



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 13, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: April 6, 2023

Dear Administrator:

On June 8, 2023, we informed you of imposed enforcement remedies.

On June 7, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be 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.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 6, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 6, 2023.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 6, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Operations Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 6, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 6, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

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

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

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

Highland Operations LLC

June 13, 2023

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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/ltr_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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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June 13, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: Event ID: CCEY11

Dear Administrator:

The above facility survey was completed on June 7, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/07/2023
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 6/6/23, through 6/7/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaint was reviewed. H50282662C (MN00094015), with a deficiency cited at F600. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600			6/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/14/2023

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

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from abuse for 2 of 4 residents (R1 and R2) reviewed when while in the elevator R1 hit R2 and held R2 on the ground. Findings include: R1's significant change Minimum Data Set (MDS) dated 5/11/23, indicated intact cognition, and independent with activities of daily living (ADL). R1's progress notes entered on 5/28/23, at 7:08 a.m. indicated an incident transpired between R1 and R2 inside the elevator before 5:02 a.m. R1's care plan initiated on 5/30/23, identified potential to be verbally and physically aggressive related to poor impulse control, with the interventions added on 6/6/23, including directions for staff to intervene before agitation escalates, and guide away from source of distress. R1's progress notes entered on 5/28/23, at 8:07 a.m. indicated R1 was in the elevator at the same time with R2. When R1 asked R2 to move out of the way, they exchanged words, and then R1 kicked R2's wheelchair and hit R2 on the head. R2 got upset and they got into a physical altercation. The facility's incident report #174 noted a physical altercation between R1 and R2 in the elevator on	F 600	F 600 R 1 and R 2 have had no further incidents in the facility. R1 and R2 risk management incidents will be completed, and a root cause identified for this incident. R1 and R2 care plans were reviewed and both resident triggers were added to their behavior care plans. R 2 will have a new BIMs and PHQ9 completed, and the MD/NP will be updated on the results. All other existing residents who have the potential to be verbally and/or physically aggressive, their care plans were reviewed, and triggers updated as needed. Future residents will be assessed for aggressive behaviors and immediate interventions will be implemented post incident. Facility staff will be in-serviced on the Resident-to-Resident Policy with emphasis on item 4f that the care plan will be updated and/or revised and that charting will reflect if the interventions are effective. Director of Nursing and/or designee is responsible for compliance. Audits on resident-to-resident incidents and care plan updates post incident and charting of effectiveness of interventions will begin 2x week for 4 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review		

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F 600	Continued From page 2 5/28/23. R2's quarterly MDS dated 5/13/23, identified R1's medical diagnoses including dementia and seizure disorder. The quarterly MDS showed that R2 was independent with ADL. The quarterly MDS also showed non-completion of R2's cognition assessment, but the immediate prior assessment completed for R2's annual MDS dated 2/11/23 indicated severe cognitive impairment. R2's care plan initiated on 10/18/22, identified R2's potential to be physically aggressive related to anger, history of harm to others, and poor impulse control. The care plan noted, "[R2's] triggers for physical aggression happens when [R2] feels someone [R2] likes is in danger." The interventions included the following: de-escalate by redirecting and removing from situation, intervene before agitation escalates, guide away from source of distress, and encourage R2 to stay on the East side of the dining room and encourage to stay away from two other identified residents, but did not include staying away from R1. R2's care plan initiated on 12/20/22, indicated potential to be verbally aggressive related to altered mental status and poor impulse control. The interventions include directions for staff to intervene before agitation escalates, and guide away from source of distress. R2's care plan initiated on 9/1/22, identified R2's risk for compromised safety and potential for abuse due to lack of awareness of personal space, and inability to identify boundaries. The interventions directed staff to remove R2 from	F 600	and recommendation. Compliance: 6/15/2023		

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F 600	Continued From page 3 potentially dangerous situations, and to redirect when confused or at risk for doing something that might cause distress. R2's progress notes dated, 5/28/23, at 8:05 a.m. documented staff went to check on the noise inside the elevator and found R1 holding R2 "on the ground" and wheelchair by the side. The progress notes indicated verbal altercation that progressed to physical altercation between R1 and R2, while they were together in the elevator. The facility's incident report #173 documented the physical altercation between R1 and R2 in the elevator on 5/28/23. However, the incident report also indicated that R2 denied an altercation with peer, as noted during a follow-up interview on 6/2/23. During interview on 6/6/23, at 12:37 p.m. R1 verified the incident with R2 and said, "It is hard to control all the people living in an enclosed place like this, you have to deal with people who have behaviors and attitudes. You try to be as tolerant, but it is hard." During interview on 6/6/23, at 2:55 p.m. nursing assistant (NA)-A, stated, "[R2] is fine if not triggered" but will react if somebody is saying something like "ape." NA-A said she learned that there was a physical altercation that happened about a week ago between R2 and R1 but did not witness it. During interview on 6/6/23, at 4:30 p.m. licensed practical nurse (LPN)-B, also stated that it is his 2nd day coming off orientation but have heard about the physical altercation between R2 and another resident that he was unable to name.	F 600			

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F 600	Continued From page 4 LPN-B said he was made to sign an education sheet about separating the 2 residents. During interview on 6/7/23, at 7:10 a.m. LPN-C, identified self as the one who heard the "loud noises" in the elevator in the morning of 5/28/23. LPN-C stated she had to open the elevator and found R1 and R2 inside. LPN-C stated that R1 was holding R2 on the floor. LPN-C also stated that R2 went upstairs while R1 stayed on the 1st floor and told LPN-C what happened, which she said she wrote in the progress notes. When asked about facility's action plan after the incident, LPN-C replied that they no had to "put [R2] on 30-minute checks to ensure they are not in contact with each other." During interview on 6/7/23, at 10:29 a.m. the director of nursing (DON) verified R2's care plan included focus areas regarding R2's potential to be physically and verbally aggressive related to altered mental status and poor impulse control and putting R2's safety at risk and potential for abuse. The DON acknowledged R2's previous altercations with other residents. The DON also verified that R2's care plan showed corresponding action plans that included R2 to stay away from specific residents R2 had previous altercations. The DON stated that staff were not able to implement the care plan interventions (de-escalate aggression, re-direct, remove before escalation) because the altercation between R2 and R1 happened inside the elevator. The DON stated staff were educated to keep eyesight on R1 and R2, and if unable to keep eyesight, to encourage them to stay away from each other, and to intervene if they see aggression between them. The DON further stated expectation that this intervention should	F 600			

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F 600	Continued From page 5 work for R1 and R2, saying it worked for R2 and the other residents whom R2 had altercations before. The DON added that even though an altercation happened between R1 and R2, there had been no further incidents between R2 and the previous residents. The DON also clarified that the "every 30-minute checking" has been in place prior to R1 and R2's altercation, and it was to prevent R2 from entering other residents' rooms. The DON verified that R1 and R2's care plans did not include directions for staff to ensure they specifically stay away from each other. The facility policy titled, Resident-to-Resident Altercations, dated 10/18/22, directed staff to monitor residents for aggressive/inappropriate behaviors towards other residents. The policy defined behaviors that may provoke a reaction by residents include verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating; physically aggressive behavior, such as hitting, kicking, grabbing, pushing/shoving, threatening gestures; and wandering into others' rooms/space. The policy indicated that if two or more residents are involved in an altercation, staff are directed to: identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; make necessary changes in the care plan approaches to any or all the involved individuals; document in the clinical record all interventions and their effectiveness.	F 600			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2023
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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: On 6/6/23 through 6/7/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed during the	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/14/23

Minnesota Department of Health

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2 000	Continued From page 1 survey. H50282662C (MN00094015). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	2 000			