Electronically delivered

June 18, 2019

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

RE: Project Numbers H5028057C, H5028058C, H5028059C, H5028060C

Dear Mr. Duxbury:

On May 30, 2019, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on May 15, 2019.

Also, on May 30, 2019, the Minnesota Department of Health completed a second abbreviated standard survey at your facility 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 and to completed an investigation of complaint numbers H5028058C, H5028059C, H5028060C.

This survey found the most serious deficiencies in your facility 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.

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs, is imposing the following remedy, and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 15, 2019. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 15, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 15, 2019.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; 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 August 15, 2019, 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 Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 15, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro A Survey Team
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: karen.aldinger@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial

compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 August 15, 2019 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 November 15, 2019 (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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE 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 5/24/19, 5/28/19, 5/29/19, and 5/30/19, an abbreviated survey was completed at your facility to conduct complaint investigations for H5028058C, H5028059C, and H5028060C. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5028058C Deficiency issued at F Tag # F61 and F697 H5028059C Deficiency issued at F Tag # F557 and F697 H5028060C Deficiency issued at F Tag # F697 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		6/23/19

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

Electronically Signed | 06/28/2019

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F 561	Continued From page 1 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident preferences for 1 of 3 (R1) residents reviewed for choices. Findings include: R1's admission Minimum Data Set (MDS) dated 4/12/19, included severe cognitive impairment, no behavior problems, did not reject cares, was always incontinent of bowel and bladder and required extensive assistance of two plus persons for incontinent cares.	F 561	R1 has been interviewed and resident choices have been updated. Care plan and group sheets have been updated to include R1's preferences regarding pericare. An audit was completed to ensure that resident's voice is identified relating to self cares. Preferences will be reviewed using the care conference schedule, weekly catch up meetings and individual concerns. Education provided to licensed staff on	

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F 561	Continued From page 2 R1's neurology progress report dated 5/16/19, indicated R1 had a stroke which affected his ability to speak. R1's care plan dated 4/11/19, included an area of vulnerability related to communication and speech. However, there were no interventions to guide staff in communicating with R1. R1's care plan for activities of daily living updated 5/23/19, directed staff to encourage to participate to the fullest extent possible with each interaction. R1's mobility care plan updated 5/23/19, directed staff to, "Encourage independence by providing resident with washcloth for hygiene cares. Resident is able to perform self peri-cares. Provide resident with wet wipes during brief changes." R1's mood care plan updated 5/23/19, directed staff, "The resident needs encouragement/assistance/support to maintain as much independence and control as possible. The [sik] has upper body strength and stronger on left side of body," and "The resident needs time to talk to express feelings." An anonymous report dated 5/20/19, included, R1 had indicated he did not want NA-A to take care of him and anonymous reporter offered to assist him instead. R1 did not want to go to bed at that time. NA-A grabbed R1's wheel chair and told R1 he did not have the right to choose who took care of him and had to go to bed when he was told. R1 told anonymous reporter he did not like NA-A and did not want NA-A caring for him. RN-B had witnessed this and did not intervene. The anonymous reporter also indicated R1 has trouble speaking and staff are not patient with him. R1's Incident Tracking report dated 5/22/19,	F 561	regulation related to self-determination. Audits of care plans to ensure resident choices are being met will be completed 3 times per week for 4 weeks and then 2 times per week for 4 weeks and then weekly for 4 weeks. The DON or designee will complete random audits weekly of care plans. DON or designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed. Date certain for compliance is 6/23/19	

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F 561	Continued From page 3	F 561		

included, "Resident reports per interview with social services. [R1] stated the aide brought him into his room and asked if he wanted to be changed now. [R1] told her no and that he can do it himself. [R1] stated she proceeded to take his brief off and she touched him inappropriately when she did. It was not sexual. [R1] is upset because he is able to change himself and clean himself." Intervention placed by facility included, "Staff group sheets changed to encourage staff to allow resident to wipe self during pericare when possible." A follow up investigation note included, "NAR [nursing assistant, registered] interviewed on other shifts state they let him wash with some success. Resident will let them know if he needs more help-care guide updated."

During observation on 5/24/19, at 2:50 p.m. nursing assistant (NA)- E and licensed practical nurse (LPN)-D performed pericare on R1 without offering or allowing R2 to do this himself as indicated in the care plan. R1 did not resist.

When interviewed on 5/24/19, at 3:15 p.m. NA-E stated R1 had reported to her on 5/22/19, at 2:00 p.m. that a male nurse aide had performed pericare on him when he stated he wanted to do it himself. R1 had stated he was touched, "inappropriately," but not sexually, just unwanted touching of his private parts during pericare when he was capable of doing this himself. NA-E reported this to the director of nursing (DON) who started an investigation.

During observation on 5/28/19, at 11:45 a.m. R1 was being wheeled in wheel chair towards the dining room. NA-D asked R1 if he wanted to sit by the window. R1 clearly stated he did not, at which point NA-D repeated the question. R1

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F 561	Continued From page 4 became visibly upset at being asked again, after already answering the question, he started yelling that he knows what he wants and does not want. When interviewed on 5/28/19, at 12:53 p.m. R1 stated, "It would be better if they would let me do what I want and not try to control me." R1 went on to explain he can do some things himself, and it is frustrating when staff just do it for him. He felt his rights had been taken away from him. When interviewed on 5/28/19, at 2:52 p.m. registered nurse (RN)-D stated, she was aware R1 was upset that a staff member performed pericare when he wanted to do it himself and this was investigated. RN-D stated he usually was doing own pericare with set up from staff. R1 has difficulty speaking and staff need to take the time to listen to him. When interviewed on 5/29/19, at 2:53 p.m. NA-A denied ever having any difficulties providing care for R1 and denied R1 refusing to have them care for him. When interviewed on 5/29/19, at 3:30 p.m. the DON stated she would expect staff to honor resident choices, if refusing care, leave and re-approach later. R1's specific choices should have been included in the care plan.	F 561		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		7/12/19

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F 697	Continued From page 5 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 2 of 3 residents (R2 and R3) reviewed for pain received prescribed pain medication timely, in order to ensure pain relief. Findings include: R2's Diagnosis Report dated 5/27/19, indicated R2 had diagnoses which included aftercare following joint replacement surgery and encounter for removal of internal fixation device. R2's Discharge Minimum Data Set (MDS) dated 3/20/19, indicated R2 had been admitted to the facility On 3/14/19, from an acute hospital. The MDS also indicated R2 was cognitively intact and required extensive assistance of 1 staff for all activities of daily living except, was independent with eating. The MDS further indicated R2 received as needed (PRN) medication for frequent pain rated "8" on a 0-10 numeric scale. R2's Pain Data Collection and Assessment dated 3/15/19, indicated R2 verbalized pain described as burning and shooting in the left heel related to recent hardware removal from left heel. R2 rated the pain as a "6" on a scale of 0-10 with a verbal descriptor of mild pain. The assessment also identified R2 had experienced changes in physical activity and indicated standing/non-compliant with TTWB [toe touch weight bearing] increased the pain and medication relieved the pain. The assessment identified R2's pain goal as 0 on a 0-10 scale.	F 697	R2 had discharged from the facility prior to the survey. R3 had discharged from the facility prior to the survey. All residents receiving PRN and scheduled pain medications have been reviewed to ensure compliance. Licensed staff reviewed Pharmacy Information sheet for delivery and order times. Staff reviewed the need to follow up any stat order with a call to pharmacy to establish the four hour delivery time. If medication is not delivered within the four hour delivery time the nurse must call the pharmacy for an update and report concern to the Director of Nurses or designee. Pharmacy E-Kit use was reviewed to assure proper use. The Director of Nurses or designee will audit pain medications twice weekly. The trends of the audit will be presented to QAPI monthly for 3 months then ongoing as needed. Continued compliance will be the responsibility of the Director of Nurses or designee. Date certain for compliance is 7/12/19	

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F 697	Continued From page 6 The assessment also indicated as a sign/symptom of pain that R2 was resistive to care. The assessment concluded based on review of the data collected from pain data collection and assessment, R2 exhibited signs and/or symptoms of pain and directed, "notify physician for evaluation/re-evaluation of pain management interventions". R2's Individual Resident Care Plan dated 3/15/19, indicated R2 had a left heel wound related to hardware removal and identified frequent medication requests as a behavior. The care plan also indicated R2 had left heel pain and directed staff to observe for pain and provide medication, ice and elevate. On 5/24/19, at 11:30 a.m. R2 was interviewed by telephone and stated she did not receive her pain medication on time or have her call light answered promptly while a resident at the facility. R2 indicated she had seen her surgeon on 3/19/19, and had requested and received an order to discharge to home. However, upon return to the facility had been told she could not discharge home until the facility physician saw her. R2 indicated the facility physician saw her later in the day on 3/19/19, and did provide an order for her to discharge on 3/20/19. R2 stated the facility did not get her pain medication ordered and she had to wait from early morning until the middle of the afternoon on 3/20/19, for the medication to come from the pharmacy. R2 stated at approximately midnight on 3/20/19, the nurse had informed her she only had two half tablets of her Dilaudid (narcotic pain medication) left so she was going to give her one at that time and save the other for later in the morning hours. R2 stated the nurse had told her the reason for	F 697		

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F 697	Continued From page 7	F 697		

the lack of medication was the physician had not completed the prescription correctly, so the pharmacy could not filled the prescription.

R2 stated on 3/20/19, when she was waiting for her pain medication to get to the facility, the director of nursing (DON) came into her room with the nurse manager and asked why she had not yet left the facility. R2 stated she told her she was waiting for her pain medication. R2 said she felt belittled by the DON and angry. R2 indicated she had not received her medications and was not able to discharge until the middle of the afternoon.

R2's After Visit Summary dated 3/19/19, from the podiatrist visit indicated "OK to discharge home tomorrow".

R2's History and Physical (H&P) dated 3/19/19, from the facility physician, indicated the chief complaint R2 was seen for history and physical and also discharge. The H&P indicated R2 had been seen by orthopedics that day and was reportedly healing well. Pain was well controlled on Tylenol 325-650 (milligrams) mg every 4 hours and hydromorphone 4-6 mg every 3 hours as needed (PRN) . Patient wants to go home tomorrow. The assessment and plan indicated, "ok to discharge home on 3/20/19 with all non-returnable medications, including narcotics."

R2's Medication Administration Record (MAR) dated March 2019, included the following orders:
-cyclobenzaprine 10 mg tablet (Flexeril) 1 tab by mouth three times daily as needed for muscle spasms
-diazepam 2 mg tablet (Valium) 1 tab by mouth every 6 hours as needed for muscle spasms

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F 697	Continued From page 8 -hydromorphone 4 mg tablet (Dilaudid) 1-2 half tabs (4-6 mg) by mouth every 3 hours as needed for pain -acetaminophen 325 mg tablet (Tylenol) 1-2 tabs (325-650 mg) by mouth every 4 hours for pain - not to exceed 4000 mg/24 hours. Scheduled 8 am-12 pm-4 pm-8 pm-12 am-4 am Review of R2's Individual Narcotic Records (INR) dated 3/14/19 to 3/20/19, revealed the following: -INR page 69 identified 30 half tablets of hydromorphone 4 mg were received on 3/14/19. Fourteen entries were documented in the record with the first dose signed out 3/14/19, at 6:53 p.m. and the last dose signed out 3/16/19, at 3:30 p.m. -INR page 71 identified 30 half tablets of hydromorphone 4 mg were received on 3/16/19. Fifteen entries were documented in the record with the first dose signed out 3/16/19, at 3:30 p.m. and the last dose signed out 3/18/19, at 6:50 p.m. -INR page 72 identified 20 half tablets of hydromorphone 4 mg were received on 3/16/19. Nine entries were documented in the record with the first dose signed out 3/18/19, at 10:25 p.m. and the last dose signed out 3/20/19, at 3:20 a.m. This represented 38 doses between 3/14/19 at 6:53 p.m. and 3/20/19 at 3:20 a.m. Review of R2's medical record indicated a prescription for Hydromorphone 4 mg tablets take 1 to 1.5 pill every 3 hours as needed for pain, dispense 7 day supply was sent to the pharmacy on 3/19/19, at 6:04 p.m. but at 11:22 p.m. had not arrived at the facility. Review of R2's MAR dated March 2019, included the following medications administered on	F 697		

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F 697	Continued From page 9 3/20/19: -3:20 a.m. hydromorphone 2 mg. (2 mg less than the prescribed dose) -8:00 a.m. cyclobenzaprine 10 mg and diazepam 2 mg for left heel spasms. Medication notes indicated medications helpful. R2 also received scheduled acetaminophen. -12:00 p.m. R2 received scheduled acetaminophen. R2's Pain Monitoring Flowsheet dated March 2019, indicated the following characteristics were monitored once each shift for R2's pain: location, type, severity, non-pharmacological interventions, PRN medication given, and medication effectiveness. On 3/20/19, the night shift identified R2's left heel pain with a severity of 8 and type of aching. Non-pharmacological intervention was cold. Yes was indicated for PRN medication given and effective. The day shift identified R2's left heel pain with a severity of 8, type of aching. Non-pharmacological intervention was positioning. Yes was indicated for PRN medication given and effective. R2's Anti-psychotic flowsheet dated March 2019, identified diazepam was given for spasms. Non-pharmacological interventions and outcome were monitored each shift for R2's diazepam use. On 3/20/19, the night shift identified 1:1 support was provided and the outcome was positive. The day shift also identified 1:1 support was provided and the outcome was positive. R2's Nursing Note dated 3/20/19, at 9:10 a.m. indicated patient was out of Dilaudid due to the script did not have a quantity. Spoke with physician assistant and they will send E script [electronic prescription] from the physician. Did	F 697		

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complain of pain and also requested diazepam and Flexeril for spasms which were effective. Tylenol given and somewhat helpful.

R2's Nursing Note dated 3/20/19, at 9:38 p.m. indicated R2 was discharged at 3:45 p.m. with all medications.

R2 was interviewed again on 5/30/19, and stated she did not have any narcotic pain medications from approximately 3:15 a.m. until the middle of the afternoon on 3/20/19. R2 described the pain as burning, throbbing pain. R2 stated the facility offered muscle relaxer, and other interventions but did not offer narcotic medications because they were not available.

On 5/28/19, at 3:11 p.m. registered nurse (RN)-A stated R2 was admitted after having surgery on the left heel to remove hardware placed in the left heel following an injury to the heel. RN-A verified R2 did complain of pain frequently throughout her stay at the facility. RN-A stated on 3/19/19, R2 was seen by the house physician and an order for Dilaudid was written to refill the supply. RN-A stated the medication did not get sent from the pharmacy because the quantity of medication was not indicated on the prescription. RN-A stated the night nurse contacted the house physician to get a new prescription to the pharmacy the next morning. RN-A stated the staff were supposed to get refills sent to the pharmacy when there was one row of pills left on the medication card or less than a 2-3 day supply of pills. RN-A added all of the nurses were responsible to make sure a supply of medications does not run out. RN-A confirmed R2's Dilaudid should have never run out.

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F 697	Continued From page 11 On 5/29/19, at approximately 1:35 p.m. the director of nursing (DON) stated that she was unable to state a reason why the facility failed to get the prescriptions for R2's Dilaudid filled more quickly. When interviewed on 5/30/19, at 10:10 a.m. licensed practical nurse (LPN)-A stated he normally reordered medication when there was 10 tablets remaining or a week worth left and stated this was to be done to prevent medication run out. During a telephone interviewed on 5/30/19, at 12:37 p.m. Pharmacy technician (PT) revealed R2's Dilaudid prescription was received on 3/19/19, with invalid quantity. PT stated the medical doctor (MD) had indicated to provide a 7 day supply, however, as this was a PRN medication the prescription was invalid and could not be filled. The pharmacist had to call the MD on 3/20/19 for a valid prescription. The pharmacist obtained an order for 84 tablets from the MD on 3/20/19, at 8:19 a.m. Pharmacy staff left the pharmacy to deliver the medication to Highland Chateau Health Care Center (HCHCC) on 3/20/19, at 1:30 p.m. The medication was delivered HCHCC on 3/20/19, at 2:55 p.m. in addition, PT indicated, pharmacy staff were not aware the medication were order for immediate (STAT) delivery until staff from the facility called and ordered the medication STAT. R3's Admission MDS dated 4/30/19, indicated R3 was cognitively intact and had diagnoses which included stroke and hemiplegia/hemiparesis (weakness or paralysis of one side of the body).	F 697		

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The MDS also indicated R3 required extensive assistance with all activities of daily living (ADL) except was independent with eating. The MDS further indicated R3 received as needed (PRN) medication for pain, however, did not express pain during the assessment period.

R3's Individual Resident Care Plan dated 4/25/19, indicated R3 had pain of the right upper extremity rated 3-7 on a 0-10 scale and directed staff to use pain scale as applicable. R3's care plan lacked further interventions for the management of pain.

During interview on 5/28/19, at 2:58 p.m. R3 stated he had been at the facility for approximately 5 weeks and the care he had received was, "awful." R3 indicated he had been diagnosed with a blood clot in his lower left leg and placed on bed rest. R3 indicated he had experienced increased pain in his left lower leg due to the blood clot and was seen by the physician on 5/23/19, who had prescribed a stronger pain pill at that time. R3 stated in the early morning of 5/24/19, he had been in a lot of pain and asked for the new pain pill but had been told the supply had not come in. R3 indicated he was told the physician had not indicated to fill the medication immediately (STAT) on the order so the medication would not be sent until the morning delivery. R3 stated he requested to go to the emergency room later on 5/24/19, and had been sent by ambulance. R3 indicated he was diagnosed with gout at the hospital.

In a subsequent interview on 5/31/19, at 11:26 a.m. R3 indicated his pain on 5/24/19, was 8 to 9 on a 0-10 scale, and the facility only offered the scheduled acetaminophen and gabapentin he had ordered. R3 stated no non-medication

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interventions were offered for pain management. R3 stated he did not obtain pain relief until he received pain medications at the hospital.

R3's Physician Note dated 5/21/19, indicated R3 was admitted to the facility with right sided weakness after suffering a stroke. R3 reported some spasms in his right arm and some neuropathic symptoms, such as paresthesia, numbness, and burning sensations. R3's left lower extremity was swollen and tender due to DVT (deep vein thrombosis or blood clot) diagnosed 5/20/19. Current pain regimen included: Tylenol 1000 milligrams (mg) three times a day, gabapentin (treats nerve pain) 300 mg twice daily, Baclofen (muscle relaxant) 5 mg every 6 hours as needed for spasticity (condition in which certain muscles are continuously contracted) and diclofenac gel 1% (topical gel nonsteroidal anti-inflammatory drug used to treat arthritis pain of joints) four times daily. Pain in left lower extremity (LLE) not optimally controlled and preventing him from participating in PT/OT (physical therapy/occupational therapy). Assessment and plan indicated to increase gabapentin to 400 mg twice daily to better control his pain.

R3's Physician Note dated 5/23/19, indicated R3 was seen for follow up visit after recent medication changes. R3 indicated the pain in his left foot was still severe and he was unable to ambulate. The assessment and plan indicated left lower extremity DVT on 5/20/19. Continue Eliquis (anticoagulant to treat blood clots) as scheduled. No activity restrictions. Continue PT/OT. Start tramadol (narcotic to treat moderate to severe pain) 50 mg by mouth three times daily as needed.

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R3's Medication Administration Record dated May 2019 included the following orders:
-acetaminophen 500 mg tablet (Tylenol Extra Strength) 1000 mg by mouth three times a day, not to exceed 4000 mg/24 hours. Order start date 4/23/19. Administration documented three times daily.
-gabapentin 400 mg by mouth twice daily to better control pain. Order start date 5/21/19. Administration documented twice daily 5/22 and 5/23 and once 5/24.
-tramadol 50 mg by mouth three times daily as needed for pain. Order start date 5/23/19. No administration of the medication was documented
-Baclofen 10 mg tablet (Lioresal) ½ tab (5 mg) by mouth every 6 hours as needed for spasticity. Order start date 4/23/19. No administration of the medication was documented
-diclofenac sodium 1% gel (Voltaren) apply to affected areas topically four times daily as needed for pain. Administration documented 5/8, 5/11, 5/18, 5/18 and 5/19. Comments/Nursing observations included: 5/18 at 2:15 a.m. diflonec [sic] gel to right wrist and bilateral legs for aching - helpful.

R3's Pain Monitoring Flowsheet dated May 2019, indicated the following characteristics were monitored once each shift for R3's pain: location, type, severity, non-pharmacological interventions, PRN medication given, and medication effectiveness. Choices for pain location included only 1. Back of legs. Review of flowsheet documentation from 5/20/19 through 5/24/19 revealed the following:
-5/20/19: All shifts entered all fields "0"
-5/21/19: All shifts entered all fields "0"

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F 697	Continued From page 15 -5/22/19: Night and Day shift: all fields entered "0", PM shift: all fields blank -5/23/19: Night and Day shift: all fields entered "0", PM shift: aching pain in the back of the legs rated 6 on a 0-10 scale. Interventions documented included positioning and meds. Yes was indicated for PRN medication given and effective. -5/24/19: Night and Day shift: all fields entered "0" Review of R3's Nursing Notes dated 5/23/19 to 5/24/19 revealed the following: R3's Nursing Note dated 5/23/19, at 5:17 a.m. indicated both R3 and sister concerned about change in status related to right sided tingling. Also concerned about why right leg brace is painful to put on. "It has never been painful," they feel as though follow up is necessary. R3's vitals taken x 3 on the night shift, temp increased from 98.6 to 99.9. R3 requested help with repositioning x 4 this night shift. Edema noted in left foot. R3 complained of "tingling sensation" at 3/10 on right side of body, from head to toes. Right and left ankle and dorsum of feet are tender to touch 5/23/19 at 10:00 p.m. complained of pain to LLE at 3/10, tolerable. Recent diagnosis of DVT to LLE, UA/UC (urinalysis and culture) ordered to rule out UTI (urinary tract infection). 5/24/19 at 5:17 a.m. R3 requested tramadol PRN for pain, this is a new doctor's order and unfortunately, has yet to arrive from pharmacy. 5/24/19 at 9:10 R3 progressively weaker. Received orders to send to ER for evaluation. Per sister and R3 they chose not to hold the bed.	F 697		

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F 697	Continued From page 16 911 here to transport by stretcher. The record lacked further documentation regarding R3's pain or interventions to relieve pain. On 5/28/19, at approximately 3:00 p.m. RN-A indicated the reason R3's tramadol was not available when requested was because the physician did not write for the pharmacy to send the medication STAT, therefore, the pharmacy was going to send it in the regular morning delivery. RN-A stated the prescription did not get to the pharmacy until after 9:00 p.m. on 5/23/19. RN-A stated the medication would be expected to arrive at the facility any time after 1:00 p.m. On 5/29/19, the DON stated a medication error was found with R3's medications. The DON verified the physician had ordered R3's tramadol on 5/23/19, however, the medication did not get to the facility and was not available when requested on 5/24/19. During interview on 5/30/19, at 9:57 a.m. registered nurse (RN)-C stated she received a new order for tramadol from the MD for R3 and sent the order to the pharmacy on 5/23/19, but could not recall what time she sent the order. She recalled working that day until around 4:30 p.m. During telephone interview on 5/30/19, at 12:50 p.m. PT stated R3 was not on tramadol until 5/23/19, at 8:29 p.m. when they received the prescription from the physician assistant (PA). PT stated the order came after cut off time for delivery. In addition, PT indicated the order was not identified as an emergency prescription when	F 697		

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F 697	Continued From page 17 sent electronically and pharmacy staff were not alerted the medication was needed immediately (STAT) until 5/24/19, at 7:19 a.m. when facility staff called for a STAT order. During telephone interview on 5/30/19, at 12:57 p.m. pharmacy nurse consultant (PNC) stated R3's tramadol order was processed on 5/24/19, at 5:16 a.m. On 5/24/19, at 7:19 a.m. director of nursing (DON) ordered medication to be STAT order and spoke with the pharmacist who changed the order to STAT. Furthermore, PNC indicated, the medication left the pharmacy 5/24/19, at 7:24 a.m. to facility and the facility staff signed that they received the medication on 5/24/19, at 9:03 a.m. Omnicare Pharmacy Information document dated March 2018, indicated new medications orders sent prior to 10:00 p.m. would be delivered between 12:30-6:30 a.m. The document also indicated the facility needed to reorder refills 3-5 days prior to the day the medication runs out.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		7/12/19

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F 755	Continued From page 18 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide controlled medications in a timely manner for 2 of 3 resident (R2, R3) reviewed for pain management. Findings include: R2 was admitted to the facility on 3/14/19, from the hospital after having surgery to remove hardware from her left ankle. R2's admission progress note dated 3/14/19, indicated R2 was alert and oriented to person, place and time. R2's medication orders dated 3/14/19, indicated R2 could have 4 to 6 milligrams (mg) of dilaudid every 3 hours as needed for pain. Review of the facility narcotic control log for R2's dilaudid indicated the facility received 30 half tablets of dilaudid 4 mg on 3/14/19, and an additional 50	F 755	R2 had discharged from the facility prior to the survey. R3 had discharged from the facility prior to the survey. It is the facility and medical director believe that any order, should be filled and delivered without delay. Medications requiring immediate use will be obtained by using the facility E-Kit or the Licensed Staff alerting the pharmacy of a stat medication order. The Director of Nurses met with the pharmacy consultant to review, reviewed Pharmacy Information sheet for delivery and order times.	

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F 755	Continued From page 19 half tablets on 3/16/19. R2 was using about 30 half tablets in 48-72 hours. On 3/19/19, the narcotic log indicated R2 had only 1 half tablet left after receiving a dose at 12:05 a.m. R2's physician orders indicated the doctor wrote a new prescription for dilaudid on 3/19/19 at 3:15 p.m. On 5/24/19, at 11:30 a.m. R2 was interviewed by telephone and stated the care was not very professional. R2 stated the facility did not get her pain medication ordered, and she had to wait from early morning until middle afternoon for the medication to come from the pharmacy. R2 stated at approximately midnight on 3/20/19, the nurse told her there was only 3 half tablets of her dilaudid left so she was going to give her 2 then and save the other one for later in the morning hours. R2 stated the nurse told her it was because the medical doctor (MD) did not complete the prescription correctly so the pharmacy could not fill the prescription. R2 stated on 3/20/19, when she was waiting for her pain medication to get to the facility the director of nursing (DON) came into her room with the nurse manager and asked why she had not left yet. R2 told her she was waiting for her pain medication. R2 said she felt belittled and angry. R2 stated she called her case manager and the case manager called the facility to find out why R2's pain medications had not come yet. R2 stated the case manager call her back and instructed her not to leave the facility without the dilaudid. R2 stated she did not get her medications until the middle of the afternoon. On 5/28/19, at 11:26 a.m. registered nurse (RN)-C stated in an interview that new orders are processed by the nurses. When asked how much time do you get to get a medication to facility,	F 755	Education was provide to licensed staff. If medication is not delivered within the four hour delivery time the nurse must call the pharmacy for an update and report concern to the Director of Nurses or designee. The Director of Nurses or designee will stat medications twice weekly. The trends of the audit will be presented to QAPI monthly for 3 months then ongoing as needed. Continued compliance will be the responsibility of the Director of Nurses or designee. Date certain for compliance is 7/12/19	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE 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 755	Continued From page 20	F 755		

RN-C stated it depended on what time the order was processed and sent to the pharmacy. RN-C was unsure if there was any specific policy for pain medications, but an order marked STAT was supposed to get to the facility within 2-4 hours. RN-C stated all the nurses were responsible to make sure medication refills were received at the facility before the medication ran out. RN-C stated there was not a system to know if a medication had been ordered from the pharmacy on a refill order or a controlled substance that needed a new prescription.

On 5/28/19, at 11:35 a.m. RN-D was interviewed and stated all nurses were supposed to reorder the medications when the supply was getting low. RN-D stated she looks at the reorder date and does not reorder until that date. RN-D stated she did not recall any time when she ran out of an as needed medications for a resident. RN-D stated it was never alright for a resident to run out a pain medication especially a resident that had post operative pain.

On 5/28/19, at 3:11 p.m. during an interview (RN)-A stated on 3/19/19, R2 told RN-A she received an order to discharge to home from her surgeon. RN-A stated she told R2 the facility MD needed to see her first and if she left before that she would be leaving against medical advise. RN-A stated the MD was in the building and was able to see R2. The MD wrote the discharge order and included a prescription for dilaudid 4 mg (4-6 mg) every 3 hours as needed for pain. The facility sent the prescription to the pharmacy. When RN-A stated the MD did not put a quantity on the prescription so the pharmacy did not fill it. When asked what the staff should have done, RN-A stated the staff was supposed to get a new

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F 755	Continued From page 21	F 755		

prescription from the MD to go to the pharmacy. RN-A stated R2's dilaudid should have been ordered at least 2 days before it was going to run out so there was time to get it filled. RN-A stated the facility did not know there was a problem with the prescription because the pharmacy did not let us know until the nurse called to ask why it had not been sent out.

On 5/29/19, at approximately 1:35 p.m. the director of nursing (DON) stated that she was unable to say why the facility failed to get the medications or the reason the prescription was not filled DON stated she could not explain why the medication was not at the facility more timely.

When interviewed on 5/30/19, at 10:10 a.m. licensed practical nurse (LPN)-A stated he normally reorder medication when there is 10 tablets remaining or a week worth left and this is to be done to prevent medication run out.

During a telephone interviewed on 5/30/19, at 12:37 p.m. Pharmacy technician (PT) revealed R2's Dilaudid first prescription was received from the facility, was an admission orders dated on 3/12/19, but the prescription was received on 3/14/19, and 15 tablets was delivered on 3/14/19, then 25 tablets was supplied on 3/16/19. PT stated, another prescription was received on 3/19/19, with invalid quantity because medical doctor (MD) wrote only 7 days and this was an as needed orders, which they cannot filled because the prescription was invalid. The pharmacist had to call the MD on 3/20/19, for valid prescription. The pharmacist obtained 84 tablets from the MD on 3/20/19 at 8:19 a.m. Pharmacy staff left the pharmacy to deliver the medication to Highland Chateau Health Care Center (HCHCC) on

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F 755	Continued From page 22	F 755		

3/20/19, at 1:30 p.m. The medication was delivered HCHCC on 3/20/19, at 2:55 p.m. in addition, PT indicated, pharmacy staff were not aware the medication were order for immediate (STAT) delivery until staff from the facility called and ordered the medication STAT.

R3 was admitted to the facility 4/23/19, from the hospital with diagnoses hemiplegia from a cerebral vascular accident (CVA) on the dominant side and adjustment disorder. R3 was alert and oriented to person, place and time when interviewed. R3 was there for rehabilitation following the CVA. R3's physician orders indicated an order for Ultram 50 mg by mouth three times a day as needed for pain was written on 5/23/19. Review of progress notes indicated resident requested Ultram at 5:17 a.m. on 5/24/19, and was told no supply was available. No documentation was noted that indicated any alternative interventions were implemented. R3 was sent to ER on 5/24/19, at 9:50 a.m.

On 5/28/19, at 2:12 p.m. R3 was interviewed by telephone. R3 stated on 5/23/19, he was experiencing increased pain in his right leg and back. R3 stated the medical doctor (MD) assessed him and order a stronger pain medication for him. R3 stated later on 5/23/19, his temperature went up and sometime in the early morning of 5/24/19, he asked for the stronger pain medication and was told by the nurse that the medication had not come from the pharmacy. R3 stated he was told the MD did not put STAT on the prescription so the pharmacy thought it could wait until the regular delivery. In a subsequent interview on 5/31/19, at 11:26 a.m. R3 stated his pain was a 8 to 9 on a 0-10 scale and was a generalized aching. R3 also stated the

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F 755	Continued From page 23 staff offered nothing but the scheduled acetaminophen for his pain. On 5/28/19, at approximately 3:00 p.m. RN-A stated because the MD did not write for the pharmacy to send it STAT (immediately) the pharmacy was going to send it in the regular morning delivery. RN-A stated the prescription did not get to the pharmacy until after 9:00 p.m. When asked when that delivery would get to the facility RN-A stated any time after 1:00 p.m. When interviewed on 5/30/19, at 9:57 a.m. registered nurse (RN)-C stated, the pharmacy have dates on the medication cards of when to reorder medication. RN-C added, she received a new order Ultram from the MD for R3 and send the order to the pharmacy on 5/23/19, but could recalled what time she send the order to the pharmacy. She does recalled working that day until around 4:30 p.m. During a telephone interviewed on 5/30/19, at 12:50 p.m. PT stated R3 was never on Ultram until 5/23/19, at 8:29 p.m. when they received the prescription for Ultram from the physician assistant (PA). The order came after cut off time for delivery. In addition, PT indicated that PA Ultram order was an electronic order with no Emergency prescription on it and no facility staff called pharmacy t alert them that the medication was needed immediately (STAT) until 5/24/19, at 7:19 a.m. when facility staff called for a STAT order. During a telephone interviewed on 5/30/19, at 12:57 p.m. pharmacy nurse consultant (PNC) stated R3's Ultram order was process on 5/24/19,	F 755		

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F 755	Continued From page 24 at 5:16 a.m. On 5/24/19, at 7:19 a.m. director of nursing (DON) ordered medication to be STAT order and spoke with the pharmacist who changed the order to STAT. Furthermore, PNC indicated, the medication left the pharmacy 5/24/19, at 7:24 a.m. to facility and the facility staff signed that they received the medication on 5/24/19, at 9:03 a.m. A facility policy New Orders for Schedule III-V Controlled Substances dated 10/31/16, failed to include information on timely filling of medications. Omnicare Pharmacy Information document dated March 2018, indicated new medications orders sent prior to 10:00 p.m. would be delivered between 12:30-6:30 a.m. The document also indicated the facility needed to reorder refills 3-5 days prior to the day the medication runs out.	F 755		

Electronically delivered
June 18, 2019

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

Re: State Nursing Home Licensing Orders - Project Number H5028057C

Dear Administrator:

The above facility was surveyed on May 24, 2019 through May 30, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5028058C, H5028059C, H5028060C. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Kathleen Lucas, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343 Fax: (320) 223-7348

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
00494	HIGHLAND CHATEAU HEALTH CARE CENTER 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116	05/30/2019

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:

An investigation of complaints H5028058C, H5028059C, and H5028060C was conducted in the facility from 5/24/19, 5/28/19, 5/29/19, and 5/30/19. The complaints were found to be substantiated along with the (MN Rule #/MN Statue#) are as follows:

H5028058C: 4658.0520
H5028059C: 4658.0520
H5028060C: 4658.0520 and 144.611 subpart 10

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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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.

On 5/24/19, 5/28/19, 5/29/19, and 5/30/19, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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 surveyors findings are the Suggested Method of Correction and 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.

2 830 Adequate and Proper Nursing Care; General

Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that

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2 830 Continued From page 1

the resident must remain in bed or the resident prefers to remain in bed.

Based on observation, interview, and document review, the facility failed to accommodate resident preferences for 1 of 3 (R1) residents reviewed for choices.

Findings include:

R1's admission Minimum Data Set (MDS) dated 4/12/19, included severe cognitive impairment, no behavior problems, did not reject cares, was always incontinent of bowel and bladder and required extensive assistance of two plus persons for incontinent cares.

R1's neurology progress report dated 5/16/19, indicated R1 had a stroke which affected his ability to speak. R1's care plan dated 4/11/19, included an area of vulnerability related to communication and speech. However, there were no interventions to guide staff in communicating with R1. R1's care plan for activities of daily living updated 5/23/19, directed staff to encourage to participate to the fullest extent possible with each interaction. R1's mobility care plan updated 5/23/19, directed staff to, "Encourage independence by providing resident with washcloth for hygiene cares. Resident is able to perform self peri-cares. Provide resident with wet wipes during brief changes." R1's mood care plan updated 5/23/19, directed staff, "The resident needs encouragement/assistance/support to maintain as much independence and control as possible. The [sik] has upper body strength and stronger on left side of body," and "The resident needs time to talk to express feelings."

An anonymous report dated 5/20/19, included, R1 had indicated he did not want NA-A to take care of him and anonymous reporter offered to assist him instead. R1 did not want to go to bed at that time. NA-A grabbed R1's wheel chair and told R1 he did not have the right to choose who took care of him and had to go to bed when he was told. R1 told anonymous reporter he did not like NA-A and did not want NA-A caring for him. RN-B had witnessed this and did not intervene. The anonymous reporter also indicated R1 has trouble speaking and staff are not patient with him.

R1's Incident Tracking report dated 5/22/19, included, "Resident reports per interview with social services. [R1] stated the aide brought him into his room and asked if he wanted to be changed now. [R1] told her no and that he can do it himself. [R1] stated she proceeded to take his brief off and she touched him inappropriately when she did. It was not sexual. [R1] is upset because he is able to change himself and clean himself." Intervention placed by facility included, "Staff group sheets changed to encourage staff to allow resident to wipe self during pericare when possible." A follow up investigation note included, "NAR [nursing assistant, registered] interviewed on other shifts state they let him wash with some success. Resident will let them know if he needs more help-care guide updated."

During observation on 5/24/19, at 2:50 p.m. nursing assistant (NA)- E and licensed practical nurse (LPN)-D performed pericare on R1 without offering or allowing R2 to do this himself as indicated in the care plan. R1 did not resist.

When interviewed on 5/24/19, at 3:15 p.m. NA-E stated R1 had reported to her on 5/22/19, at 2:00 p.m. that a male nurse aide had performed pericare on him when he stated he wanted to do it himself. R1 had stated he was touched, "inappropriately," but not sexually, just unwanted touching of his private parts during pericare when he was capable of doing this himself. NA-E reported this to the director of nursing (DON) who started an investigation.

During observation on 5/28/19, at 11:45 a.m. R1 was being wheeled in wheel chair towards the dining room. NA-D asked R1 if he wanted to sit by the window. R1 clearly stated he did not, at which point NA-D repeated the question. R1 became visibly upset at being asked again, after already answering the question, he started yelling that he knows what he wants and does not want.

When interviewed on 5/28/19, at 12:53 p.m. R1 stated, "It would be better if they would let me do what I want and not try to control me." R1 went on to explain he can do some things himself, and it is frustrating when staff just do it for him. He felt his rights had been taken away from him.

When interviewed on 5/28/19, at 2:52 p.m. registered nurse (RN)-D stated, she was aware R1 was upset that a staff member performed pericare when he wanted to do it himself and this was investigated. RN-D stated he usually was doing own pericare with set up from staff. R1 has difficulty speaking and staff need to take the time to listen to him.

When interviewed on 5/29/19, at 2:53 p.m. NA-A denied ever having any difficulties providing care for R1 and denied R1 refusing to have them care for him.

When interviewed on 5/29/19, at 3:30 p.m. the DON stated she would expect staff to honor resident choices, if refusing care, leave and re-approach later. R1's specific choices should have been included in the care plan.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive proper nursing care and treatment regarding pain management; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.

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2 830 Continued From page 2

21550 Adminiatration of Medications; Pharmacy Serv.

Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.

Based on interview and document review the facility failed to provide controlled medications in a timely manner for 2 of 3 resident (R2, R3) reviewed.

Findings include:

R2 was admitted to the facility on 3/14/19, from the hospital after having surgery to remove hardware from her left ankle. R2's admission progress note dated 3/14/19, indicated R2 was alert and oriented to person, place and time. R2's medication orders dated 3/14/19, indicated R2 could have 4 to 6 milligrams (mg) of dilaudid every 3 hours as needed for pain. Review of the facility narcotic control log for R2's dilaudid indicated the facility received 30 half tablets of dilaudid 4 mg on 3/14/19, and an additional 50 half tablets on 3/16/19. R2 was using about 30 half tablets in 48-72 hours. On 3/19/19, the narcotic log indicated R2 had only 1 half tablet left after receiving a dose at 12:05 a.m. R2's physician orders indicated the doctor wrote a new prescription for dilaudid on 3/19/19 at 3:15 p.m.

On 5/24/19, at 11:30 a.m. R2 was interviewed by telephone and stated the care was not very professional. R2 stated the facility did not get her pain medication ordered, and she had to wait from early morning until middle afternoon for the medication to come from the pharmacy. R2 stated at approximately midnight on 3/20/19, the nurse told her there was only 3 half tablets of her dilaudid left so she was going to give her 2 then and save the other one for later in the morning hours. R2 stated the nurse told her it was because the medical doctor (MD) did not complete the prescription correctly so the pharmacy could not fill the prescription. R2 stated on 3/20/19, when she was waiting for her pain medication to get to the facility the director of nursing (DON) came into her room with the nurse manager and asked why she had not left yet. R2 told her she was waiting for her pain medication. R2 said she felt belittled and angry. R2 stated she called her case manager and the case manager called the facility to find out why R2's pain medications had not come yet. R2 stated the case manager call her back and instructed her not to leave the facility without the dilaudid. R2 stated she did not get her medications until the middle of the afternoon.

On 5/28/19, at 11:26 a.m. registered nurse (RN)-C stated in an interview that new orders are processed by the nurses. When asked how much time do you get to get a medication to facility, RN-C stated it depended on what time the order was processed and sent to the pharmacy. RN-C was unsure if there was any specific policy for pain medications, but an order marked STAT was supposed to get to the facility within 2-4 hours. RN-C stated all the nurses were responsible to make sure medication refills were received at the facility before the medication ran out. RN-C stated there was not a system to know if a medication had been ordered from the pharmacy on a refill order or a controlled substance that needed a new prescription.

On 5/28/19, at 11:35 a.m. RN-D was interviewed and stated all nurses were supposed to reorder the medications when the supply was getting low. RN-D stated she looks at the reorder date and does not reorder until that date. RN-D stated she did not recall any time when she ran out of an as needed medications for a resident. RN-D stated it was never alright for a resident to run out a pain medication especially a resident that had post operative pain.

On 5/28/19, at 3:11 p.m. during an interview (RN)-A stated on 3/19/19, R2 told RN-A she received an order to discharge to home from her surgeon. RN-A stated she told R2 the facility MD needed to see her first and if she left before that she would be leaving against medical advise. RN-A stated the MD was in the building and was able to see R2. The MD wrote the discharge order and included a prescription for dilaudid 4 mg (4-6 mg) every 3 hours as needed for pain. The facility sent the prescription to the pharmacy. When RN-A stated the MD did not put a quantity on the prescription so the pharmacy did not fill it. When asked what the staff should have done, RN-A stated the staff was supposed to get a new prescription from the MD to go to the pharmacy. RN-A stated R2's dilaudid should have been ordered at least 2 days before it was going to run out so there was time to get it filled. RN-A stated the facility did not know there was a problem with the prescription because the pharmacy did not let us know until the nurse called to ask why it had not been sent out.

On 5/29/19, at approximately 1:35 p.m. the director of nursing (DON) stated that she was unable to say why the facility failed to get the medications or the reason the prescription was not filled DON stated she could not explain why the medication was not at the facility more timely.

When interviewed on 5/30/19, at 10:10 a.m. licensed practical nurse (LPN)-A stated he normally reorder medication when there is 10 tablets remaining or a week worth left and this is to be done to prevent medication run out.

During a telephone interviewed on 5/30/19, at 12:37 p.m. Pharmacy technician (PT) revealed R2's Dilaudid first prescription was received from the facility, was an admission orders dated on 3/12/19, but the prescription was received on 3/14/19, and 15 tablets was delivered on 3/14/19, then 25 tablets was supplied on 3/16/19. PT stated, another prescription was received on 3/19/19, with invalid quantity because medical doctor (MD) wrote only 7 days and this was an as needed orders, which they cannot filled because the prescription was invalid. The pharmacist had to call the MD on 3/20/19, for valid prescription. The pharmacist obtained 84 tablets from the MD on 3/20/19 at 8:19 a.m. Pharmacy staff left the pharmacy to deliver the medication to Highland Chateau Health Care Center (HCHCC) on 3/20/19, at 1:30 p.m. The medication was delivered HCHCC on 3/20/19, at 2:55 p.m. in addition, PT indicated, pharmacy staff were not aware the medication were order for immediate (STAT) delivery until staff from the facility called and ordered the medication STAT.

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R3 was admitted to the facility 4/23/19, from the hospital with diagnoses hemiplegia from a cerebral vascular accident (CVA) on the dominant side and adjustment disorder. R3 was alert and oriented to person, place and time when interviewed. R3 was there for rehabilitation following the CVA. R3's physician orders indicated an order for Ultram 50 mg by mouth three times a day as needed for pain was written on 5/23/19. Review of progress notes indicated resident requested Ultram at 5:17 a.m. on 5/24/19, and was told no supply was available. No documentation was noted that indicated any alternative interventions were implemented. R3 was sent to ER on 5/24/19, at 9:50 a.m.

On 5/28/19, at 2:12 p.m. R3 was interviewed by telephone. R3 stated on 5/23/19, he was experiencing increased pain in his right leg and back. R3 stated the medical doctor (MD) assessed him and order a stronger pain medication for him. R3 stated later on 5/23/19, his temperature went up and sometime in the early morning of 5/24/19, he asked for the stronger pain medication and was told by the nurse that the medication had not come from the pharmacy. R3 stated he was told the MD did not put STAT on the prescription so the pharmacy thought it could wait until the regular delivery. In a subsequent interview on 5/31/19, at 11:26 a.m. R3 stated his pain was a 8 to 9 on a 0-10 scale and was a generalized aching. R3 also stated the staff offered nothing but the scheduled acetaminophen for his pain.

On 5/28/19, at approximately 3:00 p.m. RN-A stated because the MD did not write for the pharmacy to send it STAT (immediately) the pharmacy was going to send it in the regular morning delivery. RN-A stated the prescription did not get to the pharmacy until after 9:00 p.m. When asked when that delivery would get to the facility RN-A stated any time after 1:00 p.m.

When interviewed on 5/30/19, at 9:57 a.m. registered nurse (RN)-C stated, the pharmacy have dates on the medication cards of when to reorder medication. RN-C added, she received a new order Ultram from the MD for R3 and send the order to the pharmacy on 5/23/19, but could recalled what time she send the order to the pharmacy. She does recalled working that day until around 4:30 p.m.

During a telephone interviewed on 5/30/19, at 12:50 p.m. PT stated R3 was never on Ultram until 5/23/19, at 8:29 p.m. when they received the prescription for Ultram from the physician assistant (PA). The order came after cut off time for delivery. In addition, PT indicated that PA Ultram order was an electronic order with no Emergency prescription on it and no facility staff called pharmacy t alert them that the medication was needed immediately (STAT) until 5/24/19, at 7:19 a.m. when facility staff called for a STAT order.

During a telephone interviewed on 5/30/19, at 12:57 p.m. pharmacy nurse consultant (PNC) stated R3's Ultram order was process on 5/24/19, at 5:16 a.m. On 5/24/19, at 7:19 a.m. director of nursing (DON) ordered medication to be STAT order and spoke with the pharmacist who changed the order to STAT. Furthermore, PNC indicated, the medication left the pharmacy 5/24/19, at 7:24 a.m. to facility and the facility staff signed that they received the medication on 5/24/19, at 9:03 a.m.

A facility policy New Orders for Schedule III-V Controlled Substances dated 10/31/16, failed to include information on timely filling of medications.

Omnicare Pharmacy Information document dated March 2018, indicated new medications orders sent prior to 10:00 p.m. would be delivered between 12:30-6:30 a.m. The document also indicated the facility needed to reorder refills 3-5 days prior to the day the medication runs out.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures to ensure timely and accurate acquisition of medications. Nursing staff could be educated as necessary to the importance of ensuring medications are acquired as ordered and in a timely manner. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.

21830 Patients & Residents of HC Fac.Bill of Rights

Subd. 10. Participation in planning treatment; notification of family members.

(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

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(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

Based on observation, interview, and document review, the facility failed to accommodate resident preferences for 1 of 3 (R1) residents reviewed for choices.

Findings include:

R1's admission Minimum Data Set (MDS) dated 4/12/19, included severe cognitive impairment, no behavior problems, did not reject cares, was always incontinent of bowel and bladder and required extensive assistance of two plus persons for incontinent cares.

R1's neurology progress report dated 5/16/19, indicated R1 had a stroke which affected his ability to speak. R1's care plan dated 4/11/19, included an area of vulnerability related to communication and speech. However, there were no interventions to guide staff in communicating with R1. R1's care plan for activities of daily living updated 5/23/19, directed staff to encourage to participate to the fullest extent possible with each interaction. R1's mobility care plan updated 5/23/19, directed staff to, "Encourage independence by providing resident with washcloth for hygiene cares. Resident is able to perform self peri-cares. Provide resident with wet wipes during brief changes." R1's mood care plan updated 5/23/19, directed staff, "The resident needs encouragement/assistance/support to maintain as much independence and control as possible. The [sik] has upper body strength and stronger on left side of body," and "The resident needs time to talk to express feelings."

An anonymous report dated 5/20/19, included, R1 had indicated he did not want NA-A to take care of him and anonymous reporter offered to assist him instead. R1 did not want to go to bed at that time. NA-A grabbed R1's wheel chair and told R1 he did not have the right to choose who took care of him and had to go to bed when he was told. NA-A then told R1 he was, "just acting like a child." R1 told anonymous reporter he did not like NA-A and did not want NA-A caring for him. RN-B had witnessed this and did not intervene and also stated R1 was acting like a child. The anonymous reporter also indicated R1 has trouble speaking and staff are not patient with him.

R1's Incident Tracking report dated 5/22/19, included, "Resident reports per interview with social services. [R1] stated the aide brought him into his room and asked if he wanted to be changed now. [R1] told her no and that he can do it himself. [R1] stated she proceeded to take his brief off and she touched him inappropriately when she did. It was not sexual. [R1] is upset because he is able to change himself and clean himself." Intervention placed by facility included, "Staff group sheets changed to encourage staff to allow resident to wipe self during pericare when possible." A follow up investigation note included, "NAR [nursing assistant, registered] interviewed on other shifts state they let him wash with some success. Resident will let them know if he needs more help-care guide updated."

During observation on 5/24/19, at 2:50 p.m. nursing assistant (NA)- E and licensed practical nurse (LPN)-D performed pericare on R1 without offering or allowing R2 to do this himself as indicated in the care plan. R1 did not resist.

When interviewed on 5/24/19, at 3:15 p.m. NA-E stated R1 had reported to her on 5/22/19, at 2:00 p.m. that a male nurse aide had performed pericare on him when he stated he wanted to do it himself. R1 had stated he was touched, "inappropriately," but not sexually, just unwanted touching of his private parts during pericare when he was capable of doing this himself. NA-E reported this to the director of nursing (DON) who started an investigation.

During observation on 5/28/19, at 11:45 a.m. R1 was being wheeled in wheel chair towards the dining room. NA-D asked R1 if he wanted to sit by the window. R1 clearly stated he did not, at which point NA-D repeated the question. R1 became visibly upset at being asked again, after already answering the question, he started yelling that he knows what he wants and does not want.

When interviewed on 5/28/19, at 12:53 p.m. R1 stated, "It would be better if they would let me do what I want and not try to control me." R1 went on to explain he can do some things himself, and it is frustrating when staff just do it for him. He felt his rights had been taken away from him.

When interviewed on 5/28/19, at 2:52 p.m. registered nurse (RN)-D stated, she was aware R1 was upset that a staff member performed pericare when he wanted to do it himself and this was investigated. RN-D stated he usually was doing own pericare with set up from staff.

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R1 has difficulty speaking and staff need to take the time to listen to him.

When interviewed on 5/29/19, at 2:53 p.m. NA-A denied ever having any difficulties providing care for R1 and denied R1 refusing to have them care for him.

When interviewed on 5/29/19, at 3:30 p.m. the DON stated she would expect staff to honor resident choices, if refusing care, leave and re-approach later. R1's specific choices should have been included in the care plan.

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and honoring individual resident choice, and educate all staff on those policies. The DON and/or designee could conduct audits of staff interactions with residents to ensure residents are treated with dignity and resident choices are honored by staff.

TIME PERIOD FOR CORRECTION: twenty-one (21) days.