

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 06/06/2025
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	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to appropriately monitor and comprehensively assess complaints of pain for 1 of 3 residents (R1) reviewed for pain management. Additionally, the facility failed to assess or monitor blood glucose levels and for 1 of 1 resident (R1) reviewed with blood glucose monitoring. R1 complained of pain rated as 9/10 (pain that is extremely severe or excruciating) four assessments in a row, was not administered pain medication as ordered, and R1 waited approximately 9 hours for prescribed pain medication. This resulted in harm when R1 called 911 for himself, and returned to the hospital for pain management, assessment, and monitoring.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, admitted to the facility on [DATE], and had diagnoses that included multiple fractures, trauma, respiratory failure, and diabetes.</p> <p>R1's hospital Discharge Orders dated 5/17/25, indicated the following for pain management:</p> <ul style="list-style-type: none"> - Acetaminophen (pain medication used for mild to moderate pain) oral tablet 500 milligrams (mg), give 1000 mg by mouth three times a day for pain, max (maximum) 4000 mg in 24 hours - Oxycodone (narcotic pain medication used to treat moderate to severe pain) 5 mg, take 1-2 tablets (5-10) mg by mouth every 4 hours as needed for pain - Lantus Solostar (long acting insulin used to manage blood glucose) 100 unit (U)/milliliter (ml), inject 45 U subcutaneously (subq) two times a day - Aspart FlexPen (short acting insulin used to manage blood glucose) 100 U/ml, inject 10 U subq once [daily] as needed if glucose >180 [milligrams/deciliter] - Mounjaro pen (medication used to treat blood glucose) 7.5 mg/.5 ml, inject 7.5 mg subq once weekly on Fridays <p>R1's Provider Orders dated 5/17/25 directed:</p> <ul style="list-style-type: none"> - Acetaminophen oral tablet 500 mg, dated 5/17/25, give 1000 mg by mouth three times a day for pain, max 4000 mg in 24 hours <p>(continued on next page)</p>

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
---	-------	-----------

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 06/06/2025
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	
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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Oxycodone HCl 10 mg give 10 mg by mouth one time only for pain</p> <p>- Oxycodone HCl 5 mg give 10 mg by mouth every 4 hours for pain rated 6-10/10</p> <p>- Oxycodone HCl 5 mg give 5 mg by mouth every 4 hours for pain (5 out of 10), discontinued 5/17/25</p> <p>- Oxycodone HCl 5 mg to start 5/18/25, give 5 mg by mouth every 4 hours as needed for pain rated 1-5/10</p> <p>- NovoLog (short-acting injectable medication used to treat diabetes) to start 5/18/25 inject 10 U subcutaneously as needed for diabetes if blood glucose is over 180 [milligrams/deciliter (mg/dl)]</p> <p>R1's Provider Orders dated 5/18/25 directed:</p> <p>- Lantus Solostar (long-acting injectable medication used to treat diabetes) subcutaneous (under the skin) solution, inject 45 units (U) subcutaneously two times a day for diabetes.</p> <p>R1's Provider Orders dated 5/19/25 directed staff to check blood glucose three times a day with meals and at HS (bedtime) related to type II diabetes.</p> <p>R1's care plan dated 5/20/25 indicated R1 had acute pain, and staff should administer medications as ordered. The care plan for unstable blood glucose was initiated on 5/20/25, and indicated monitor for signs and symptoms of hypoglycemia (low blood glucose) and hyperglycemia (high blood glucose).</p> <p>R1's progress notes dated 5/17/25 at 3:43 p.m., indicated R1 admitted to the facility at 1:00 p.m., and arrived by ambulance on a stretcher after an open reduction and internal fixation (ORIF - a surgical procedure that uses metal implants to hold broken bones in place while they heal). The progress note indicated R1's pain was rated as 7/10 on admission. The progress note banner indicated R1 had type II diabetes, chronic obstructive pulmonary disease (lung disease), and acute and chronic respiratory failure with hypoxia (absence of enough oxygen to sustain bodily functions). The progress note further indicated R1 had focal complaints of pain rated as 9/10 with spasms. R1 was offered non-medication interventions for pain, but the note did not specify what was tried, and indicated the non-medication interventions were not successful. The progress note indicated see the MAR (medication administration record) for details, which indicated R1 was given Tylenol. The admission progress note included a full set of VS. The progress notes lacked indication VS were assessed again until 5/20/25 at 9:55 p.m., or blood glucose was assessed on admission or until 5/19/25 at 10:57 p.m.</p> <p>R1's progress notes dated 5/17/25 at 11:28 p.m., indicated staff contacted an on-call provider at 8:15 p.m., for an order for a one-time order for oxycodone HCl 10 mg for pain rated as 10/10, and at 11:30 p.m., indicated R1 received the first dose of oxycodone HCl 10 mg.</p> <p>R1's progress notes dated 5/18/25 at 10:40 p.m., indicated at around 5:30 p.m., R1 called 911 and reported to paramedics the facility failed to manage his pain. He told them when he came to the facility, he had to wait over 8 hours before he received pain medication. R1 took his belongings, declined a bed hold, and was transported to the hospital.</p> <p>R1's progress notes dated 5/19/25 at 1:50 a.m. indicated he returned from the hospital.</p> <p>(continued on next page)</p>		

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 06/06/2025
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	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's progress notes dated 5/19/25 at 10:11 a.m., indicated R1 was out of prescribed pain medications, had pain rated as 8/10, and had gone to the emergency room the prior night.</p> <p>R1's progress noted dated 5/19/25 at 8:22 p.m., indicated R1 received oxycodone HCl 5 mg, 2 tablets by mouth for pain. The progress notes lacked indication oxycodone was administered between 5/19/25 at 10:11 a.m., and 5/19/25 at 8:22 p.m.</p> <p>R1's May 2025 Medication Administration Record (MAR) and progress notes indicated the following:</p> <ul style="list-style-type: none"> - Oxycodone HCl 5 mg 2 tablets, were administer for the first time on 5/17/25 at 11:30 p.m. - Acetaminophen 500 mg 2 tablets were administered on 5/17/25 at 9:00 p.m., and were ineffective. - Oxycodone HCl 10 mg, give 10 mg by mouth one time only for pain 5/17/25, between 8:20 p.m., and 11:59 p.m., but the dose was not administered until 5/18/25 at 3:33 a.m., and was rated ineffective. <p>During that time R1's pain ratings were as follows:</p> <p>5/17/25 at 2:27 p.m., pain rated as 9/10, and was not administered pain medication.</p> <p>5/17/25 at 4:14 p.m., pain rated as 9/10, and was not administered pain medication.</p> <p>5/17/25 at 4:28 p.m., pain rated as 9/10, and was not administered pain medication.</p> <p>5/17/25 at 4:34 p.m., pain rated as 9/10, and was not administered pain medication.</p> <ul style="list-style-type: none"> - Oxycodone HCl 5 mg, give 2 tablets (for a total of 10 mg) by mouth every 4 hours as needed for pain rated 6-10/10 mg was administered as follows: <p>5/17/25 at 11:30 p.m., for pain rated as 7/10, and was rated effective.</p> <p>5/18/25 at 5:13 a.m., for pain rated as 8/10, and was rated effective.</p> <p>5/18/25 at 8:14 a.m., for pain rated as 10/10, and was rated effective.</p> <p>5/18/25 at 2:28 p.m., for pain rated as 10/10, and was rated ineffective.</p> <p>5/19/25 at 8:22 p.m., for pain rated as 10/10 and was rated ineffective.</p> <p>R1's blood glucose records indicated R1's blood glucose was not tested until 5/19/25 at 10:57 p.m., even though R1 was admitted on [DATE].</p> <p>(continued on next page)</p>

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 06/06/2025
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	
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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/25 at 10:01 a.m., R1 stated he was not able to get the prescribed oxycodone HCl after he was admitted [DATE] around 1:00 p.m., until around 11:30 p.m., and laid suffering in agony until he got the medication. He was given Tylenol [acetaminophen] but it did not help, nor did he think he should have Tylenol as he was a life-long drinker [of alcohol] and he thought Tylenol was not good for his liver. His VS were not assessed, and his blood glucose levels were not checked until a couple of days after admission. He was concerned about why staff wasn't checking his blood glucose or VS and stated, How will they know if I am going to tank it and die? R1 stated he felt like he was not being assessed or cared for properly.</p> <p>On 6/5/25 at 1:18 p.m., licensed practical nurse (LPN)-B stated diabetic residents should have blood glucose checks per the physician orders, and any resident who used insulin should have blood glucose checks. Every resident on the Transitional Care Unit (TCU) should have VS daily. R1 had not had VS assessed after admission until 5/19/25, and had not blood glucose checks until 5/19/25, but didn't know why.</p> <p>On 6/5/25 at 2:12 p.m., registered nurse (RN)-A stated blood glucose checks were done according to the provider orders, but typically before meals and before bed. VS were checked more often for residents who had medications with specific parameters, but otherwise daily to weekly, but required an order.</p> <p>On 6/6/25 at 9:32 a.m., RN-B stated the process for obtaining narcotic pain medications upon resident admission was to fax the order to the pharmacy, and if the resident didn't come with the prescription, the nurse would call the hospital. The call could be transferred all over to get the prescription, and instead the nurse would call the pain management provider for medication. R1's pain was assessed to be 9/10 four times, and then 7/10, and stated, That's a lot of pain. He could have shock. With ongoing pain, staff should check VS, and the provider should have been notified, but there was no indication the provider was notified. If a resident had diabetes, and there were no orders to check blood glucose, the facility standing orders indicated check blood glucose once a day. R1 admitted on [DATE], and blood glucose was first checked on 5/19/25, but should have been checked 5/17/25 and 5/18/25 also. With ongoing pain, staff should check VS, and the provider should have been notified. There was no indication the provider was notified. R1 would have been frustrated if he had ongoing pain without relief, and was not getting VS or blood glucose checks.</p> <p>On 6/6/25 at 10:30 a.m., the pharmacy technician (PHT)-A stated the pharmacy provided the medications for the e-kit, and the facility staff was responsible to fill the e-kit with the medications provided by the pharmacy. Oxycodone HCl 10 mg was supposed to be supplied in the e-kit.</p> <p>On 6/6/25 at 10:34 a.m., PHT-B stated R1 had a prescription for oxycodone HCl 5 mg, and the pharmacy received it on 5/17/25 at 3:15 p.m., by fax. The prescription was filled for eight tablets and was delivered on 5/17/25 at 10:34 p.m., on the scheduled delivery. The facility called for a code to use the e-kit (an emergency stock of medications used to quickly address urgent or unexpected symptoms that may arise in residents) earlier, but the e-kit was out of the dose prescribed. When the e-kit was reduced to four tablets, it would trigger the pharmacy to refill, but that had not happened, and the PHT-B didn't know why. The facility could have ordered the medication stat (immediately) by phone, but had not.</p> <p>(continued on next page)</p>		

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 06/06/2025
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	
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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/6/25 at 10:55 a.m., the pharmacist (PH)-A stated on 5/17/25, the facility did not have oxycodone HCl 10 mg tablets in the e-kit, as requested in a one-time order. The facility sent an order for oxycodone HCl 5 mg initially, not 10 mg. Facility staff should have requested oxycodone HCl 10 mg tablets re-stock before running out.</p> <p>On 6/6/25 at 11:57 a.m., the director of nursing (DON) acknowledged when R1 first reported pain, there should have been immediate interventions, and VS should have been completed as part of the assessment followed by a report to the provider. She did not know why that was not done. Additionally, R1 should have had a blood glucose check on admission as an insulin-dependent diabetic and stated it also got missed. R1 could have had low or high blood glucose, and staff would not have known. The emergency kit was out of the prescribed pain medication, and the pharmacy did not deliver the medication right away.</p> <p>The Automated Dispensing Machine for First Dose and Emergency Medications policy dated 5/22, indicated the automated dispensing machine (ADM also known as e-kit) was used for emergency medications, and the contents were the property of the pharmacy so authorization from the pharmacy was required prior to use. The policy indicated replenishment of medications in the ADM was scheduled so that no medication supply was exhausted.</p> <p>The Pain-Clinical Protocol dated 2001, directed the staff and physician would evaluate how pain affected mood, activities of daily living, sleep, and the resident's quality of life.</p> <p>The Medication and Treatment Orders policy dated 7/17, directed drug orders must be recorded on the physician's order sheet in the resident's chart. Such orders were reviewed by pharmacy monthly.</p> <p>The Administering Pain Medications policy dated 10/7/21, directed the pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain.</p> <p>The Diabetes - Clinical Protocol was requested and not provided.</p> <p>A policy for Quality of Care was requested and not provided.</p>		

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 06/06/2025
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	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure oxycodone hydrochloride (HCL, a narcotic pain medication used to treat moderate to severe pain) was administered per physician orders for 1 of 3 residents (R1) reviewed for pain management.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, admitted to the facility on [DATE], and had diagnoses that included multiple fractures and trauma.</p> <p>R1's care plan dated 5/19/25 and reviewed 6/5/25 and lacked information related to pain management.</p> <p>R1's Provider Orders indicated the following for pain management:</p> <p>acetaminophen oral tablet 500 mg, dated 5/17/25, give 1000 mg by mouth three times a day for pain, max 4000 mg in 24 hours</p> <p>gabapentin oral capsule (medication used to treat nerve pain) 600 mg, dated 5/11/25 to start 5/18/25, give 1200 mg by mouth one time a day for pain</p> <p>gabapentin oral capsule 300 mg, dated 5/11/25 to start 5/17/25 at 8:00 p.m., give 900 mg orally one time a day for nerve pain</p> <p>oxycodone HCl 10 mg, dated 5/17/25, give 10 mg by mouth one time only for pain</p> <p>oxycodone HCl 5 mg dated 5/17/25, give 10 mg by mouth every 4 hours for pain rated 6-10/10</p> <p>oxycodone HCl 5 mg dated 5/17/25, give 5 mg by mouth every 4 hours for pain (5 out of 10), discontinued 5/17/25</p> <p>oxycodone HCl 5 mg dated 5/17/25 to start 5/18/25, give 5 mg by mouth every 4 hours as needed for pain rated 1-5/10</p> <p>R1's progress notes and May 2025 Medication Administration Record (MAR) printed 6/5/25, indicated the following:</p> <p>*On 5/17/25, R1 received oxycodone HCl 5 mg, 2 tablets at 11:30 p.m., oxycodone HCl 10 mg at 3:33 a.m., and oxycodone HCl 5 mg, 2 tablets, at 5:13 a.m., and 8:14 a.m.</p> <p>*On 5/20/25, R1 received oxycodone HCl 10 mg at 12:15 a.m., 5:21 p.m., and 9:25 p.m. On 5/20/25 R1 also received oxycodone HCl 5 mg, 2 tablets (10 mg) at 12:25 a.m., 8:20 a.m.</p> <p>*On 5/25/25, R1 received oxycodone HCl 10 mg at 12:00 a.m., 7:00 a.m., 8:06 a.m., 1:33 p.m., and 7:01 p.m.</p> <p>(continued on next page)</p>

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 06/06/2025
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	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The orders indicated maximum dose of 4 doses per day, and every 4 hours apart.</p> <p>On 6/5/25 at 10:01 a.m., R1 stated he was not given oxycodone [HCl] when he required it but there were days he got oxycodone [HCl] more often than every 4 hours, and more than 4 doses in a day. R1 could not recall which dates, but thought it was in the first few weeks after admission.</p> <p>On 6/5/25 at 1:18 p.m., licensed practical nurse (LPN)-B stated the facility had run out of medications in the e-kit (an emergency stock of medications used to quickly address urgent or unexpected symptoms that may arise in residents) when staff didn't reorder them. It was a medication error when the facility ran out of medications and then the medications were not available for administration when a resident needed them.</p> <p>On 6/5/25 at 2:12 p.m., registered nurse (RN)-A stated R1 had active oxycodone HCl orders, the order on 5/17/25 from 8:20 p.m. to 11:59 p.m., was administered after the allotted time, and although oxycodone HCl was ordered for every 4 hours, R1 received the medication more often than the order allowed. A resident could have respiratory complications or death related to oxycodone use. RN-A stated, That is very concerning.</p> <p>On 6/5/25 at 4:42 p.m., LPN-C acknowledged the narcotic book indicated four doses of oxycodone HCl 10 mg were administered on 5/25/25, but the progress notes and MAR indicated 5 doses were administered and could not account for the difference. Additionally, the narcotic count book, pages 15 and 21 for R1's oxycodone 10 mg tablets indicated See MAR for the instructions. LPN-C stated the order should be written on the page, including the maximum dose and frequency, and acknowledged it was not.</p> <p>On 6/5/25 at 4:48 p.m., LPN-A acknowledged the use of see MAR was not proper instructions for medications in the narcotic count book, and without proper dosing instructions R1 could have overdosing, medication errors, and interference and interactions with other medications.</p> <p>On 6/6/25 at 9:32 a.m., RN-B stated on 5/18/25 at 3:32 a.m., staff administered oxycodone HCl 15 mg instead of 10 mg, there was less than 4 hours between some of the doses, and it appeared in both the MAR and progress notes R1 got 5 doses on 5/25/25 instead of 4. There were only four doses of oxycodone HCl recorded on 5/25/25, and was unsure how the count could be correct in the narcotic book if five doses were administered as stated in the MAR and progress notes. The narcotic book should have the order, the pharmacy, and the doctor recorded at the top of the page, but acknowledged entries were lacking that information and stated there were mistakes because there were no orders on the book.</p> <p>On 6/6/25 at 10:55 a.m., the pharmacist (PH)-A stated when R1 received both oxycodone HCl 5 mg and 10 mg on 5/20/25 at 12:25 a.m., and 12:15 a.m., respectively, it was a medication error. A 15 mg dose was not the correct order, and the plan was to use the minimum effective dose. Most people have pain controlled by oxycodone HCl 10 mg, and if not, the provider would typically try something else and should have been notified. Additionally, the most current prescription for R1's oxycodone was received by the pharmacy on 5/22/25, for 10 mg every 4 hours as needed, with a maximum daily dose of 60 mg a day, but the facility was not using that order, and dosing as often as they could. Oxycodone HCl should be dosed four hours apart, and if doses were administered one hour apart, or three hours apart, it would not likely cause an overdose, but R1 could be out of it, and have respiratory breathing that was kind of heavy. Dosing closer than four hours apart should not happen.</p> <p>(continued on next page)</p>		

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 06/06/2025
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	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/6/25 at 11:57 a.m., the director of nursing (DON) acknowledged R1 received oxycodone HCl 10 mg and 5 mg on 5/25/25 at 3:23 a.m., and should not have. She could not explain why five doses were administered on 5/25/25, but the narcotic book only indicated four entries. She was not aware of R1's new oxycodone HCl order dated 5/22/25, and stated it must not have been transcribed. If a resident received oxycodone HCl more frequently than four hours apart as ordered, it was an error, and could cause the resident to be sleepy, cause falls, and the errors should have been reported to the provider, but were not. R1 received doses that were closer than four hours apart and didn't know why.</p> <p>The Medication and Treatment Orders policy dated 7/17, directed drug orders must be recorded on the physician's order sheet in the resident's chart. Such orders were reviewed by pharmacy monthly.</p>		