment performed on March 14, 2025. All current residents, their weekly bath assessment schedules were reset on March 8, 2025 per resident preference. Resident refusals will be documented. Future residents who admit to the facility will have a weekly bath assessment completed per facility policy. Licensed nurses and nurse aides will be in-serviced on the Shower/Tub Bath policy with emphasis on observing and then recording the date, how the resident tolerated the shower and if there is resident refusal the license nurse will reapproach and record acceptance or	3/25/25

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F 677	Continued From page 5 staff for lower body dressing and substantial/maximum assistance for upper body dressing. R1's care plan dated 1/14/25, identified a focus of current functional performance. Interventions included total one person assist for dressing, extensive assist for bed mobility, transfers total assist of two people. R1's care plan did not identify R1's bathing preferences or how much assistance R1 required with bathing. R1's point of care charting dated 3/6/25, identified bathing was completed by a nursing assistant on 1/14/25, 1/18/25, 1/25/25, and 2/22/25. R1's point of care charting dated 3/6/25, identified bathing was not completed by a nursing assistant on: 1/10/25- resident not available. R1 had no documentation that bathing was completed by nursing assistants on: 2/1/25, 2/8/25, and 2/15/25. R2 R2's face sheet dated 3/6/25, identified diagnoses of dementia, hemiplegia (weakness in one side of the body) and hemiparesis (severe loss of strength or paralysis) affecting non-dominant left side, transient ischemic attack (short period of symptoms similar to a stroke). R2's quarterly MDS dated 2/2/25, identified R2 had no cognitive impairment. R2's functional ability was not completed. R2's care plan dated 8/17/24, identified R2 was dependent on staff for showering and preferred to	F 677	refusal. Director of Nursing and/or designee will be responsible for compliance. Audits on resident weekly bath assessment completion and resident documented refusals 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	

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HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

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F 677	Continued From page 6 shower twice a week on the PM shift. R2's point of care charting dated 3/6/25, identified bathing occurred on 1/3/25, 1/7/25, 1/10/25, 1/17/25, 1/21/25, 1/24/25, 1/31/25, 2/4/25, 2/7/25, 2/14/25, 2/18/25, 2/21/25, and 2/28/25. R2 had no documentation that bathing occurred on 1/14/25, 1/28/25, 2/11/25, and 2/25/25. During an interview on 3/6/25 at 3:08 p.m., nursing assistant (NA)-A stated all the residents are scheduled for a shower/bath on the day and evening shifts. They are charted in point of care when the bath is given. During an interview on 3/6/25 at 11:36 a.m., registered nurse (RN)-A stated nurses have a weekly skin assessment that would be completed when the shower occurred. During an interview on 3/6/25 at 11:40 a.m., assistant director of nursing (ADON) stated NA's are to document in point of care charting when bathing occurred. The NA's are supposed to alert the nurse if the shower/bath was refused. ADON verified that R1 was missing documentation of bathing from all other weeks. During an interview on 3/7/25 at 12:50 p.m., Director of nursing (DON) stated it was the expectation that bathing occurred weekly on all residents and that refusals be documented in the chart and followed through as appropriate by licensed staff. The facilities Shower/Tub bath policy dated 2/23/24, identified documentation should be recorded in the residents activities of daily living	F 677		

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	245028	A. BUILDING ______ B. WING ______	C 03/07/2025

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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F 677	Continued From page 7 (ADL) record and/or medical record: date and time shower/tub bath was performed, name and title of individual completing shower/tub bath, all assessment data obtained during the shower/tub bath, how the resident tolerated the shower/tub bath, if the resident refuses the reason why and the intervention taken.	F 677		

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: EO6T11

Dear Administrator:

The above facility was surveyed on March 6, 2025 through March 7, 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.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: ______ B. WING ______	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH AND REHABILI	**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 3/6/25 and 3/7/25, 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	2 000		

Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1	2 000		

and identify the date when they will be completed.

The following complaints were reviewed: H50289221C (MN00111159), H50289463C (MN00111046), and H50289462C (MN00110939) with licensing orders issued at 0570.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is

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2 000	Continued From page 2 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		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to include residents bathing preferences and bathing in the care plan for 2 of the 3 residents (R1, R3). Findings include: R1 R1's face sheet dated 3/6/25, identified R1 had diagnoses of morbid obesity (extremely	2 570	Corrected	3/25/25

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2 570	Continued From page 3	2 570		

overweight) and weakness.

R1's admission Minimum Data Set (MDS) dated 1/15/25, identified R1 had no cognitive impairment. R1 required substantial/maximum assistance for bathing activities, dependent on staff for lower body dressing, and substantial/maximum assistance for upper body dressing.

R1's care plan dated 1/14/25, identified a focus of current functional performance. Interventions included total one person assist for dressing, extensive assist for bed mobility, transfers total assist of two people. R1's care plan did not identify R1's bathing preferences or level of assistance R1 required for bathing.

R3

R3's face sheet dated 3/6/25, identified R3 had diagnoses that included quadriplegia (paralysis that affects all four limbs of the torso), legal blindness, non-traumatic intracerebral hemorrhage (brain bleed).

R3's quarterly MDS dated 2/16/25, identified R3 could not make himself understood, could not communicate with others, R3 was blind, and had an inability to make cognitive decisions for self. R3's functional ability assessment was not completed.

R3's care plan dated 2/5/25, identified R3 required two person physical assist for dressing, bed mobility, transfers, and toileting. R3's care plan did not identify bathing assistance or bathing preferences.

During an interview on 3/7/25 at 9:19 a.m.,

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2 570	Continued From page 4	2 570		

nursing assistant (NA)-B stated he would look in the care plan or kardex to direct the plan of care for the residents.

During an interview on 3/6/25 at 11:36 a.m., registered nurse (RN)-A stated the assistant director of nursing (ADON) and director of nursing (DON) created and updated the care plans for residents. ADON stated the care plan should include the assistance required for bathing and what the residents preference is for bathing.

During an interview on 3/7/25 at 12:50 p.m., DON stated it was her expectation that bathing preferences be included in the care plan along with the level of assistance required for bathing. DON stated it was a toss-up between the social worker and nurse manager (which would be DON or ADON) who is responsible for interventions being added to the care plans. The DON expected these interventions would be included in the care plan.

The facility Comprehensive Person-Centered care plan policy dated 1/20/2025, identified a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs would be developed and implemented for each resident. Assessments of residents are ongoing and care plans revised as information about the residents and the residents conditions change. The interdisciplinary team reviews and updates the care plan.

The facility Care Planning Interdisciplinary Team policy dated 1/20/2025, identified the interdisciplinary team is responsible for the development of resident care plans. The care plans are based on the resident assessments.

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2 570	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		