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	01/24/2025

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview, and document review, the facility failed to perform an assessment for self-administration of medications (SAM), and failed to perform Interdisciplinary Team (IDT) review for SAM for 1 of 3 residents (R5) reviewed for accurate medication administration, who kept an antiseizure medication locked in her bedside table and self-administered the medication twice daily without staff oversight. Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact. R5's Orders dated 1/23/25, indicated levetiracetam (generic Keppra) 500 milligrams (mg), Give 1500 mg by mouth two times a day for seizures. Take three tablets. Make sure that a nurse witnesses her taking the Keppra. R5's Diagnoses List printed 1/24/25, lacked indication R5 had a diagnosis of seizures. R5's care plan printed 1/24/25, lacked indication R5 could self-administer Keppra (antiseizure medication). R5's Medication Administration Record (MAR) indicated R5 had not missed doses of Keppra, though R5 had taken the medication independently and unwitnessed. On 1/24/25 at 9:25 a.m., licensed practical nurse (LPN)-A stated she documented in a progress note on 1/17/25 at 5:32 p.m., R5 had a seizure. It was the first seizure R5 had in the facility, but she knew R5 had a history of seizures prior to admission to the facility. When she notified R5's family member (FM)-B about the seizure, FM-B inquired if R5 had taken her seizure medication. She informed FM-B, She takes it [Keppra] herself. As far as I know, she is self-administration. LPN-A acknowledged R5's medical record did not contain a SAM assessment and acknowledged the medical record lacked indication IDT reviewed R5's ability to self-administer Keppra. She further acknowledged she had not witnessed R5 taking Keppra on 1/24/25, as instructed in the order. She was not aware of the order to witness Keppra administration. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 9:47 a.m., the director of nursing, (DON) stated she knew R5 had Keppra in her bedside table. R5 was supposed to give the medication to staff, but she had not checked to ensure the medication had been given to staff. She acknowledged R5 had not had a SAM assessment nor IDT review to self-administer the Keppra. On 1/24/25 at 10:10 a.m., R5 stated she kept Keppra in her bedside drawer, staff did not witness when she self-administered Keppra, and staff had not performed an assessment to ensure she knew how to self-administer Keppra. LPN-A had not witnessed her self-administering the Keppra that morning. R5 opened her bedside drawer and demonstrated she had a labeled bottle of Keppra. On 1/24/25 at 1:38 p.m., pharmacist (P)-A stated the resident's medical provider typically authorized SAM, and if the resident was not assessed for SAM and took the medications incorrectly, the resident could have seizures if doses were missed. On 1/24/25 at 2:07 p.m., medical doctor (MD)-A stated she had not assessed R5, but had not previously allowed any resident in the facility to self-administer Keppra. She was not aware a SAM assessment and IDT review was required for SAM, as she was new to working in this facility. The facility policy Self-Administration of Medications dated 12/13/21, indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview, and document review, the facility failed to ensure adequate staffing to answer call lights timely for 3 of 3 residents (R2, R3, R4) reviewed for call lights. In addition, the facility failed to provide adequate staffing to ensure scheduled baths were provided to residents who required assistance from staff for activities of daily living (ADLs). Findings include: R2 R2's Medicare 5-day Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact. The MDS further indicated R2 was dependent upon staff for toileting, was always incontinent of bowels, and required maximum assist of staff for bathing and rolling left and right in bed. R2's diagnoses list printed 1/23/25, included acute and chronic respiratory failure, weakness, failure to thrive, chronic pain, and obesity. R2's care plan dated 1/14/25, indicated R5 required extensive assistance of one staff for bed mobility, personal hygiene, and toileting. R2 required total assistance of two staff for transfers. R2's call light logs indicated the following call light wait times: On 1/19/25 at 9:34 p.m., 18 minutes On 1/19/25 at 9:57 p.m., 33 minutes On 1/20/25 at 1:47 a.m., 55 minutes On 1/20/25 at 3:21 p.m., 19 minutes On 1/20/25 at 11:18 p.m., 23 minutes On 1/21/25 at 1:05 p.m., 247 minutes On 1/21/25 at 5:19 p.m., 91 minutes On 1/21/25 at 9:00 p.m., 83 minutes On 1/22/25 at 6:11 p.m., 63 minutes On 1/22/24 at 11:06 p.m., 48 minutes On 1/23/25 at 9:15 a.m., 66 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 12:51 p.m., 99 minutes On 1/23/25 at 1:43 p.m., R2 stated he needed his incontinent brief changed, and had been waiting fifteen minutes. He typically waited from fifteen minutes to up to an hour for his call light to be answered. That morning, he had waited over an hour after he soiled his incontinent brief. He was annoyed and angry when he had to wait so long for the call light to be answered. One day he waited three hours for staff to come. On 1/24/25 at 11:22 a.m., R2 stated he did not get a bath on 1/23/25. He did not know why, but, I want one. R3 R3's admission MDS dated [DATE], indicated R3 was cognitively intact, had impairment of both lower extremities, and was fully dependent upon staff for toileting, bathing, and personal hygiene. The MDS also indicated R3 was always incontinent of bladder and frequently incontinent of bowel. R3's Diagnoses List printed 1/23/25, included morbid obesity, reduced mobility, chronic pain, muscle spasms, weakness, and sciatica (pain radiating along the sciatic nerve which runs down one or both legs from the lower back). R3's care plan dated 1/14/25 indicated R3 required extensive assistance of one staff for bed mobility, and total assist of one staff for toileting. R3's call light logs indicated the following call light wait times: On 1/19/25 at 12:55 p.m., 49 minutes On 1/20/25 at 8:34 a.m., 22 minutes On 1/20/25 at 9:46 a.m., 31 minutes On 1/21/25 at 10:28 a.m., 53 minutes On 1/21/25 at 12:08 p.m., 80 minutes On 1/21/25 at 1:40 p.m., 55 minutes On 1/21/25 at 3:11 p.m., 83 minutes On 1/21/25 at 6:38 p.m., 63 minutes On 1/21/25 at 7:51 p.m., 40 minutes On 1/22/25 at 9:31 p.m., 38 minutes On 1/23/25 at 10:31 a.m., 55 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 11:00 a.m., 40 minutes On 1/23/25 at 12:23 p.m., 37 minutes On 1/23/25 at 1:52 p.m., 46 minutes On 1/23/25 at 4:33 p.m., R3's incontinent brief was pushed partially under her, with most of the brief sticking out over the bed. R3's hair was uncombed and appeared greasy. R3 stated the incontinent brief would not work properly the way it was positioned, and further stated, Sometimes they don't answer my light at all. No one comes. I wait for hours some days. It makes me feel terrible. I feel nasty when I am dirty and they don't come. I don't feel cared for. Usually when I use my call light, I need to be changed. R4 R4's significant change MDS dated [DATE], indicated R4 was cognitively intact, had impairment on one lower extremity, required a wheelchair, and was frequently incontinent of bowel and bladder. R4's Diagnoses List printed 1/23/25, included a right below the knee amputation. R4's care plan dated 1/5/25 indicated R4 required extensive assistance of one staff for personal hygiene and toileting, and total assistance of two staff for transfers. R4's call light logs indicated the following call light wait times: On 1/19/25 at 7:59 p.m., 42 minutes On 1/19/25 at 6:12 p.m., 40 minutes On 1/21/25 at 8:10 p.m., 26 minutes On 1/21/25 at 4:14 p.m., 27 minutes On 1/21/25 at 11:29 a.m., 92 minutes On 1/22/25 at 4:36 a.m., 38 minutes On 1/22/25 at 11:43 a.m., 147 minutes On 1/23/25 at 8:52 a.m., 41 minutes On 1/23/25 at 11:34 a.m., 68 minutes On 1/23/25 at 12:35 p.m., during an observation of the call light banner at the end of the first floor hallway, R4's call light was on at 12:35 p.m., and de-activated at 1:00 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 4:51 p.m., R4 stated he waited a couple of hours for an incontinent brief change after having a bowel movement, and further stated, It was not comfortable. It had been a couple of weeks since he had a shower, and he was frustrated. Nursing assistant (NA)-A had come in to answer his call light today, and told him he had to wait another thirty minutes for help, but it was an hour before anyone came back. R4 further stated he preferred to have his hair washed weekly, and was uncomfortable that it had not been washed in the past few weeks. I feel incomplete, and I would like to have it washed and cut. R4's hair appeared greasy, and there was an odor of bowel movement in the room. On 1/23/25 at 12:25 p.m. NA-A stated she worked for a staffing agency, and was currently working as the only NA for nineteen residents. Resident showers often don't get done, she was supposed to do three showers on her current shift, but would not get to them as she was supposed to care for all nineteen residents and train a new NA. That day, it took about thirty minutes or more to answer call lights, with the longest call light wait time being about two hours. She knew she was supposed to answer call lights in five to ten minutes, but could not, and the residents complained about not getting enough help. On 1/23/25 at 12:35 p.m., during an observation of the call light banner at the end of the first floor hallway, the banner indicated R4's call light was on at 12:35 p.m and de-activated at 1:00 p.m. On 1/23/25 at 1:12 p.m., NA-B stated NA-A was supposed to be training her, but instead NA-B was working on the floor. There were quite a few call lights during the shift, and it was taking from ten to thirty minutes to answer the lights. The residents who were supposed to get baths would not get them that day. On 1/23/25 at 1:29 p.m., during a continuous observation, R2's call light was on at 1:29 p.m. At 2:47 p.m. it remained activated and unanswered. On 1/23/25 at 2:48 p.m., the director of nursing (DON) stated R2's call light should have been answered in five minutes. There was only one NA and a NA trainee working on the unit that day with 22 residents, after a staff called in. On 1/23/25 at 5:12 p.m., licensed practical nurse (LPN)-B stated when the unit was staffed with just one NA, call lights weren't answered timely, and residents waited up to an hour for help. On 1/24/25 at 11:40 a.m., NA-C stated he had previously worked the whole first floor by himself, but could not recall the date, and it took up to an hour to answer call lights. When he worked alone, residents did not get baths and residents got frustrated waiting for staff to answer call lights. On 1/24/25 at 2:51 p.m., the scheduler (S)-A stated the facility was short a nurse on 1/9/25, for the morning shift, and short a NA on 1/19/25, 1/22/25, and 1/23/25, during the morning shift. The shortages were due to staff call-ins. On 1/24/25 at 3:19 p.m., the administrator stated the facility did not meet the staffing minimums on four days from 1/9/25 to 1/24/25, and acknowledged the facility was short a nurse on 1/9/25, and short a NA on 1/18/25, 1/22/25, and 1/23/25, all for morning shift. It was not all right residents missed baths on 1/23/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 3:21 p.m., the DON stated, The residents probably feel horrible when they don't get their baths. The Facility Assessment indicated day and evening shifts for the 100 unit would be staffed with two NAs and two nurses. The Answering the Call Light Policy reviewed 8/5/21, indicated answer the resident call lights as soon as possible, and if staff promised the resident to return with an item or information, do so promptly.