Electronically delivered

February 21, 2020

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

RE: CCN: 245028
Cycle Start Date: February 5, 2020

Dear Administrator:

On February 5, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 5, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 5, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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 02/05/2020

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 2/4/20 and 2/5/20 abbreviated survey was completed at your facility to conduct a complaint investigation. 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: H5028068C. Deficiency issued at F684 H5028065C. Deficiency issued at F697 The following complaints were found to be SUBSTANTIATED with NO deficiencies cited due to actions implemented by the facility prior to survey. H5028067C H5028069C H5028066C 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. From (dates), an abbreviated standard survey was completed at your facility by the Minnesota	F 000		

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

Electronically Signed | 02/28/2020

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F 000	Continued From page 1 Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor cardiac status for 1 of 1 resident's (R2) who required daily monitoring due to congestive heart failure (CHF) with a recent hospital stay. Findings include: R2's Minimum Data Set (MDS) indicated an entry to the facility on 9/3/19 and death in the facility on 9/8/19. R2's admission MDS dated 9/8/19, included R2 was cognitively intact, did not reject cares, required extensive to total assistance for most activites of daily living (ADL's) and received a diuretic (water pill) 4 days out of the 7 day assessment period. The MDS did not include a diagnosis of CHF and did not include any height or weight for R2. R2's hospital record, dated 8/27/19 to 9/3/19,	F 684	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission	3/18/20

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F 684	Continued From page 2 included, "Acute on chronic HFpEF [heart failure with preserved ejection fraction," and, "hypotension [low blood pressure]." R2's hospital care included, "daily weights were taken." R2's diagnosis report, dated 9/3/19, included, chronic diastolic (congestive) heart failure, essential (primary) hypertension [high blood pressure], and acute kidney failure, unspecified. R2's physician progress note, dated 9/5/19, included, "He was admitted [to hospital] 8/27-9/3/ with severe low back pain after fall at home. Found to also have decompensated CHF-treated with IV diuretics-->developed AKI [acute kidney injury]." "Found to have also have had decompensated CHF--weight was up 15 lbs [pounds] from baseline," and directed staff, "daily weights please." The progress note further included, "Essential (primary hypertension): Fluctuating BP's [blood pressure]," and directed staff, "Monitor BP's." R2's physician progress note, dated 9/6/19, included, "Chronic diastolic (congestive) heart failure" and directed, "daily weights please." R2's vitals report failed to include any blood pressure, pulse, respiration or oxygen saturation for 9/5/19. R2's vitals report failed to include any weights from entry on 9/3/19 through death on 9/8/19. R2's progress notes, dated 9/3/19 through 9/8/19, failed to include any monitoring of edema or daily weights. R2's September 2019 medication and treatment administration record (MAR/TAR) revealed R2	F 684	of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. R2 no longer resides at the community All other residents with diagnosis of CHF have been reviewed and have daily weight monitoring unless otherwise indicated by provider. Licensed nurses educated daily CHF monitoring to include daily weights. Audit of daily weights will be completed 3 times per week for 4 weeks then monthly for 2 months to ensure daily weights are being completed. DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed	

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F 684	Continued From page 3	F 684		

refused to be weighted on 9/7/19. No other weights or attempts to weigh were documented.

R2's individual resident care plan, dated 9/5/19, included a diet order for, "cardiac 2 g NA [grams sodium] per day." No other problems, goals or interventions addressed R2's diagnosis of CHF or any monitoring required for this diagnosis.

On 2/5/20, at 9:51 a.m. a confidential reporter (CR)-2 reported R2 was not being monitored appropriately for cardiac diagnoses. CR-2 explained R2 had been hospitalized prior to admission for cardiac issues. CR-2 explained while doing a review of R2's record, she noted R2's weights and vitals were not monitored on a daily basis, as required. CR-2 noted she had brought the issue to the attention of administrator, but since change in leadership staff at facility, was not aware of the issues being resolved.

On 2/5/20, at 2:00 p.m. the transitional care nurses (RN)-A and (RN)-B, reported weights and vitals should be done daily for patients with CHF. RN-A and RN-B were not familiar with R2 and unable to locate any weights.

On 2/5/20, at 3:00 p.m. the assistant administrator acknowledged there were no recorded weight for R2 and staff missed R2's 9/5/19 BP, pulse, respirations and oxygen saturation.

The facility's Standing Orders, last updated 7/27/18, directed staff, "For patients with CHF: 1. Weigh daily. 2. Call for weight gain >2# [over 2 pounds] in 24 hours or 5# above weekly weight. 3. Assess lung sounds, peripheral edema, and respiratory effort daily."

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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, 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 1 of 3 residents (R1) reviewed had a comprehensive individualized care plan to manage pain and associated anxiety. Findings include: R1's admission Minimum Data Set (MDS) dated 12/21/19, included, severe cognitive impairment, diagnoses of cancer, hip fracture and anxiety, and required extensive assistance for most activities of daily living (ADL's). R1's pain had not been assessed, however had received scheduled pain medication, no PRN (as needed) pain pain medication and no non-medication interventions for pain during the assessment period. A care area assessment (CAA) for pain had not been completed. R1's 5 day MDS dated 1/17/20, included, frequent pain rated at a, "09" (0 being no pain and 10 being most severe pain). R1's pain limited his day to day activities. R1 received scheduled and prn pain medications. R1 did not receive non-medication intervention for pain. R1's hospital discharge summary, dated 12/14/19, included the following diagnoses: malignant bone pain, unspecified intellectual	F 697	R1 no longer resides at the community All resident's pain assessments will be reviewed and care plan updated as indicated Licensed nurses will be educated on comprehensive pain assessment and treatment for pain and related anxiety. Audits will be conducted 3 times weekly for 4 weeks then monthly for 2 months to ensure pain is assessed and care plans are updated. DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed.	3/18/20

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F 697	Continued From page 5	F 697		

disabilities, metastasis (spread) from malignant (cancerous) tumor of lung and closed fracture of trochanter of right femur. R1's discharge summary noted "[R1] had a daily physical complaint," and, "he perseverates on fears of dying. This made an assessment of patient's pain very difficult."

R1's baseline care plan, dated 12/6/19 and signed 12/20/19, included, "Presence of pain: No."

R1's care plan initiated 12/24/19, and revised 1/9/20, failed to identify pain as a focus, have any goals for pain management, and failed to direct staff on how to manage R1's pain or anxiety.

R1's medication and treatment administration record (MAR/TAR), dated December 2019 and January 2020, included the following scheduled pain medication orders: Oxycodone (opioid pain medication) 5 mg (milligrams) orally four times daily, ordered 1/15/20; Acetaminophen 1000 mg orally every 8 hours, ordered 12/14/19, Aspercreme 4% lidocaine cream to right should and right upper chest three times daily, ordered 12/18/19; Aspirin EC 325 mg orally twice daily with meals for 30 days, ordered 12/14/19; Gabapentin 300 mg orally twice daily, ordered 12/18/19; Lidocaine 5% adhesive patch, on at 8 a.m. and off at 8 p.m., ordered 12/12/14; Oxycodone 5 mg orally every 8 hours, ordered 1/6/20 to 1/15/20.

R1's December 2019 and January 2020 MAR/TAR displayed R1's orders and administration of prn pain medications: *Hydromorphone (opioid pain medication) HCL 2 -4 mg orally every 3 hours as needed, 2 mg for

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F 697	Continued From page 6 pain less than 5 or 4 mg for pain greater than 5, ordered 12/13/19 and end 1/7/20: administered once on 12/14/19, 12/15/19 and 12/17/19, twice on 12/18/19 and 12/19/19, once on 12/20/19, 12/20/19, 12/21/19 and 12/22/19, once on 12/24/19 and 12/25/19, three times on 12/26/19, twice on 12/27/19, 12/28/19 and 12/29/19, once on 12/30/19, twice on 12/31/19, twice on 1/1/20, twice on 1/4/20, once on 1/5/20, twice on 1/6/20 and 1/7/20 *Oxycodone 5 mg orally every day prn at least 2 hours from scheduled dose, start 1/6/20 and end 1/15/20: administered once each on 1/8/20, 1/9/20, 1/10/20 and 1/13/20 *Oxycodone 5 mg orally every 6 hours prn, ordered 1/15/20: administered twice on 1/21/20 and 1/22/20 *Acetaminophen 600 mg every 6 hours prn, ordered 1/22/20: not administered R1's January 2020 MAR/TAR revealed a pain monitoring tool for each shift. Each shift was to monitor the type of pain (e.g. aching dull or burning), location of pain, severity level from 1-10, non pharmacological intervention (e.g.. relaxation, positioning, distraction), if a prn medication was given and if it was effective. R1 was noted as experiencing pain at severity levels above "0" on the following dates and shifts: 8 on 1/20/20 day shift; 7 on 1/15/20 day shift; 8 on 1/22/20 day shift; and 6 on 1/3/20 evening shift. Pain monitoring was not completed for December 2019. On 2/4/20, at 12:31 p.m. a confidential reporter (CR) was interviewed. CR reported observing R1 calling out daily due to pain and anxiety. CR reported R1 made statements such as "my body	F 697		

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F 697	Continued From page 7	F 697		

doesn't feel good" and "going to die." R1 would ask to go to the hospital. CR reported R1 had intellectual disability and had trouble understanding his medical condition. R1 was unable to make medical decisions for himself, but had not been assigned a guardian or someone to make decisions for him. CR reported some staff attempted to make R1 more comfortable by repositioning, medications, distraction and activities. Some staff did not assist R1 with his pain. CR stated she did not think staff were trained in how to to respond to R1 as his behavior and communication was different related to his intellectual disability. CR reported R1 had end of life system failure, had increased discomfort in his last days and died after being sent to the hospital via emergency medical services on 1/22/20.

On 2/4/20, at 4:07 p.m. registered nurse (RN)-A, reported R1 had difficulty verbalizing pain. R1 would appear, "restless" or "scream" if he had pain. RN-A reported he had called the nurse practitioner or physician when he noticed an increase in pain from baseline.

On 2/4/20, at 5:27 p.m. the director of nursing (DON) reported R1 did experience pain. DON reported pain was not on R1's care plan and verified pain was not triggered as a care area assessment. DON reported a pain focus, goal and interventions specific to R1 should have been included on his care plan. DON reported the previous director of nursing and both nurse managers had left without notice, which caused comprehensive care plans to not be created for some residents.

On 2/4/20, at 5:55 p.m. nursing assistant (NA)-A

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F 697	Continued From page 8 reported R1, "always had pain," and would call out sometimes. NA-A reported some days R1's pain was worse than others. NA-A reported R1 was more anxious when he was in pain. NA-A reported on the day R1 left via emergency medical services (EMS), he had been asking to go to the hospital. NA-A reported he was still in pain after she laid him down and the nurse gave him pain medication. On 2/4/20, at 3:30 p.m. (NA)-B reported R1 was always complaining of pain. NA-B reported the day R1 left via EMS he was complaining he could not breathe and moaning. On 2/5/20, at 2:20 p.m. RN-A and RN-B reviewed the pain monitoring tool on R1's January 2020 MAR/TAR. RN-A and RN-B explained the pain monitoring tool was not specific to R1, but used for all patients. It was not part of R1's care plan. RN-A reported R1 had difficulty articulating his pain and staff had difficulty understanding him related to his intellectual disability. RN-A reported this led to the pain monitoring tool being difficult to fill out as R1 would not answer the questions clearly related to pain. RN-A explained this led to a discrepancy between R1's pain monitoring tool and the usage of prn pain medications. Policies on care plans and pain managements were requested but not provided.	F 697		

Electronically delivered
February 21, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: YT7W11

Dear Administrator:

The above facility was surveyed on February 4, 2020 through February 5, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor
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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 02/05/2020

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

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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: A complaint investigation was conducted on 2/4/20 and 2/5/20 to investigate complaints H5028067C, H5028069C, H5028066C, H5028065C and H5028068C. As a result the following was identified: The complaints were found to be substantiated:	2 000		

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2 000	Continued From page 1 H5028067C, H5028069C and H5028066C with no corresponding citations issued. The complaints were found to be substantiated: H5028065C and H5028068C with licensing orders issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 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 the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor cardiac status for 1 of 1 resident's (R2) who required daily monitoring due to congestive heart failure (CHF) with a recent hospital stay. In addition, based on	2 830	Corrected	3/18/20

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2 830	Continued From page 2 interview and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed had a comprehensive individualized care plan to manage pain and associated anxiety. Findings include: R2's Minimum Data Set (MDS) indicated an entry to the facility on 9/3/19 and death in the facility on 9/8/19. R2's admission MDS dated 9/8/19, included R2 was cognitively intact, did not reject cares, required extensive to total assistance for most activites of daily living (ADL's) and received a diuretic (water pill) 4 days out of the 7 day assessment period. The MDS did not include a diagnosis of CHF and did not include any height or weight for R2. R2's hospital record, dated 8/27/19 to 9/3/19, included, "Acute on chronic HFpEF [heart failure with preserved ejection fraction," and, "hypotension [low blood pressure]." R2's hospital care included, "daily weights were taken." R2's diagnosis report, dated 9/3/19, included, chronic diastolic (congestive) heart failure, essential (primary) hypertension [high blood pressure], and acute kidney failure, unspecified. R2's physician progress note, dated 9/5/19, included, "He was admitted [to hospital] 8/27-9/3/ with severe low back pain after fall at home. Found to also have decompensated CHF-treated with IV diuretics-->developed AKI [acute kidney injury]." "Found to have also have had decompensated CHF--weight was up 15 lbs [pounds] from baseline," and directed staff, "daily weights please." The progress note further included, "Essential (primary hypertension): Fluctuating BP's [blood pressure]," and directed	2 830		

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2 830	Continued From page 3 staff, "Monitor BP's." R2's physician progress note, dated 9/6/19, included, "Chronic diastolic (congestive) heart failure" and directed, "daily weights please." R2's vitals report failed to include any blood pressure, pulse, respiration or oxygen saturation for 9/5/19. R2's vitals report failed to include any weights from entry on 9/3/19 through death on 9/8/19. R2's progress notes, dated 9/3/19 through 9/8/19, failed to include any monitoring of edema or daily weights. R2's September 2019 medication and treatment administration record (MAR/TAR) revealed R2 refused to be weighted on 9/7/19. No other weights or attempts to weigh were documented. R2's individual resident care plan, dated 9/5/19, included a diet order for, "cardiac 2 g NA [grams sodium] per day." No other problems, goals or interventions addressed R2's diagnosis of CHF or any monitoring required for this diagnosis. On 2/5/20, at 9:51 a.m. a confidential reporter (CR)-2 reported R2 was not being monitored appropriately for cardiac diagnoses. CR-2 explained R2 had been hospitalized prior to admission for cardiac issues. CR-2 explained while doing a review of R2's record, she noted R2's weights and vitals were not monitored on a daily basis, as required. CR-2 noted she had brought the issue to the attention of administrator, but since change in leadership staff at facility, was not aware of the issues being resolved. On 2/5/20, at 2:00 p.m. the transitional care	2 830		

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2 830	Continued From page 4 nurses (RN)-A and (RN)-B, reported weights and vitals should be done daily for patients with CHF. RN-A and RN-B were not familiar with R2 and unable to locate any weights. On 2/5/20, at 3:00 p.m. the assistant administrator acknowledged there were no recorded weight for R2 and staff missed R2's 9/5/19 BP, pulse, respirations and oxygen saturation. The facility's Standing Orders, last updated 7/27/18, directed staff, "For patients with CHF: 1. Weigh daily. 2. Call for weight gain >2# [over 2 pounds] in 24 hours or 5# above weekly weight. 3. Assess lung sounds, peripheral edema, and respiratory effort daily." R1's admission Minimum Data Set (MDS) dated 12/21/19, included, severe cognitive impairment, diagnoses of cancer, hip fracture and anxiety, and required extensive assistance for most activities of daily living (ADL's). R1's pain had not been assessed, however had received scheduled pain medication, no PRN (as needed) pain pain medication and no non-medication interventions for pain during the assessment period. A care area assessment (CAA) for pain had not been completed. R1's 5 day MDS dated 1/17/20, included, frequent pain rated at a, "09" (0 being no pain and 10 being most severe pain). R1's pain limited his day to day activities. R1 received scheduled and prn pain medications. R1 did not receive non-medication intervention for pain. R1's hospital discharge summary, dated 12/14/19, included the following diagnoses:	2 830		

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2 830	Continued From page 5 malignant bone pain, unspecified intellectual disabilities, metastasis (spread) from malignant (cancerous) tumor of lung and closed fracture of trochanter of right femur. R1's discharge summary noted "[R1] had a daily physical complaint," and, "he perseverates on fears of dying. This made an assessment of patient's pain very difficult." R1's baseline care plan, dated 12/6/19 and signed 12/20/19, included, "Presence of pain: No." R1's care plan initiated 12/24/19, and revised 1/9/20, failed to identify pain as a focus, have any goals for pain management, and failed to direct staff on how to manage R1's pain or anxiety. R1's medication and treatment administration record (MAR/TAR), dated December 2019 and January 2020, included the following scheduled pain medication orders: Oxycodone (opioid pain medication) 5 mg (milligrams) orally four times daily, ordered 1/15/20; Acetaminophen 1000 mg orally every 8 hours, ordered 12/14/19, Aspercreme 4% lidocaine cream to right should and right upper chest three times daily, ordered 12/18/19; Aspirin EC 325 mg orally twice daily with meals for 30 days, ordered 12/14/19; Gabapentin 300 mg orally twice daily, ordered 12/18/19; Lidocaine 5% adhesive patch, on at 8 a.m. and off at 8 p.m., ordered 12/12/14; Oxycodone 5 mg orally every 8 hours, ordered 1/6/20 to 1/15/20. R1's December 2019 and January 2020 MAR/TAR displayed R1's orders and administration of prn pain medications: *Hydromorphone (opioid pain medication) HCL 2 -4 mg orally every 3 hours as needed, 2 mg for	2 830		

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2 830	Continued From page 6 pain less than 5 or 4 mg for pain greater than 5, ordered 12/13/19 and end 1/7/20: administered once on 12/14/19, 12/15/19 and 12/17/19, twice on 12/18/19 and 12/19/19, once on 12/20/19, 12/20/19, 12/21/19 and 12/22/19, once on 12/24/19 and 12/25/19, three times on 12/26/19, twice on 12/27/19, 12/28/19 and 12/29/19, once on 12/30/19, twice on 12/31/19, twice on 1/1/20, twice on 1/4/20, once on 1/5/20, twice on 1/6/20 and 1/7/20 *Oxycodone 5 mg orally every day prn at least 2 hours from scheduled dose, start 1/6/20 and end 1/15/20: administered once each on 1/8/20, 1/9/20, 1/10/20 and 1/13/20 *Oxycodone 5 mg orally every 6 hours prn, ordered 1/15/20: administered twice on 1/21/20 and 1/22/20 *Acetaminophen 600 mg every 6 hours prn, ordered 1/22/20: not administered R1's January 2020 MAR/TAR revealed a pain monitoring tool for each shift. Each shift was to monitor the type of pain (e.g. aching dull or burning), location of pain, severity level from 1-10, non pharmacological intervention (e.g.. relaxation, positioning, distraction), if a prn medication was given and if it was effective. R1 was noted as experiencing pain at severity levels above "0" on the following dates and shifts: 8 on 1/20/20 day shift; 7 on 1/15/20 day shift; 8 on 1/22/20 day shift; and 6 on 1/3/20 evening shift. Pain monitoring was not completed for December 2019. On 2/4/20, at 12:31 p.m. a confidential reporter (CR) was interviewed. CR reported observing R1 calling out daily due to pain and anxiety. CR reported R1 made statements such as "my body doesn't feel good" and "going to die." R1 would	2 830		

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2 830	Continued From page 7 ask to go to the hospital. CR reported R1 had intellectual disability and had trouble understanding his medical condition. R1 was unable to make medical decisions for himself, but had not been assigned a guardian or someone to make decisions for him. CR reported some staff attempted to make R1 more comfortable by repositioning, medications, distraction and activities. Some staff did not assist R1 with his pain. CR stated she did not think staff were trained in how to to respond to R1 as his behavior and communication was different related to his intellectual disability. CR reported R1 had end of life system failure, had increased discomfort in his last days and died after being sent to the hospital via emergency medical services on 1/22/20. On 2/4/20, at 4:07 p.m. registered nurse (RN)-A, reported R1 had difficulty verbalizing pain. R1 would appear, "restless" or "scream" if he had pain. RN-A reported he had called the nurse practitioner or physician when he noticed an increase in pain from baseline. On 2/4/20, at 5:27 p.m. the director of nursing (DON) reported R1 did experience pain. DON reported pain was not on R1's care plan and verified pain was not triggered as a care area assessment. DON reported a pain focus, goal and interventions specific to R1 should have been included on his care plan. DON reported the previous director of nursing and both nurse managers had left without notice, which caused comprehensive care plans to not be created for some residents. On 2/4/20, at 5:55 p.m. nursing assistant (NA)-A reported R1, "always had pain," and would call out sometimes. NA-A reported some days R1's	2 830		

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2 830	Continued From page 8 pain was worse than others. NA-A reported R1 was more anxious when he was in pain. NA-A reported on the day R1 left via emergency medical services (EMS), he had been asking to go to the hospital. NA-A reported he was still in pain after she laid him down and the nurse gave him pain medication. On 2/4/20, at 3:30 p.m. (NA)-B reported R1 was always complaining of pain. NA-B reported the day R1 left via EMS he was complaining he could not breathe and moaning. On 2/5/20, at 2:20 p.m. RN-A and RN-B reviewed the pain monitoring tool on R1's January 2020 MAR/TAR. RN-A and RN-B explained the pain monitoring tool was not specific to R1, but used for all patients. It was not part of R1's care plan. RN-A reported R1 had difficulty articulating his pain and staff had difficulty understanding him related to his intellectual disability. RN-A reported this led to the pain monitoring tool being difficult to fill out as R1 would not answer the questions clearly related to pain. RN-A explained this led to a discrepancy between R1's pain monitoring tool and the usage of prn pain medications. Policies on care plans and pain managements were requested but not provided. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary care and services to prevent or improve areas from occurring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment.	2 830		

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2 830	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		