Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 17, 2023

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: CCN: 245507
Cycle Start Date: July 27, 2023

Dear Administrator:

On July 27, 2023, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 October 27, 2023 (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 January 27, 2024 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(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
E 000	Initial Comments On 7/24/23 through 7/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/24/23 through 7/27/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55073885C (MN00085364), H55073884C (MN00091191), H55073313C (MN00094864). 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 substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2023

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 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to inform resident/resident representative in advance of care, of the risks and benefits, possible alternatives to treatment, and receive consent of proposed care prior to initiating psychotropic (mood) medication for 1 of 4 residents (R44) reviewed for dementia care. Findings include: R44's quarterly minimum data set (MDS) assessment dated 5/4/23, indicated moderate cognitive impairment, had clear speech, was able to understand and be understood by others, exhibited mild symptoms of depression (mood disorder), had no behaviors, wandered	F 552	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -Informed Consent for Required Medication form was completed for R44. How the facility will identify other residents having the potential to be affected by the	9/1/23

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F 552	Continued From page 2 occasionally, and received antipsychotic and antidepressant (mood disorder) medications. Furthermore, the MDS indicated R44's diagnoses included list Alzheimer's dementia (brain disease causing memory loss and abnormal thinking), anxiety, depression, and hallucinations (mental disorder causing abnormal perception). Facility Medication Review Report, printed on 7/27/23, indicated an order dated 7/2/23, initial order start date 1/12/23, for scheduled duloxetine (antidepressant) medication, to give 30mg by mouth twice daily for anxiety. However, an informed consent indicating possible risks/side effects, discussing alternatives to treatment had not been provided to R44 or R44's representative for duloxetine. Medication review report also indicated an order start date of 7/11/23, for scheduled mirtazapine (antidepressant) medication, to give 7.5mg by mouth at bedtime for major depression. However, an informed consent indicating possible risks/side effects, discussing alternatives to treatment had not been provided to R44's representative until 7/15/23, after mirtazapine had been started. Review of progress note dated 7/15/23 at 11:11 a.m., indicated an informed consent for required medications (Remeron, also known as mirtazapine), sent in mail to R44's representative for approval, signature, and return on 7/18/23. During an interview, on 7/27/23 at 8:48 a.m., licensed practical nurse (LPN)-A, also known as care coordinator, stated process when starting any psychotropic medications, was to discuss with residents/resident representatives regarding risks/side effects of medication use, obtaining consent for approval of medication treatment, and	F 552	same deficient practice: -All residents receiving psychotropic medications have the potential to be affected. All current psychotropic medications have been audited to confirm the facility has received informed consent for administration. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nurses and Nurse Leaders were educated on Monarch's Psychotropic Medication Use policy and resident or resident representative consent prior to psychotropic medication administration. New psychotropic medications will have an Informed Consent for Required Medications form completed with documented consent. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits of new psychotropic medication orders to ensure completion of an Informed Consent for Required Medication form. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations.	

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F 552	Continued From page 3 resident/resident signature prior to initiating medication therapy. LPN-A indicated provider orders were initially received by unit licensed nurse, unit licensed nurse would enter physician orders in resident electronic medical record (EMR) system, unit licensed nurse would fax provider orders to pharmacy for medication fill, unit care coordinator reviewed provider notes when received, (which could be 2-3 days after physician visit and provider orders to implement psychotropic medications), would then follow up with resident/resident representative to discuss risk/side effects of psychotropic medication and obtain consent/signature needed. LPN-A stated due to provider notes not being available for 2-3 days after visit/order request, consent for psychotropic medication initiation was delayed, residents would already be taking psychotropic medications. LPN-A reviewed informed consent for psychotropic medication use for R44's duloxetine and mirtazapine medications, stated could not find an informed and signed consent for R44's duloxetine medication on file, indicated R44's mirtazapine was ordered on 7/11/23, informed consent was signed per R44's representative on 7/20/23, confirmed R44 was already taking mirtazapine prior to informed/signed consent, verified R44 still taking duloxetine. LPN-A indicated R44's representative involved in R44's care, aware of all medications R44 taking, will contact R44's representative regarding informed consent of duloxetine right away. While interviewed, on 7/27/23 at 2:01 p.m., the director of nursing (DON) indicated it was her expectation when residents were prescribed psychotropic medications, staff should discuss risk/benefit of psychotropic medication use and	F 552		

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F 552	Continued From page 4 obtain consent with signature for treatment from resident/resident representative prior to initiating medication therapy, stated if psychotropic medications received from pharmacy prior to informed consent/signature could be obtained for psychotropic medication use, psychotropic medication should be placed on hold until informed consent/signature received per resident/resident representative. The facility Psychotropic Medication Use undated, indicated psychotropic medications may be considered for residents in which symptoms have been identified and the interdisciplinary team has deemed would benefit from use of these meds. Psychotropic medication types can include, but is not limited to, antidepressants, antianxiety medications, stimulants, antipsychotics, mood stabilizers, and other medications that impact brain activity ordered in place of a psychotropic medication. Informed consent including effects and potential side effects will be obtained from resident and/or responsible party for each psychotropic medication.	F 552		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622		9/1/23

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F 622	Continued From page 5 services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care	F 622		

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F 622	Continued From page 6 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate and required information was documented and communicated to a receiving healthcare facility to ensure	F 622	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability	

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F 622	Continued From page 7 continuity of care for 1 of 1 resident (R44) reviewed for hospitalization, had transferred to hospital emergently. This deficient practice had the potential to affect all 59 residents residing in the facility. Finding include: R44 was admitted to the facility on 12/14/22, R44's diagnoses listed on face sheet included: Type 2 diabetes (blood sugar abnormality), muscle weakness, Alzheimer's disease (brain disease causing memory loss and abnormal thinking), malnutrition, major depression (mood disorder), hallucinations (mental disorder causing abnormal perception), anxiety, chronic kidney disease, and pseudo hole of right eye (visual changes). R14's quarterly minimum data set (MDS) assessment dated 5/4/23, identified R44 as having moderate cognitive impairment. R44 was able to understand and was understood. R44 required extensive assistance of 1 staff with majority of activities of daily living (ADL's), did require limited assist of 1 staff for walking in room. R44 used a walker and wheelchair for mobility, no impairment of extremities. Review of progress notes, dated 6/26/2023, indicated at 4:55 p.m., R44 had sustained a fall, complained of right hip pain, was assessed, had full range of motion (ROM) to left leg, unable to assess ROM to right leg due to pain, provider contacted and gave verbal order to send R44 to emergency department (ED) for further evaluation, R44's family member updated on fall incident and plan to send to ED. Furthermore, progress notes reviewed from 6/26/23 lacked	F 622	by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R44 is no longer a resident at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected by the alleged deficiency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nurses, Nurse Leaders, Social Services, and Health Information were educated on Monarch's Transfer or Discharge, Emergency policy and reviewed the Transfer/Discharge Report and progress notes. Transfers out will include a copy of the Transfer/Discharge Report for the resident's record or a detailed progress note including everything shared with EMS, if applicable, and the receiving healthcare facility. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will conduct audits of Transfer/Discharge Reports and progress notes for resident transfers. Audits will be completed 1x/week x 2 months and will report to the QA	

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F 622	Continued From page 8 transfer information provided to ambulance and ED staff. Review of progress notes, dated 6/28/23, indicated facility staff were updated on R44's condition, would be admitted to hospital for surgery of fractured right hip. R44's 6/26/23, transfer and discharge report, printed on 7/26/23, lacked sufficient documentation for transfer, chief complaint (reason for transfer), relevant information (usual physical/mental functioning), and miscellaneous information (date/time of transfer, place/time of transfer, personal belongings sent with date/time and whom, staff signature with date/time) were left blank. While interviewed, on 7/27/23 at 9:08 a.m., licensed practical nurse (LPN)-A, also known as care coordinator, indicated resident transfer process consisted of notifying provider and resident representative of reason for resident transfer, facility transfer report form was filled out and all pertinent medical information, including resident face sheet, medication administration record (MAR), provider orders for life sustaining treatment (POLST), and a progress note providing detail of transfer reason were to be provided to the admitting facility. LPN-A reviewed R44's transfer report form from 6/26/23 fall incident, confirmed report form lacked sufficient documentation needed for admitting facility to provide continuation of care, stated unawareness of what transfer information had been provided to admitting facility by staff due to lack of documentation on report form and in nursing progress notes reviewed from 6/26/23.	F 622	committee for further review and recommendations.	

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F 622	Continued From page 9 During an interview, on 7/27/23 at 2:04 p.m., the director of nursing (DON) indicated resident transfer process included, licensed nursing staff to complete an initial assessment of medical status, provider contacted to update on condition, resident representative notified of resident status and need for transfer, transfer report form completed and pertinent medical information regarding resident condition at time provided to emergency medical services (EMS), facility staff would call ED to update on resident impending arrival and provide medical information needed for continuation of care. The DON reviewed R44's transfer report form from 6/26/23 fall incident, confirmed report form lacked sufficient documentation needed for admitting facility to provide continuation of care. The facility Transfer or Discharge, Emergency policy revised 5/23, indicated emergency transfers or discharges may be necessary to protect the health and/or well-being of the resident(s), should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; e. Notify the representative (sponsor) or other family member; f. Assist in obtaining transportation; and g. Others as appropriate or as necessary. When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a	F 622		

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F 622	Continued From page 10 facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer, copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.	F 622		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		9/1/23

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F 676	Continued From page 11 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided, including nail care for 1 of 6 residents (R112) reviewed, who needed staff assistance to maintain good personal hygiene. Findings include: R112's admission Minimum Data Set (MDS) assessment, dated 7/17/23, indicated R112 had moderate cognitive impairment and required staff assistance for personal hygiene. R112's order summary, printed on 7/27/23, indicated for licensed nurse to complete weekly skin inspection in the evening every Tuesday. R112's care plan, printed on 7/27/23; indicated R112 required assistance by 1 staff member for personal hygiene needs. R112's admission/data collection assessment, completed on 7/10/23, indicated bathing preference included showers during daytime, skin assessed with no concerns at time. Review of R112's weekly skin assessment,	F 676	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -Nail care was offered and documented for R112. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected by the alleged deficiency. All residents were audited to ensure nail care was completed per their preference. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -CNAs, Nurses, and Nurse Leaders were educated on Monarch's Activities of Daily Living/Maintain Abilities policy. Residents	

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F 676	Continued From page 12 reviewed from 7/13/23-7/25/23, indicated a skin assessment had been completed on 7/25/23. Review of R112's bathing task, reviewed from 7/13/23-7/25/23, indicated shower received on 7/19/23, shower received on 7/25/23. Review of Southwest unit bath schedule, dated 7/24/23, indicated R112's bath/shower days were Tuesday evenings. During an observation and interview, on 7/24/23 at 9:20 a.m., R112 had messy and greasy looking hair, nails to bilateral hand were all longer in length with jagged edges and dark colored debris. R112 indicated he occasionally received assistance from staff in meeting ADL needs including dressing, grooming, and hygiene. R112 stated he could not trim own nails due to hand tremors and would like nails trimmed if offered by staff. While interviewed, on 7/25/23 at 7:16 p.m., nursing assistant (NA)-B indicated awareness of R112's hygiene needs, stated nail care was completed on bath days following skin audit completed by licensed nursing staff, reported R112 received bath/shower cares on Tuesday evenings per unit bath schedule, indicated NAs completed R112's nail care unless diabetic, then licensed nurse completed. During an interview and observation, on 7/25/23 at 7:21 p.m., licensed practical nurse (LPN)-C, also known as agency nurse, indicated resident nail care was completed following bath/shower per NAs and skin audit completed per licensed nursing staff. LPN-C reviewed R112's since admission, unable to verify nail care had been	F 676	will be offered nail care on their bath day and PRN, whether they accept bathing assistance or decline. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits to ensure nail care is offered on bath days. Audits will be completed 1x/week x 2 months and report to the QA committee for further review and recommendations.	

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F 676	Continued From page 13 completed, stated was unfamiliar with R112 care needs as only second day at facility. Upon observation of R112's nails to bilateral hand following bath/shower on 7/25/23, LPN-C confirmed nails were all longer in length with jagged edges and dark colored debris, stated would have NA complete nail care and ensure noted on 7/25/23 skin audit completed. LPN-C offered nail care to R112, R112 agreed. While interviewed, on 7/27/23 at 2:16 p.m., the director of nursing (DON) indicated it was her expectation for staff to check and trim resident nails any time needed when completing routine cares, especially on resident scheduled bath days following skin audit, and to ensure documentation of nail care provided. The facility Activities of Daily Living (ADLs)/Maintain Abilities policy revised 3/31/23, indicated care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, the facility will provide care and services for the following activities of daily living: a.Hygiene- bathing, dressing, grooming, and oral care	F 676		
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	F 684		9/1/23

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F 684	Continued From page 14 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 observation, interview and document review, the facility failed to assess and provide proper wheelchair positioning to prevent foot drop/contractures for 1 of 2 residents (R16) reviewed for positioning needs. Findings include: R16's current diagnoses found on the undated diagnosis sheet included: cerebral vascular accident (CVA) (damage to the brain from interrupted blood supply), hemiparesis of the left side (muscle weakness or partial paralysis on one side of the body) and muscle weakness (decreased strength of the muscles). Observation on 7/24/23 at 10:55 a.m., R16 was noted to be sitting in a wheelchair in a sloughed position. R16's right foot was dangling, with only the tip of the toes touching the floor. There was no foot pedal on the wheelchair to provide support. R16's left leg had a protective boot on and resting on a wheelchair pedal. R16's quarterly minimum data set (MDS) assessment dated 6/19/23, identified R16 as having a brief interview of mental status (BIM'S) score of "6" (meaning severely impaired cognition). R16 required extensive assistance with mobility that included positioning and transfers. R16 had upper and lower extremity impairment on 1 side and utilizes a wheelchair for	F 684	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R16 has been evaluated by OT for wheelchair positioning to prevent foot drop and contractures. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents who use a wheelchair for mobility have the potential to be affected. An audit of all residents for appropriate wheelchair positioning was completed with referrals to OT as indicated. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Staff have been educated on appropriate wheelchair positioning and “Hey Therapy” communication forms to alert nursing leaders to changes in resident’s positioning and/or therapy needs.	

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F 684	Continued From page 15 mobility. R16 does not currently receive therapy services. R16's plan of care reviewed on 5/9/23, identified R16 as having alteration in mobility related to CVA with hemiplegia of the left side. Interventions: staff assistance of 2 and mechanical stand with transfers and positioning in wheelchair, apply left foot brace each day, dycem (non-slip floor mat) to wheelchair and recline wheelchair back after each meal. Observation on 7/25/23 at 5:30 p.m. R16 was sitting up in his wheelchair again in a sloughed position. R16's right foot was dangling, with just the tip of the toes touching the floor. The wheelchair had a foot rest on the left side, but the residents left leg was not placed on the pedal. R16's left left foot had a protective boot on and partially resting on the floor. Observation on 7/26/23 at 9:00 a.m. R16 was sitting in his wheelchair. Again, R16's right foot was dangling with just the tip of the toes touching the floor. The wheelchair had a foot rest on the left side, but not the right side. R16's left leg was not placed on the pedal, and the upper part of foot was resting on the floor. Review of a physical therapy (PT) progress note and assessment dated 7/17/23, (and after confirming through interview with the facility PT, about the positioning of R16's right leg/foot) indicated R16 had documentation of a foot drop since admission on 2/2015. The assessment indicated R16 wears a left foot protector on the left leg for positioning, when in the wheelchair. The wheelchair does not have a right foot pedal, that currently fits on the wheelchair. R16's right	F 684	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will conduct random audits for appropriate wheelchair positioning and follow through by OT. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations.	

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F 684	Continued From page 16 foot does not rest on anything promoting planta fasciopathy (PF) (overarching of the ligament tissues in the foot). The left foot also does not stay on the foot pedal, as R16 does move his hips in the wheelchair. Interview on 7/25/23 at 4:00 p.m., nursing assistant (NA)-H confirmed R16 did not have a foot pedal on the wheelchair for the right foot to rest on. NA-H further indicated R16 only had a foot pedal for the left foot. NA-H was unsure why R16 did not have support for the right foot/leg to rest on, because his foot never fully touched or rested on the floor. Interview on 7/25/23 at 5:45 p.m., registered nurse (RN)-G indicated R16 had never been assessed by occupational therapy (OT) or PT for the right leg. RN-G indicated she was unsure why R16 did not have a foot rest on the right side of the wheelchair, to support the right foot/leg. RN-G further indicated she had not been aware of R16 not being able to fully rest his right foot on the floor. Interview on 7/26/23 at 9:30 a.m., with facility corporate RN-H indicated she had not been aware of R16's right foot not fully resting on the floor. RN-H also indicated she was unsure why the wheelchair did not have a right foot rest on it, and only the left. RN-H confirmed R16's right foot should fully be resting flat on the floor and not dangling while sitting in the wheelchair. A policy was requested, but not provided.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		9/1/23

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F 688	Continued From page 17 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative services to maintain and/or improve mobility was received for 1 of 3 residents (R49), reviewed for mobility. Findings include: R49's significant change in status Minimum Data Set (MDS) assessment, dated 6/6/23, indicated R49 had intact cognition, had impairment to both lower extremities (LEs), no impairment to both upper extremities (UEs); required limited assistance for bed mobility and ambulating (walking) in room, required extensive assistance with transfers, used a wheelchair and walker for mobility needs. R49's face sheet, printed on 7/27/23, identified	F 688	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R49 has been informed of therapy recommendations for a restorative walking program. Nursing staff has been reeducated on expectation to complete restorative services as recommended by therapy. Restorative walking program has been added to R49’s TAR to ensure completion.	

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F 688	Continued From page 18 diagnoses list to include morbid obesity, chronic pain, history of falls, dementia (abnormal thinking and memory loss), major depression (mood disorder), acute osteomyelitis (bone infection) to left foot/ankle, partial amputation of left foot. R49's order summary report, printed on 7/27/23, indicated R49 was okay to walk with shoes or post op shoes, no walking with slippery socks, every shift, occupational therapy (OT) to evaluate and treat as indicated, physical therapy (PT) to evaluate and treat as indicated, when in question ambulation and transfer ability determined by in-house PT. R49's care plan, printed on 7/27/23, indicated altered mobility related to partial amputation of left foot and other acute osteomyelitis of left ankle/foot, and instructed staff to follow PT per medical doctor (MD) order, follow PT instructions. R49's care plan, updated later on 7/27/23, consisted of walking plan- ambulate with resident 1-2 times daily using front wheeled walker (FWW) assist of 1 (Ax1) gait belt and wheelchair (w/c) follow. Make sure surgical shoes are on when walking. PT discharge summary report, dated 6/23/23, indicated R49's gait/mobility had plateaued, therefore PT discharge (DC), R49 independent for all mobility in room with FWW, short distance gait, staff assistance for long distance gait. During an observation and interview, on 7/24/23 at 2:26 p.m., R49 observed sitting in wheelchair in room, stated would complete therapy band (elastic band used for strengthening) exercises independently for limited mobility to left upper extremity (LUE), was not aware of receiving any	F 688	How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents who have recommendations for restorative services have the potential to be affected. An audit of all residents with restorative services was completed and ensured restorative services were implemented and consistent across facility Ambulation/ROM sheets, TAR, and care plan. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nursing department staff have been educated on expectation to complete restorative services as recommended by therapy. Nursing assistants will complete restorative services and document on facility Ambulation/ROM sheets, nurses will confirm completion and document on TAR, nurse managers will routinely review documentation to ensure compliance. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee will conduct random audits to ensure restorative services are provided as recommended by therapy. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations.	

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F 688	Continued From page 19 restorative services, walking program, for BLEs. While interviewed, on 7/25/23 at 12:33 p.m., nursing assistant (NA)-C indicated had worked at facility for three months, was aware of R49's care needs, could find R49's care needs in her care plan in electronic medical record (EMR). NA-C stated unawareness of R49 receiving any restorative services, walking program, for BLEs, NA-C observed to review R49's care plan and NA task assignment in EMR, confirmed R49 was not receiving any restorative services, walking program, for BLEs at time. During an interview, on 7/26/23 at 8:36 a.m., registered nurse (RN)-B, indicated was aware of limitations in mobility to R49's BLEs, was unaware of any restorative services, walking program, to be provided. While interviewed, on 7/26/23 at 10:56 a.m., physical therapy aide (PTA)-G, indicated PT had seen R49 to work on ambulation and was discharged from PT services on 6/23/23 as R49's walking ability plateaued. PTA-G stated at time of R49's PT discharge, PT recommended R49 to receive restorative services walking program, recommendations provided to care coordinator. During an interview, on 7/26/23 at 11:22 a.m., licensed practical nurse (LPN)-D, also known as care coordinator, indicated awareness of R49's care needs, stated R49 had limitations in LUE, which remained unchanged since admission approx. 1 year ago, R49 was independent in range of motion (ROM) therapy exercises, had limitations in BLEs due to partial amputation of left foot, was initially admitted to facility due to partial amputation of left foot. LPN-D indicated	F 688		

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F 688	Continued From page 20 R49 had seen PT for ambulation services, was recently discharged from PT, was aware R49 was to be receiving walking program restorative services per PT recommendations. LPN-D indicated she was responsible for ensuring PT recommendations were updated in care plans and updating NA daily assignment sheets titled, toileting and cares record- southwest wing. LPN-D stated R49's care plan and NA daily assignment sheet were updated to reflect PT recommendations, LPN-D reviewed R49's care plan at time, confirmed PT recommendations from 6/23/23 discharge had not been updated by her and should have been. LPN-D reviewed NA daily assignment sheets titled, Ambulation Programs, time frame reviewed from 7/19/23-7/24/23, stated assignment sheets instructed staff to ambulate with R49 1-2 times daily using FWW, assist of 1 with gait belt and wheelchair follow, ensure R49 wearing surgical shoes when walking. LPN-D indicated staff were aware of R49's walking program and had been completing since PT discharge on 6/23/23. LPN-D reviewed NA daily assignment sheets, time frame reviewed from 7/19/23-7/24/23, confirmed staff had not documented providing R49 with ambulation for all days reviewed and should have. Furthermore, LPN-D stated upon review of NA daily assignment sheets since R49's PT discharge on 6/23/23, staff had not been consistently documenting R49's walking program, admitted staff were only occasionally documenting, verified staff should be documenting completion of or refusal daily. While interviewed, on 7/27/23 at 2:12 p.m., the director of nursing (DON) indicated PT's recommendation for restorative service needs was communicated on form titled, rehab	F 688		

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F 688	Continued From page 21 communication, following PT discharge. The DON stated form was provided to unit care coordinator, unit care coordinator updates care plan and NA daily assignment sheets. The DON stated it was her expectation once unit care coordinators received rehab recommendations, care plans and NA daily assignment sheets were updated right away, unit care coordinators communicate new rehab recommendations amongst unit staff, NAs responsible to ensure all resident restorative services provided and resident refusals are documented. The facility Activities of Daily Living (ADLs)/Maintain Abilities policy revised 3/31/23, indicated care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, the facility will provide care and services for the following activities of daily living: b. Mobility- transfer and ambulation, including walking	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		9/1/23

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F 689	Continued From page 22 by: Based on observation, interview, and document review, the facility failed to ensure staff were implementing fall risk prevention measures for 1 of 3 residents (R44) reviewed for accidents. Findings include: R44's face sheet, printed 7/27/23, indicated diagnosis list included fracture of right femur (leg), type 2 diabetes (blood sugar abnormality), muscle weakness, Alzheimer's disease (brain disease causing memory loss and abnormal thinking), malnutrition, major depression (mood disorder), hallucinations (mental disorder causing abnormal perception), anxiety, chronic kidney disease, spinal stenosis (narrowing of spine) of lumbar (back) region with neurogenic claudication (nerve pain), and pseudo hole of right eye (visual changes). R44's quarterly Minimum Data Set (MDS) assessment dated 5/4/23, indicated R44 had severely impaired cognition, exhibited no behaviors, occasionally wandered, required extensive assist by 1 staff for bed mobility, transfers, locomotion on/off unit, dressing, toileting, personal hygiene, and required limited assistance from 1 staff when ambulating in room. R44 had no impairment of all extremities, used a walker and wheelchair for mobility. R44's admission fall risk assessment dated 2/1/23, indicated R44 was at high risk for falls due to impaired cognition, medications including cathartics (laxatives), narcotics (opioid pain-relieving medications), psychotropics (mood altering medications), had minimal difficulty hearing, had occasional bowel/bladder	F 689	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R44 is no longer a resident of this facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents at risk for falls have the potential to be affected. An audit of all resident's fall care plan was completed to ensure they contained appropriate and current fall interventions. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nursing department staff were educated on the expectation to implement fall risk prevention measures and interventions as care planned. The facility implemented use of Point Click Care Kardex, visible on Point of Care, with ability to view updated fall interventions in real time. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee will	

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F 689	Continued From page 23 incontinence, was anxious, had an unsteady gait. Facility progress notes dated 6/26/23, indicated R44 had an unwitnessed fall on 6/26/23 at 4:55 p.m. Report indicated R44 was yelling for help, staff found R44 in room on floor, on knees, next to bedside. Staff assisted R44 to bed, R44 complained of pain to right hip, was assessed per licensed nurse, due to inability to assess right lower extremity (RLE) due to pain, R44 was sent to ER for further evaluation, provider and R44's representative contacted and updated on fall incident. Facility progress notes dated 6/27/23, indicated R44 had been admitted to hospital due to fractured right hip/leg, underwent surgery to repair. Facility incident review and analysis dated 7/3/23, indicated R44 had an unwitnessed fall on 6/26/23 at 4:55 p.m. Report indicated R44 was found in room on floor, on knees, next to bedside, was attempting to self-transfer from bed to wheelchair when fell. Root cause of fall reviewed per interdisciplinary team (IDT), fall determined to be caused by R44's unsteady gait, her history of falls, was forgetful, and did not recognize limitations in mobility. R44's care plan, printed on 7/27/23, instructed staff to place wheelchair (WC) next to bed with breaks locked, dycem to wheelchair/name sign placed on R44's door, grippy socks or shoes on at all times as allows, skid strips in front of bed, soft-touch call-light outside of the bed, follow PT and OT instructions for mobility function. R44's care plan instructed 1 staff to assist with all activities of daily living (ADL), including mobility;	F 689	conduct random audits to ensure fall risk prevention measures and interventions are implemented as care planned. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations.	

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F 689	Continued From page 24 instructed staff to ensure R44's safety, 15 min checks, 1:1 supervision as needed, to provide cues, reorientation, and supervision as needed, be alert to mood and behavioral changes, monitor and respond to unmet needs, may exhibit wandering, impulsive moments, self-transferring, depression, and anxiety. R44's updated fall care plan interventions, included low bed dated 7/3/23, anti-roll backs to back of wheelchair dated 7/25/23, call-light within reach at all times dated 7/27/23, staff to anticipate needs every shift dated 7/27/23, staff to provide optimal lighting and clutter free environment dated 7/27/23. Facility unit resident information sheet, provided on 7/25/23, indicated R44 required assist of 1 with self cares, EZ stand with assist of 2 staff for mobility, had chronic back pain, became anxious, was alert to person only, was generally pleasant and cooperative, was impulsive, had poor judgement and safety awareness. Unit resident information sheet instructed staff to offer toileting every 2-3 hours and as needed (PRN), place wheelchair next to bed with brakes locked, soft-touch call-light to outside of bed, grippy socks or shoes on at all times as allows, low bed. During an observation, on 7/25/23 at 12:47 p.m., R44 visualized in room, lying in bed asleep. Bed observed to be in lowest position, call-light within R44's reach, skid-strips in front of bed, wheelchair next to bedside with dycem in place over wheelchair cushion, wheelchair right brake observed locked, wheelchair left braked visualized unlocked, anti-roll back lock in place to wheelchair. Right arm rest of wheelchair pushed against, wheelchair turned slightly towards left and away from bedside, approx 1.5-2 feet away from bedside.	F 689		

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F 689	Continued From page 25 During an observation and interview, on 7/25/23 at 12:51 p.m., nursing assistant (NA)-D was observed going into R44's room, noted to lock R44's left wheelchair brake. NA-D stated awareness of R44's care needs as care needs could be found in R44's care plan in electronic medical records (EMR) system and on unit resident information sheet kept at nursing station desk for staff to review. NA-D indicated fall risk prevention measures in R44's care plan and on resident information sheet included to place wheelchair next to bedside with brakes locked. While observed and interviewed, on 7/25/23 at 3:53 p.m., R44 was noted in room, lying semi-reclined in bed, was awake staring at bedside wall, tray table next to bedside, call-light observed in R44's reach, wheelchair visualized at foot side end of bed, approx. 3 ft away from bedside. NA-E indicated was caring for R44 during shift, aware of R44's care needs as could be found in R44's care plan and on unit resident information sheet, stated R44's fall prevention measures in care plan and on resident information sheet included to place wheelchair next to bedside with brakes locked. NA-E confirmed R44's wheelchair was not placed at bedside; wheelchair brakes were locked. During an interview, on 7/27/23 at 1:58 p.m., the director of nursing (DON) indicated a resident's fall risk and interventions to prevent falls were found in resident care plans in EMR, some fall interventions could also be noted on resident information sheets located on each unit. The DON stated it was her expectation for staff to follow all resident care plans provided, as care plans provide staff information about the resident,	F 689		

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F 689	Continued From page 26 cares needing to be completed, and how to complete those cares. The DON indicated resident care plans were created at time of admission, updated if readmitted back to facility and anytime new changes/orders were provided. The DON indicated care plans were reviewed and updated as needed weekly per unit care coordinators. The facility Fall Prevention and Management, revised date 2/21, consisted of identifying resident at risk for falls, implementing fall prevention interventions. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Staff will implement interventions, including assistive devices consistent with a resident's needs, goals, care plan, and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident. Staff will monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		9/1/23

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F 756	Continued From page 27 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 2 of 5 residents (R8, R12) reviewed for unnecessary medications. Findings include: R8's face sheet printed on 7/26/23, included diagnoses of schizophrenia (a disorder that	F 756	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 756	Continued From page 28 affects ability to think, feel and behave), high blood pressure, atrial fibrillation (irregular heart beat) and kidney failure. R8's quarterly Minimum Data Set (MDS) assessment dated 5/11/23, indicated severe cognitive impairment requiring extensive assistance of one or two staff for most activities of daily living (ADL's). R8's physician orders included multiple scheduled and as needed medications. R8's care plan dated 1/29/21, indicated R8's medications would be reviewed by a provider and pharmacist. During record review for the past 12 months, the consultant pharmacist entered a monthly progress note into R8's electronic medical record (EMR) indicating either "no irregularities" or "see pharmacist recommendation." For five of the 12 months: 3/19/23, 2/18/23, 11/16/22, 9/11/22, and 8/10/22, the pharmacy consultant note indicated to see pharmacy recommendation. During record review, the pharmacy recommendation forms were not available in the EMR. On 7/25/23 at 12:00 p.m., pharmacy consultant recommendation forms were requested for these dates. R12's face sheet printed on 7/26/23, included diagnoses of Alzheimer's disease (a type of dementia) and epilepsy (a disorder of the brain causing seizures). R12's quarterly MDS assessment dated 5/19/23, indicated severe cognitive impairment and total dependence or extensive assistance of one staff	F 756	practice: -Pharmacy recommendations for R8 and R12 were reviewed and addressed by the provider. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected. Consultant pharmacist recommendations from July and August were reviewed to ensure they were addressed by the provider. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Following the consultant pharmacist rounds, the Nurse Manager will distribute all recommendations to the resident's primary care provider for further direction. Process updated to include that the Director of Nursing or designee will track consultant pharmacist recommendations to ensure all are addressed by the primary care provider. Education was provided to nurse leaders on expectations for consultant pharmacist recommendations, updated process, and Polaris Consultant Pharmacist Reports Medication Regimen Review policy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits of consultant pharmacist recommendations to ensure that the	

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F 756	Continued From page 29 for ADL's. R12's physician orders included multiple scheduled and as needed medications. R12's care plan dated 3/30/22, indicated R12's medications would be review by a provider and pharmacist. During document review for the past 12 months, the consultant pharmacist entered a monthly progress note into R12's EMR indicating either "no irregularities" or "see pharmacy recommendation." For four of the 12 months: 12/12/22, 10/3/22, 9/12/22, and 8/10/22, the pharmacy consultant note indicated to see pharmacy recommendation. During record review, the pharmacy recommendation forms were not available in the EMR. On 7/25/23 at 12:00 p.m., the pharmacy consultant recommendation forms were requested for these dates. During an interview on 7/26/23 at 12:23 p.m., the director of nursing (DON) who was new to the facility, stated she had received her first batch of pharmacy reviews on 7/21/23 and emailed them to nursing care coordinators with instructions to return them to her after obtaining physician input. The pharmacy recommendation form was to be scanned into the EMR after being addressed by the provider. The DON stated she was aware pharmacy recommendations had not been located for some residents and stated going forward she would ensure the process was followed. The DON stated pharmacy consultant recommendations and provider responses were important for the management of a residents care.	F 756	recommendations were addressed by the primary care provider. Audits will be completed 1x/week x 2 months and report to QA committee for further review and recommendations.	

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F 756	Continued From page 30 During an interview on 7/26/23 at 12:29 p.m., licensed practical nurse (LPN)-B stated the previous DON printed pharmacy recommendations and put them in the nursing care coordinators mailboxes. The care coordinators had been responsible for following up with providers on the pharmacy recommendations. Once the provider signed off, care coordinators gave the forms to the health information department to scan into the EMR. LPN-B could not say if pharmacy consultant recommendations had been missed in the past year; she only saw them if given to her by the DON. During an interview on 7/26/23 at 1:22 p.m., the regional director of operations (RDO)-B stated the facility did not have the pharmacy consultant recommendations that were requested for R8 and R12. RDO-B stated the facility process lacked redundancy, no duplication of the process in case of failure. Further, the RDO-B stated if the former DON had not given the pharmacy recommendations to the nursing care coordinators, the recommendations had not been addressed. During a telephone interview on 7/26/23 at 1:28 p.m., pharmacy consultant (PC)-E stated she had been temporarily covering for the usual pharmacist. PC-E stated pharmacy recommendation forms were sent to someone at the facility, usually the DON via email. PC-E stated each facility was different in how the forms were dispersed from there but were given to the appropriate provider for a response. PC-E stated the pharmacist did not always see the provider comment to their recommendation but would see	F 756		

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F 756	Continued From page 31 if a medication order had changed per their recommendation. If a medication order change was recommended and not seen, the pharmacist would do a repeat request. PC-E stated there had been a lot of turnover of DON's at the facility and that always hindered the process. The facility Consultant Pharmacy Reports policy dated May 2022, indicated the consultant pharmacist performed a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) included evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. MRR also involved reporting of findings with recommendations for improvement. All findings and recommendations were reported to the director of nursing and the attending physician, the medical director, and the administrator. Recommendations were acted upon and documented by the facility staff and/or the prescriber. The prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 1	F 760	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not	9/1/23

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F 760	Continued From page 32 resident (R29) reviewed for insulin administration using an insulin pen. Findings include: R29's admission Minimum Data Set (MDS) assessment dated 6/30/23, indicated R29 had intact cognition, diagnoses list included diabetes mellitus (abnormal blood sugars), Alzheimer's disease (brain disease causing abnormal thinking and memory loss), hemiplegia/hemiparesis (paralysis), depression (mood disorder), and received injectable insulin. R29's order summary, dated 6/27/23, indicated physician orders for insulin aspart flexpen subcutaneous solution pen-injector 100 unit/mL- Inject subcutaneously with meals related to type 2 diabetes mellitus (DM) with diabetic chronic kidney disease (CKD), blood sugar greater than 400 call medical doctor (MD) and insulin glargine subcutaneous solution 100 unit/mL- Inject 25 units subcutaneously at bedtime related to type 2 DM with diabetic CKD. During an observation, on 7/25/23 at 5:05 p.m., licensed practical nurse (LPN)-C A cleaned the tip of the insulin aspart injector pen with an alcohol wipe, applied the needle, dialed up six units of insulin aspart as prescribed for sliding scale insulin for blood sugar (BS) result of 214. LPN-C had not primed aspart insulin pen needle prior to dialing up six units insulin, R29 was potentially shorted two units of insulin, LPN-C stopped prior to entering R29's room and asked about priming insulin pen. LPN-C confirmed she had not primed aspart insulin pen needle prior to six units being dialed, stated she forgot, was aware insulin pen needle should be primed with 2cc insulin	F 760	constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R29 was not directly impacted by alleged deficiency as the insulin was wasted, therefore not administered to the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents receiving insulin have the potential to be affected by the alleged deficiency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nurses and Nurse Leaders were educated on the Administering Medications policy and priming insulin pens, along with a review of Monarch's Medication Error Reconciliation Form. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits of insulin administration 3x/week x 1 month. DON or designee will review Medication Error Reconciliation Form audits 5x/week x 1 month. Audits will be reported to the QA committee for further review and recommendations.	

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F 760	Continued From page 33	F 760		

prior to dialing units needed. LPN-C then wasted aspart insulin 6 units previously dialed, dialed another 6 units of aspart insulin prior to administering to R29.

During an interview, on 7/27/23 at 2:07 p.m. the director of nursing (DON) indicated all licensed nursing staff, including licensed agency nursing staff have been educated on insulin preparation and administration at time of orientation. The DON stated facility licensed nursing staff had many days of education and orientation to floor with medication preparation/administration, competency check-off of insulin preparation/administration had to be completed prior to being independent of. The DON indicated licensed agency nursing staff received very little orientation to facility, was expected per agency contract agreement all agency nursing staff were to be competent in all skill areas related to licensure prior to sending to facility. The DON stated it was her expectation insulin pen needles should be primed with two units of insulin, wasted, then insulin dialed to units as prescribed to ensure resident received the correct insulin dosage.

The facility Administering Medications policy revised 4/19, indicated medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions.

Novo Nordisk Inc., manufacturer for Novolog

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F 760	Continued From page 34 (aspart) insulin, dated 3/23, Novolog (insulin aspart) injection flexpen- page 9. Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen and contact Novo Nordisk at 1-800-727-6500. G A small air bubble may remain at the needle tip, but it will not be injected.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		8/30/23

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F 761	Continued From page 35 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 2 refrigerators observed in use for medication storage. This had potential to affect 2 of 2 residents (R15 and R48) residing in the facility who receive this medication. Findings include: On 7/26/23 at 11:44 a.m., the locked north medication room was observed with registered nurse (RN)-A, a locked refrigerator was present. RN-A opened the refrigerator and inside was a box of lorazepam oral concentrate 2 mg/ml labeled with R15's name and a bottle of lorazepam oral concentrate 2 mg/ml labeled with R48's name. RN-A stated the facility practice was to store the lorazepam in the refrigerator and the facility practice did not include the lorazepam stored in a separately affixed box within the refrigerator. On 7/26/23 at 11:58 a.m., during an interview the director of nursing (DON) confirmed lorazepam is a scheduled controlled substance and should be	F 761	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -Controlled substances requiring refrigeration for R15 and R48 were moved into a separately affixed box within the refrigerator. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents receiving controlled substances that require refrigeration have the potential to be affected. All controlled substances requiring refrigeration have been moved into a separately affixed box within the refrigerator.	

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F 761	Continued From page 36 stored in a separately affixed box within the refrigerator. The facility Medication Storage controlled substance storage policy in the facility dated 5/22, Policy Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Procedures A. The director of nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized licensed nursing and pharmacy personnel have access to controlled substances. B. Schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications or per state regulation. Alternatively, in a unit dose system, medications may be kept with other medications in the cart if the supply of medication(s) is minimal and a shortage is readily detectable. The access system to controlled medications is not the same as the system giving access to other medications (the key that opens the compartment is different from the key that opens the medication cart). If a key system is used, the medication nurse on duty maintains possession of the key to controlled substance storage areas. Back-up keys to all medication storage areas, including those for controlled substances, are	F 761	What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -All medication storage refrigerators were provided with a separately affixed, secured box within the refrigerator. All controlled substances that require refrigeration will be placed in these boxes to reduce the risk of theft. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits of medication storage refrigerators to ensure that all controlled substances that require refrigeration are stored in the appropriate manner. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations.	

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F 761	Continued From page 37 kept by the director of nursing or designee. C. Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator. D. A controlled substance record is prepared by the pharmacy/facility for all Schedule II, III, IV, and V medications. The following information is completed on the form upon dispensing or receipt of a controlled substance: 1) Name of resident, if applicable. 2) Prescription number, if applicable. 3) Name, strength, and dosage form of medication. 4) Date received. 5) Quantity received. 6) Name of person receiving medication supply.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		9/1/23

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F 812	Continued From page 38 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturers instructions for cleaning and sanitizing two ice machines used for resident consumption. This had the potential to affect all 59 residents who resided in the facility. Findings include: During an observation and interview on 7/24/23 at 8:18 a.m., culinary services director (CSD)-A stated the facility had two ice machines, one located in the kitchen and one in the adjacent dining room. CSD-A stated dietary staff cleaned the outside and maintenance staff deep cleaned the inside. CSD-A stated residents had the potential to consume ice from both ice machines. During document review, paper logs titled Ice Machine Cleaning indicated ice machines had been cleaned monthly in 2022 and 2023. The log did not indicate the type of cleaning that had been conducted. During an interview on 7/26/23 at 11:53 a.m., maintenance assistant (MA)-A stated he was not sure if there were manufacturer instructions for how to, or how often ice machines should be cleaned and sanitized; he had not thought to look at manufacturer instructions for that information. MA-A obtained manufacturer instructions for both ice machines and together they were reviewed. MA-A acknowledged he had not been following the instructions outlined in the booklets and instead was just emptying the ice from the ice	F 812	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -The manufacturer’s instructions have been reviewed by maintenance and supplies per manufacturer’s instructions have been gathered. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected by the alleged deficiency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Maintenance was educated on the manufacturer’s instructions for cleaning the ice machines both in frequency and tools needed and that is the standard of descaling and sanitizing. A tracker was created to ensure date accuracy of the last cleaning. How the facility will monitor its corrective actions to ensure that the deficient	

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F 812	Continued From page 39 machine bins and wiping the bin with vinegar. MA-A stated proper cleaning of ice machines was important to prevent the spread of bacteria and acknowledged this could include Legionella. During an interview on 7/26/23 at 12:08 p.m., the administrator was informed of findings for ice machine cleaning and sanitization. The administrator was unaware of this and expected staff to following manufacturer instructions for cleaning and sanitizing equipment. During an interview on 7/26/23 at 12:14 p.m., the director of nursing (DON) who was also the infection preventionist and new to both roles, stated she had not had infection preventionist training yet and therefore ice machine cleaning and sanitization had not been on her radar. The DON stated she was aware infection prevention encompassed many areas within the facility and would now be aware it included ice machines. The facility policy on ice machines was requested and a TELS (software used for building maintenance) document was received dated 6/30/23, and indicated ice machines would be sanitized per manufacturer instructions. Manufacturer instructions for the following Scotsman brand ice machines were the same, however the cleaning and sanitization frequency varied: --Model MDT5N40 - instruction book dated November 2008, indicated cleaning/sanitizing should be done a minimum of twice per year. --Model MDT6N90 - instruction book dated May 2001, indicated to sanitize the ice storage bin a minimum of four times a year.	F 812	practice is being corrected and will not recur: -Administrator or designee will audit the tracker 2x/quarter x 1 year and will report to the QA committee for further review and recommendations.	

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F 812	Continued From page 40 CLEANING and SANITIZING for both model ice machines: Maintenance and Cleaning/Sanitizing should be scheduled at a minimum of twice per year. 1. Check and clean any water treatment devices, if any are installed. 2. Remove screws and remove the upper front panel. 3. Move the ON-OFF switch to OFF. 4. Remove the cover to the ice storage bin, and remove the ice. 5. Remove the cover to the water reservoir and block the float up. 6. Drain the water reservoir and freezer assembly using the drain tube attached to the freezer water inlet. Return the drain tube to its normal upright position and replace the end cap. 7. Prepare the cleaning solution: Mix eight ounces of Scotsman Ice Machine Scale Remover with three quarts of hot water. The water should be between 90-115 degrees Fahrenheit (F). 8. Slowly pour the cleaning solution into the water reservoir until it is full. Wait 15 minutes, then switch the master switch to ON. 9. As the ice maker begins to use water from the reservoir, continue to add more cleaning solution to maintain a full reservoir. 10. After all of the cleaning solution has been added to the reservoir, and the reservoir is nearly empty, switch the master switch to OFF. 11. After draining the reservoir, as in step 6, wash and rinse the water reservoir. TO SANITIZE: Repeat steps 8-11, only use an approved sanitizing solution in place of the cleaning solution. A possible sanitizing solution to use could be 1 ounce of household bleach mixed with 2 gallons of warm (95 degrees F. water).	F 812		

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F 812	Continued From page 41 12. Remove the block from the float in the water reservoir. 13. Switch the master switch to ON 14. Continue ice making for at least 15 minutes, to flush out any cleaning solution. Check ice for acid taste - continue ice making until ice tastes sweet. Do not use any ice produced from the cleaning solution. Be sure no ice remains in the bin. 15. Remove all ice from the storage bin. 16. Add warm water to the ice storage bin and thoroughly wash and rinse all surfaces within the bin. 17. Sanitize the bin cover, dispensing vane, bin bottom, and interior with an approved sanitizer using the directions for that sanitizer. 18. Replace the ice storage bin cover, and the front panel.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		9/15/23

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F 880	Continued From page 42 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 43 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement and maintain an infection control program that included thorough data collection, analysis of facility infections, and tracking and trending to reduce the spread of infections within the facility. The facility failed to include in their surveillance viral-like illnesses not treated with an antibiotic for staff or residents. The facility had no process in place to identify and monitor other types of infection in the facility and there was no analysis of the data collected. This had the potential to affect all 59 residents residing in the facility. Furthermore, the facility failed to ensure staff were implementing standard precautions for infection control and prevention, appropriately disinfecting reusable resident medical equipment including a scissors (R13) and glucometer (R29). This had the potential to affect all 7 residents using reusable glucometers residing on the southwest (200) wing of unit and two residents using reusable scissors for wound care on the 100 wing of unit. Findings include: On 7/25/23 at 2:31 p.m., the director nursing (DON) stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control	F 880	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -An infection control program has been implemented and will be maintained to include thorough data collection, analysis of facility infections, and tracking and trending to reduce the spread of infections within the facility. This program will include surveillance of viral-like illnesses not treated with an antibiotic for staff and residents. R13 and R29 were reviewed for the need to utilize shared medical equipment. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected by the alleged deficiencies.	

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F 880	Continued From page 44 surveillance log. The DON stated she was not aware the facility was required to track data that included identification of all illnesses, diagnostics performed, test dates, type of tests, specimen source, results of tests, antibiotic resistant organisms, and time outs, (timeframe used after an antibiotic was initiated to assure appropriate use and effectiveness). The DON stated information regarding resident illnesses, testing, infections, were discussed daily with facility staff, however the information was not tracked or analyzed. The DON stated she had not received training for infection control surveillance and as a result was unable to complete all the necessary areas. No outbreaks were noted. The DON stated human resources received employee illnesses, however she had not tracked or reviewed employee illnesses for tracking or surveillance. On 7/25/23 2:45 p.m., during an interview the administrator and regional director of operations verified the facility had not completed infection surveillance that included data collection, analysis of facility infections, tracking and trending of infections or illnesses within of residents or staff within the facility. The facility Infection Prevention and Control Program policy dated 3/13/23, indicated Policy Statement The primary mission of Monarch Healthcare Management is to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP is a facility wide effort involving all disciplines and is part of	F 880	What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -An infection control program has been implemented and maintained by the facility's Infection Preventionist. Additional resident medical equipment, including glucometers and scissors, have been purchased to designate for staff use with individual residents. Nurses were educated on disinfection of reusable resident medical equipment with appropriate products (ie Super Sani Cloth). How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will audit infection spreadsheets to ensure collection of data for facility tracking and trending of infections 1x/week x 2 months. DON or designee will audit usage of resident medical equipment and appropriate disinfection processes 2x/week x 1 month. Audits will be reported to the QA committee for further review and recommendations.	

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F 880	Continued From page 45 the quality assurance and performance improvement program (QAPI). Scope The Infection Control Program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. The major elements of the program are: o Coordination/Oversight o Policies and Procedures o Surveillance o Data analysis o Antibiotic Stewardship o Outbreak Management o Prevention of Infection o Employee Health Policy Interpretation and Implementation 1. The facility's infection control policies and procedures apply to all personnel, consultants, contractors, residents, visitors, volunteer workers and the general public. 2. The QAPI committee, through the Infection Control Committee, shall oversee the implementation of infection control policies and procedures, and help department directors and managers ensure that they are implemented and followed. 3. All personnel will be trained on infection control policies and procedures upon hire and periodically thereafter, including when and how to find pertinent procedures and equipment related to infection control. The content of the employee training is dependent on the degree of direct resident contact and job responsibilities. 4. The facility's infection control policies and procedures will be reviewed and revised or updated as needed. The Infection Preventionist, in conjunction with the QAPI Committee, will be responsible for keeping the infection control	F 880		

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F 880	Continued From page 46 program (policies and procedures) current and staff members will be notified of changes or updates. 5. Questions about the infection control policies and procedures should be referred to the Infection Preventionist or Director of Nursing. Coordination and Oversight 1. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). 2. The qualifications and job responsibilities of the Infection Preventionist are outlined in the Infection Preventionist Job Description. 3. The infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Surveillance 1. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. 2. The information obtained from infection control surveillance activities will be reviewed month over month and compared with that from the facilities baseline and used to assess the effectiveness of established infection prevention and control practices. 3. Standard criteria are used to distinguish community-acquired from facility acquired infections. Data Analysis 1. Data gathered during surveillance is used to oversee infections and spot trends.	F 880		

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F 880	Continued From page 47 2. One method of data analysis is by manually calculating number of infections per 1000 resident days a. The infection preventionist collects data from the nursing units, categorizes each infection by body site (these can also be categorized by organism or according to whether they are facility- or community-acquired), and records the absolute number of infections; b. To adjust for differences in bed capacity or occupancy on each unit, and to provide a uniform basis for comparison, infection rates can be calculated as the number of infections per 1000 patient days(a patient day refers to one patient in one bed for one day), both for each unit and for the entire facility. c. Monthly rates can then be plotted graphically or otherwise compared sideby-side to allow for trend comparison; and d. Finally, calculating means and standard deviations (using computer software) allows for screening of potentially clinically significant rates of infections (greater than two standard deviations above the mean). 3. The Medical Director will help design data collection instruments, such as infection reports and antibiotic usage surveillance forms, used by the Infection Preventionist. Monitoring Employee Health 1. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including: a. situations when these individuals should report their infections or avoid the facility (for example, draining skin wounds, active respiratory infections with considerable coughing and sneezing, or	F 880		

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F 880	Continued From page 48 frequent diarrheal stools); Glucometer Testing On 7/25/23 at 5:05 p.m., licensed practical nurse (LPN)-C performed a blood sugar check, using an assure prism glucometer, for R29. LPN-C hand sanitized, donned gloves wiped R29's finger with alcohol wipe, poked finger using lancet. Blood sugar reading was 214. LPN-C disposed of lancet in sharps container, used an alcohol wipe to disinfect glucometer, glucometer placed on med cart to air dry, doffed gloves, hand sanitized, glucometer placed back in med cart. LPN-C stated unawareness of facility policy for disinfecting glucometer, was an agency nurse and second day at facility, was orientated 1 hour prior to working alone on floor. LPN-C stated thought alcohol wipe was an acceptable disinfection measure for infection control of reusable glucometer, unaware of contact time for alcohol wipe. Wound Care On 7/26/23 at 2:15 p.m., LPN-C performed wound care to R13. LPN-C hand sanitized, explained to R13 what she was going to do, grabbed wound care supplies in R13's basin, placed basin on tray table, donned gloves, removed dressing from R13's mid back, removed scissors from her scrub pocket and placed on tray table, grabbed measuring paper tape from basin and measured wound to R13's mid back. Wound measurements were 1.8cmx1.5cmx0.1cm. LPN-C placed measuring paper tape back in basin, grabbed wound cleanser from basin to cleanse wound, wound	F 880		

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F 880	Continued From page 49 cleanser placed on tray table. LPN-C doffed gloves, donned clean pair of gloves, removed 2"x2" xeroform from basin, picked up scissors from tray table, cut xeroform piece and put scissors back on tray table, left cut xeroform piece in package, cleansed around wound site with skin prep, applied piece of cut xeroform to wound site, covered wound with 4"x4" silicone foam bordered dressing, placed supplies in basin, doffed gloves, washed hands with soap/water, scissors had returned to LPN-C scrub pocket. LPN-C stated scissors had in scrub pocket was favorite she liked to use for all wound cares needed, indicated typically would clean scissors with alcohol pad prior to any wound care performed, admitted she had forgotten to disinfect scissors prior to wound care. LPN-C stated unawareness of facility policy for disinfecting scissors was an agency nurse and second day at facility, was orientated 1 hour prior to working alone on floor, thought alcohol wipe was an acceptable disinfection measure for infection control of reusable scissors, unaware of contact time for alcohol wipe. During an interview, on 7/27/23 at 2:07 p.m. the director of nursing (DON) stated all staff, including agency staff, were trained to follow the manufacturer guidelines and facility policy for cleaning and disinfecting of reusable medical equipment, including glucometer and scissors. The DON indicated the use of alcohol wipes was not an efficient method to use for infection control and prevention, and it was her expectation for staff to use super sani-cloths provided per facility policy for disinfection of reusable medical equipment, allowing contact time for at least 2 minutes, then air dry prior to next use.	F 880		

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F 880	Continued From page 50 Manufacturer guidelines for assure multi blood glucose monitoring system, revised 8/15, indicated to minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions as follows, the meter should be cleaned and disinfected after use on each patient. The assure prism multi blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer ' s disinfection procedures are followed, the cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure, the disinfection procedure is needed to prevent the transmission of blood-borne pathogens. A variety of the most commonly used EPA-registered wipes have been tested and approved for cleaning and disinfecting of the Assure Prism multi Blood Glucose Monitoring System, including super sani-cloth germicidal disposable wipe. Manufacturer guidelines for super sani-cloth germicidal disposable wipe, copyright date 2019, indicated general guidelines for use and consisted of ensuring wipe is dispensed through lid, when not in use keep lid closed to prevent moisture loss, remove wipe with a uniform pull away from face and eyes, remove heavy soil loads if present prior to disinfecting, unfold a clean wipe and thoroughly wet surface, allow treatment surface to remain wet for least 2 minutes and let air dry, do not reuse towelette.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		9/6/23

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F 881	Continued From page 51 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 59 residents at the facility. Findings include: On 7/25/23 at 2:31 p.m., the director nursing (DON) stated she was the infection prevention nurse and assisted with infection prevention since she started the position as the DON one month ago. The DON stated the antibiotic use was not tracked. The DON stated the nurses completed monitoring of resident symptoms, possible infections, and reported to the provider. The DON stated the providers were responsible to review or track culture results to ensure proper antibiotics were prescribed. The DON confirmed infections, antibiotic indications for use, dosage, duration, cultures, signs, symptoms of infection upon onset, follow-up to ensure symptoms had resolved or an antibiotic had been discontinued timely was not tracked. On 7/25/23 2:45 p.m., during an interview the administrator and regional director of operations	F 881	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -The facility implemented a process for antibiotic review and trending of all residents. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -The Director of Nursing was educated on Monarch's Antibiotic Stewardship policy including antibiotic review and trending requirements. Antibiotic tracking, review,	

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F 881	Continued From page 52 verified infection surveillance or antibiotics were not tracked or logged for appropriate indications, dosage, duration, trends of antibiotic use and resistance. The facility Antibiotic Stewardship Program Antibiotic Use policy dated 3/13/23, indicated: The Infection Preventionist, (IP), or designee, will review all antibiotic orders to determine if treatment is appropriate. Treatment is not appropriate if: The organism is not susceptible to the antibiotic chosen. The organism is susceptible to a narrower spectrum antibiotic. Therapy was ordered for prolonged surgical prophylaxis. Therapy was started awaiting culture, but no organism was isolated after 72 hours. Interventions that may resolve inappropriate treatment include: Drug change Dosage change Duration change Obtain culture Discontinue antibiotic treatment The provider will be notified of the review findings and recommendations and a response will be documented in the resident's medical record. Tracking: The Infection Preventionist, along with the Consultant Pharmacist, will monitor antibiotic use by utilizing a facility approved infection/antibiotic surveillance tracking form and thru monthly medication reviews. The information gathered will include: Resident name Unit and room number	F 881	and trending has been implemented and is up to date. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits of facility antibiotic surveillance tracking form to ensure that appropriate tracking, review, and trending is being completed. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations.	

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F 881	Continued From page 53 Date symptoms appeared Name of antibiotic Start date of antibiotic Pathogen identified Site of infection Date of culture Stop date Total days of therapy Outcome Adverse events, if applicable Reporting: The Infection Preventionist and the Pharmacy Consultant will provide regular feedback on antibiotic use and outcomes to facility staff and the QAPI committee. Feedback will also be provided to providers on their individual prescribing patterns of cultures ordered and antibiotics prescribed, as indicated.	F 881		
F 882 SS=C	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized	F 882		8/27/23

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F 882	Continued From page 54 training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 59 residents residing in the facility. Findings include: On 7/25/23 at 2:31 p.m., the director nursing (DON) stated she was the infection prevention (IP) nurse and was responsible for IP since started the position as a DON at the facility a month ago. The DON confirmed the required IP education was not completed and stated she was in the process of infection training. On 7/26/23 at 8:00 a.m., the administrator confirmed the facility did not have a staff member who had completed the infection preventionist training and oversaw IP for the facility. The facility Infection Prevention and Control Program policy dated 3/13/23, indicated: Coordination and Oversight 1. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). 2. The qualifications and job responsibilities of the Infection Preventionist are outlined in the Infection Preventionist Job Description.	F 882	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -The facility Infection Preventionist has successfully completed the specialized training provided in the CDC Nursing Home Infection Preventionist Training Course. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -The Administrator and Director of Nursing were educated on the requirement to designate an Infection Preventionist who has completed specialized training in infection prevention and control. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not	

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F 882	Continued From page 55	F 882	recur: -The Administrator or designee will conduct an audit to ensure successful completion of the CDC Nursing Home Infection Preventionist Training Course in the event of a change in the designated nursing leader. Audits will be completed 5x/week x 1 month, or until certification is completed and will report to the QA committee for further review and recommendations.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bathroom call light cords were within reach from the bathroom floor for 3 of 3 residents (R2, R43, R47), reviewed for call lights. Findings include: R2's facesheet printed on 7/27/23, included diagnosis of macular degeneration (eye disease that causes vision loss). R2's quarterly Minimum Data Set (MDS)	F 919	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R2, R43 and R47 bathroom call light cords have been replaced with cords that	8/24/23

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F 919	Continued From page 56 assessment dated 7/13/23, indicated R2 was cognitively intact, had clear speech, could understand, and be understood. R2 required supervision for most activities of daily living (ADL's) including walking in his room and transferring. R2 required extensive assistance of one for toileting. During an observation on 7/24/23 at 11:10 a.m., there was no call light cord observed in R2's bathroom, just a small, older style push button call light on the wall; not intended for a cord to hang from it. During an interview on 7/25/23 at 6:55 p.m., registered nurse (RN)-A confirmed R2 used the toilet in his bathroom and pressed the call light button for assistance. Together looked at the call light button which was a round silver plate with a small black button in the middle. RN-A acknowledged R2 would not be able to reach the button for assistance if he were lying on the floor. R43's facesheet printed on 7/27/23, included diagnoses of Alzheimer's disease, traumatic amputation of right shoulder and arm and unsteadiness on feet. R43's quarterly MDS assessment dated 7/7/23 indicated R43 was cognitively intact, had clear speech, was usually understood, and could usually understand. R43 required supervision for toileting with set-up help only. During an observation on 7/24/23 at 10:00 a.m., R43 was resting in his recliner. Observed the call light cord in his bathroom to be about two feet from the floor. R2 stated he toileted himself.	F 919	are within reach from the bathroom floor. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected by the alleged deficiency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Maintenance was educated on the Monarch Call Light policy and requirement for bathroom call light cords to be within reach from the bathroom floor. All resident bathroom call lights were audited for cord length and replaced if cord was not within reach from the bathroom floor, as indicated by being within 6 inches of the floor per the policy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will complete random audits of resident bathroom call light cords to ensure they meet the requirement to be within reach from the bathroom floor 3x/week x 4 weeks and will report to the QA committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(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 919	Continued From page 57 R47's facesheet printed on 7/27/23, included diagnosis of visual loss and dementia. R47's annual MDS assessment dated 5/26/23, indicated R47 had significant cognitive impairment, clear speech, was usually understood and could usually understand. R47 required supervision of one staff for toileting. During an observation on 7/26/23 at 1:36 p.m., together with nursing assistant (NA)-A, observed R47's call light cord in R47's bathroom. The cord was looped, wrapped, and tied in knots around the grab bar next to the toilet causing it to be about six inches in length. NA-A acknowledged that if R47 was on the floor, he would not be able to reach the call light cord for assistance. During an interview on 7/26/23 at 1:05 p.m., maintenance assistant (MA)-A stated he was aware call light cords in bathrooms needed to reach close to the floor and had been working on replacing the button-style call lights in bathrooms on the 500 wing. MA-A stated he had not been aware call light cords in other resident bathrooms throughout the facility did not hang down far enough for a resident to reach if lying on the floor. The facility Call Light Policy updated on 5/16/23, indicated a nurse call [system] must be provided for each resident bathroom and facility bathroom and in all areas used for resident bathing. If a pull cord was provided it must extend to within six inches above the floor, so it is accessible to a resident lying on the floor.	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE** **MANKATO, MN 56001**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/27/2023. At the time of this survey, Hillcrest Care & Rehab Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. This one-story with partial basement facility was constructed in 1957, with one building addition constructed in 1963. Both buildings were determined to be of Type II(000) construction. The facility is fully fire sprinkler protected throughout. The facility has a capacity of 80 beds and had a census of 58 at time of the survey.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 28, 2023

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: CCN: 245507
Cycle Start Date: July 27, 2023

Dear Administrator:

On September 18, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us