Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 26, 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 15, 2024, we informed you that we may impose enforcement remedies.

On February 13, 2024, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

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 - 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 26, 2024

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

Re: Event ID: WXYF11

Dear Administrator:

The above facility survey was completed on February 13, 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

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 02/13/2024

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 2/12/24 through 2/13/24, 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. H50289684C (MN00100663, MN00100644) The following complaints were reviewed. H50289651C (MN00100419) with a deficiency issued at F925 Use this statement if deficiencies are issued on this survey 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 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure adequate pest	F 925	R2 room was thoroughly cleaned and inspected for mice on 2/13/24. R3 has	3/1/24

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

Electronically Signed | 03/04/2024

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.

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F 925	Continued From page 1 control when surveyor observed three mice in the building during survey. This had the ability to affect all sixty-seven residents in the building. Findings include: During an observation on 2/12/24 at 1:18 p.m., surveyor observed a mouse run across the floor in the main dining room on the second floor. During an observation on 2/12/24 at 4:15 p.m., surveyor observed a mouse run across the floor in the main dining room on the first floor. During an observation on 2/13/24 at 9:09 a.m., surveyor observed a mouse run across the floor in the first hallway on the first floor. R2's admission record printed on 2/12/24 indicated R2 was admitted to the facility on 11/9/22 with an admission diagnosis of an acute kidney injury. R2 does not have a history of delusions or hallucinations. R2's Quarterly Resident Review Assessment dated 1/19/24 indicated R2 is visually impaired but glasses were present during the assessment and are used throughout her stay. The assessment indicated R2 was awake and alert during the assessment and was orientated to person, place, time, and situation. The assessment indicated R2 has not displayed any physical, verbal, hallucinations, or delusions within the last 7 days. The assessment indicated R2 does not use psychotropic medications. R2's Brief Interview for Mental Status (BIMs) Assessment dated 2/2/24 indicated R2 was cognitively intact with a score of 15.	F 925	since discharged from the facility. Social services and Executive Director met with R2, completed a grievance and recorded plan and resolution. On 2/14/24 Paffey's Pest control inspected the entire building. Areas of concern were noted, and several patches and baits were placed to block rodent entry and exit. A new pest control log was received from Paffey's Pest Control and implemented. Pest control visits from 2/14/24, 2/19/24, 2/26/24, 2/29/24, and 3/4/24 there were minimal sightings and activity reported. Weekly and as needed pest control visits will continue indefinitely. Facility staff were in-serviced on the Pest Control policy to report all sighting of pest within the facility and to record sightings in the pest control log. A deep room cleaning schedule was also created and implemented on 2/27/2024. In addition, the residents will be educated on the Pest Control Policy and that pest concerns can be reported directly to facility staff. Residents will be educated at the next resident council of the new pest control company and the plan to eradicate this concern. Maintenance and/or designee is responsible for compliance. Audits on pest control reports, pest citing's log, and deep cleaning of facility rooms will begin 2x week for 3 weeks, weekly x 4 weeks then monthly. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 03/01/2024	

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F 925	Continued From page 2 R3's admission record printed on 2/14/23 indicated R3 was admitted to the facility on 10/23/20 with admission diagnoses including alcohol withdrawal and was discharged home on 11/6/20. R3 was admitted back to the facility on 3/6/21 with an admitting diagnosis of alcoholic pancreatitis. R3 does not have a history of delusions or hallucinations. R3's Quarterly Resident Review Assessment dated 1/18/24 indicated R3 is not visually impaired. The assessment indicated R3 is awake and alert during the assessment and is orientated to person, place, time, and situation. The assessment indicated R3 does not use psychotropic medications. R3's BIMs Assessment dated 2/9/24 indicated R3 was cognitively intact with a score of 15. Plunket's Pest Control Report dated 1/25/24 indicated mice have been using the heating system as a way to get through the entire building. The report indicated the problem areas for mice in the facility are in the kitchen on the second floor and the boiler room. The report indicated they caught one mouse in a live trap, saw ten mice, and caught two mice. During an interview with R2 on 2/12/24 at 1:01 p.m., R2 stated mice in her room every night. R2 stated the mice are in her room from about 4:00 p.m. until the following morning. During an interview with R3 on 2/12/24 at 1:52 p.m., R3 stated there is a problem with mice in his room. R3 stated he found a dead mouse in his room on 2/10/24. R3 stated when he was lying	F 925		

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F 925	Continued From page 3 in bed, he had a mouse that came up and crawled on his shoulder. R3 was unable to verify the date that incident happened. During an interview with nursing assistant (NA)-A on 2/12/24 at 1:56 p.m., NA-A stated is a problem with mice in the facility. NA-A stated the facility has a pest control company come to the facility but stated that the treatments they are providing is not working. During an interview with the licensed social worker from a dialysis center, the licensed social worker stated R2 stated to her there is rodents in the facility. The licensed social worker stated that R2 has not had any delusions or hallucinations that she is aware of. During an interview with NA-C on 2/13/24 at 9:59 a.m., NA-C stated she has seen mice in the facility. During an interview with registered nurse (RN)-A on 2/13/24 at 10:11 a.m., RN-A stated she has had residents complain about mice in the facility but could not recall the names of the residents. During an interview with the licensed social services coordinator (LSSC) on 2/13/24 at 10:40 a.m., the LSSC stated she had received complaints about mice in the facility. The LSSC stated she has made reports to Plunket's Pest Control. The LSSC stated Plunket's Pest Control comes out regularly and she thought Plunket's came out at scheduled times, but she was not sure of the schedule. During an interview with the executive director on 2/13/24 at 2:59 p.m., the executive director stated	F 925		

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F 925	Continued From page 4 since the construction has been going on at the facility, the mice problem has increased. The executive director stated the construction started before she started her position 6 weeks ago and is unable to verify how long the construction has been going on. The executive director stated the facility has had Plunket's Pest Control visit the facility once a week and she thought Plunket's Pest Control was at the facility last week. During the interview, the executive director accessed the Plunket's Pest Control online portal, and the last visit was dated 1/25/24. Pest Control Policy and Procedure Requested from facility and none was received.	F 925		

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	00494	A. BUILDING: _____ B. WING _____	C 02/13/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/12/24 through 2/13/24 , 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 during	2 000		

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

Electronically Signed | 03/04/24

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	00494	A. BUILDING: _____ B. WING _____	C 02/13/2024

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2 000	Continued From page 1 the survey. H50289684C (MN00100663 and MN00100644) and H50289651C (MN00100419) 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		