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	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise R1's care plan after a change occurred for 1 of 3 residents reviewed for care plan development and implementation. R1's care plan was not revised to include increased needs in cares for home exercise program dated 9/11/25 by physical therapy (PT), for R1's comprehensive assessment dated [DATE] for maximum assistance in some of her ADL's, and to restart therapy on 11/18/25.Findings include: R1's care plan dated 4/28/25 indicated R1's functional status required: Dressing supervision and set-up only. Eating - independent, no set-up or physical help. Personal hygiene - independent, no set-up or physical help. Toilet use - independent, no set-up or physical help. Transfers - independent, no set-up or physical help. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 had no limited ROM in her upper extremities or lower extremities. She was independent in eating, oral hygiene, upper body dressing, personal hygiene, rolling in bed, lying to sitting on the side of the bed, sitting to standing and toilet transfer. Ambulation and showering were not assessed. She used a manual wheelchair and was dependent to wheel at least 50 feet and make two turns. R1's pertinent diagnoses were metabolic encephalopathy (a brain dysfunction from a chemical imbalance due to a systemic illness), hypothyroidism, obesity, alcohol use, opioid dependence, paroxysmal atrial fibrillation (irregular heart rate that starts and stops on its own), aphasia following cerebral infarction (difficulty swallowing following a stroke), depression, anxiety, and heart failure. R1's PT discharge summary note dated 9/11/24 indicated R1 had a home exercise program for lower extremity strength and range of motion (ROM). This order did not indicate the frequency or staff involvement for R1. R1's progress note dated 8/18/25 indicated R1 was being sent to the hospital to evaluate severe back and hip pain not resolved with opioids. R1 stated she had a fall the previous day and did not tell anyone. R1's Hospital Encounter dated 8/18/25 indicated R1 was admitted with a urinary tract infection and falls, discharging on 8/20/25 with antibiotics. R1's Hospital service date 8/27/25 indicated R1 admitted on [DATE] with acute respiratory failure with hypercapnia, acute metabolic encephalopathy, congestive heart failure, chronic obstructive pulmonary disease hypercarbic encephalopathy. R1's progress noted dated 9/1/25 indicated R1 admitted back to the facility using a wheelchair, resident was bedfast most of the time. R1's re-admission MDS dated [DATE] indicated R1 required maximum assistance with toileting hygiene, rolling from left to right in bed, sitting to lying and lying to sitting, sitting to standing and chair to bed and bed to chair transferring. Ambulation was not assessed. R1's progress note dated 10/25/25 indicated R1 was sent to the hospital due to a fall and confusion. Hospital discharge date d 10/28/25 indicated R1 admitted with acute metabolic encephalopathy after a fall and was currently on Macrobid for a urinary tract infection. R1 had a history of morbid obesity, hypercapnic respiratory failure, heart failure with preserved ejection fraction. R1 believed to be back at baseline cognitively and has gotten up and ambulated with the help of staff. Her hospital course acute metabolic encephalopathy, resolved, urinary tract infection, acute kidney injury improving, right leg pain, history of falls, bilateral neuropathy, essential tremor is new. R1's neuropathy is likely contributing to frequency of falls, R1 was recommended for home physical therapy, neurology referral for neuropathy and follow-up with primary care physician. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene, bathing, and lower body dressing. She required maximum assistance with upper body dressing and needed set-up with personal hygiene which included hair coming, shaving, applying make-up, washing and/drying face and hands. R1 was independent with rolling in bed, sitting to lying, sitting to standing and refused to transfer from the bed to the chair. R1's provider nursing home visit note dated 11/18/25 at 3:02 p.m. indicated R1's assessment indicated R1 had functional decompensation related to, deconditioning, decreased endurance, activity of daily Living (ADL's) impairment, abnormality of gait, muscle weakness, decreased activity tolerance, deep vein thrombosis risk due to decreased mobility, constipation risk due to decreased mobility and pain medication, skin breakdown risk due to decreased mobility. R1's plan was to continue with current medication regimen with the plan to increase gabapentin in two weeks if she was still having pain. R1 was ordered to participate in rehabilitation with services PT/OT/Rehab nursing. Evaluation and treatment of deficits in ADL's including patient and caregiver education, ROM/stretching, strengthening, neuromuscular re-education, modalities. This order was never processed. R1's goals were Goals being set forth as

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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	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to designate a registered nurse to serve as the director of nursing (DON) on a full-time basis following the exit of the former DON. This practice had the potential to affect all 54 residents who resided at the facility. Findings include: Upon entrance interview on 12/29/25 at 9:39 a.m. licensed practical nurse, (LPN)-B stated she was the only administration staff on duty and had been acting as the DON for the last two weeks. The former DON's human resource file indicated she was let go of her duties on 12/17/25. Upon interview on 12/30/25 at 9:17 a.m. the Director of Human Resources stated he was not certain who was acting as the DON currently. He stated that he was not involved in the hiring process of a new DON as the corporate office had been taking care of new DON applications and interviews. Upon interview on 12/30/25 at 3:46 p.m. the Administrator stated the facility did not have a DON. The facility was using a team effort with the ADON, nursing staff and the [NAME] President of Clinical Services to cover the open role. She was not certain where corporate was in the process of a new hire. Upon interview on 12/30/25 at 4:25 p.m. the [NAME] President of Clinical Services stated the facility was working without a DON and she was not able to assume the role on a full-time basis. A facility policy regarding required nursing services was requested however none received.