



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2026

Administrator
HILLCREST HEALTH CARE, LLC
714 SOUTHBEND AVENUE
MANKATO, MN 56001

RE: CCN: 245507

Cycle Start Date: August 24, 2026

Dear Administrator:

On August 24, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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, Regional Operations Supervisor
Mankato District Office
Heath Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 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 November 24, 2026 (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 February 24, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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September 8, 2026

Administrator
HILLCREST HEALTH CARE, LLC
714 SOUTHBEND AVENUE
MANKATO, MN 56001

Re: State Nursing Home Licensing Orders

Event ID: 284FBA-H1

Dear Administrator:

The above facility survey was completed on August 24, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Heath Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/24/2026	
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE , MANKATO, Minnesota, 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
E0000	Initial Comments On 8/23/26-8/24/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.			E0000			09/30/2026
F0000	INITIAL COMMENTS On 8/23/26-8/24/26, a standard recertification survey (S5507039) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55073807C (iQIES#3041966), H55073808C (iQIES#2796913), H55073809C (iQIES#2717990), H55073810C (iQIES# 3029085), H55073811C (iQIES# 2700770), H55073812C (iQIES# 2718013), and H55073813C (iQIES #3155437), NO deficiencies were cited. 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.			F0000			

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0880 SS = D	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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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			F0880	F880 – Infection Prevention & Control (POC) Please accept this Plan of Correction as the facility’s credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice The 200 hall shower room was immediately inspected and cleaned. Used linens, washcloths, bandages, basins, and other care-related items were removed from the shower room. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice All resident shower rooms were inspected to ensure they were clean and free of used linens, bandages, and other care-related items. Any concerns identified were corrected. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur Nursing staff and Housekeeping (EVS) staff were educated regarding infection prevention and control expectations for shower rooms. Including removing used linens and care-related items after use, placing used linens in the appropriate receptacle, and ensuring shower rooms and equipment are maintained in a clean and sanitary condition. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The Director of Nursing or designee will conduct random audits of resident shower rooms twice weekly x4 weeks, weekly x4 weeks, monthly x1 month, and will report to QAPI committee for further review and recommendations.		09/18/2026

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0 F0880 SS = D	Continued from page 2 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. §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 observation and interview, the facility failed to maintain infection prevention and control practices in the 200 hall shower room to prevent the potential spread of infection for 1 of 2 shower rooms observed. Findings Include: On 8/23/26 at 6:10 p.m., R70 stated he had showered independently in the shower room across the hall from his room the previous day and described the shower as "gross." R70 stated he found the cleanest towels he could find in the shower room, placed a towel on the shower chair, and showered himself. R70 stated there were used towels on the floor and used bandages in the shower room. On 8/23/26 at 6:21 p.m., the 200 hall shower room was observed with the interim administrator present. An open container containing multiple pieces of linen and washcloths was observed. A blue basin was also observed on the floor adjacent to the linen container. The basin contained two bandages and a tube/container of care-related product. The bandages were lying loose inside the basin. The interior of the basin had visible areas of discoloration and residue along the bottom and sides, giving the basin an unclean appearance. Multiple towels/linen were also observed in an open container in the shower room and appeared used.			F0880			09/18/2026

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0 F0880 SS = D	Continued from page 3 On 8/23/26 at 6:23 p.m., the director of nursing (DON) and interim administrator stated they would not expect dirty towels, bandages, or other linens to be left in the shower room. The DON stated used linen was expected to be bagged and removed after use. The DON stated used bandages were not expected to be present in the shower room and stated the shower room was expected to be cleaned. The DON confirmed the observed conditions could present an infection control issue. On 8/23/26 at 6:33 p.m., nursing assistant (NA)-A stated the 200 hall shower room was not known to have been used since Friday, two days prior. NA-A stated the linens, basin, and bandages observed in the shower room would have been present since that time. NA-A stated these items were expected to be removed after use and stated they would not expect these items to be left in the shower room. The facility policy Infection Prevention and Control Program dated 11/25, indicated the primary mission....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 the quality assurance and performance improvement program (QAPI).			F0880			09/18/2026

Minnesota Department of Health

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020000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/23/26-8/24/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H55073807C (iQIES#3041966), H55073808C (iQIES#2796913), H55073809C (iQIES#2717990),			20000			09/30/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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020000	Continued from page 1 H55073810C (iQIES# 3029085), H55073811C (iQIES# 2700770), H55073812C (iQIES# 2718013), and H55073813C (iQIES #3155437), NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			09/30/2026
821385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.			21385	Corrected		09/18/2026

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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE , MANKATO, Minnesota, 56001			
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21385	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain infection prevention and control practices in the 200 hall shower room to prevent the potential spread of infection for 1 of 2 shower rooms observed. Findings Include: On 8/23/26 at 6:10 p.m., R70 stated he had showered independently in the shower room across the hall from his room the previous day and described the shower as "gross." R70 stated he found the cleanest towels he could find in the shower room, placed a towel on the shower chair, and showered himself. R70 stated there were used towels on the floor and used bandages in the shower room. On 8/23/26 at 6:21 p.m., the 200 hall shower room was observed with the interim administrator present. An open container containing multiple pieces of linen and washcloths was observed. A blue basin was also observed on the floor adjacent to the linen container. The basin contained two bandages and a tube/container of care-related product. The bandages were lying loose inside the basin. The interior of the basin had visible areas of discoloration and residue along the bottom and sides, giving the basin an unclean appearance. Multiple towels/linen were also observed in an open container in the shower room and appeared used. On 8/23/26 at 6:23 p.m., the director of nursing (DON) and interim administrator stated they would not expect dirty towels, bandages, or other linens to be left in the shower room. The DON stated used linen was expected to be bagged and removed after use. The DON stated used bandages were not expected to be present in the shower room and stated the shower room was expected to be cleaned. The DON confirmed the observed conditions could present an infection control issue. On 8/23/26 at 6:33 p.m., nursing assistant (NA)-A stated the 200 hall shower room was not known to have been used since Friday, two days prior. NA-A stated the linens, basin, and bandages observed in the shower room would have been present since that time. NA-A stated these items were expected to be removed after use and stated they would not expect these items to be left in the shower room. The facility policy Infection Prevention and Control Program dated 11/25, indicated the primary mission....is to establish and maintain an infection			21385			09/18/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/24/2026	
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE , MANKATO, Minnesota, 56001			
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21385	Continued from page 3 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 the quality assurance and performance improvement program (QAPI). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to quality assurance performance improvement (QAPI) committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21385			09/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/24/2026	
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/24/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Hillcrest Health Care, LLC was found not 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, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			09/30/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hillcrest Care & Rehab Center is a one-story with partial basement facility that was constructed in 1957, with one building addition constructed in 1963. Both buildings were determined to be of Type II(000) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered with a fire pump. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Resident rooms are also outfitted with battery operated smoke alarms, these are not connected to the building fire alarm system. The facility has a capacity of 95 beds and had a census of 61 at the time of the survey.			K0000			09/30/2026

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K0000 Bldg. 01	Continued from page 2			K0000			09/30/2026
K0222 SS = E Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			K0222	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice The delayed egress door located on the 200 Wing was immediately reviewed following identification of the missing required signage. The facility ordered the required delayed-egress signage. The signage has been installed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice All residents of the facility have the potential to be affected by deficient delayed-egress door signage. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur Education was provided to the maintenance director regarding required delayed-egress door signage. The facility reviewed expectations for maintaining delayed-egress doors and required signage. The Maintenance Director or designee will include delayed-egress door signage in routine Life Safety rounds and will immediately address any missing, damaged, or illegible signage. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur		09/30/2026

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K0222 SS = E Bldg. 01	Continued from page 3 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.2.1.6.1.1(4). This deficient finding could have a patterned impact on the residents within the facility. Findings Include: On 08/24/2026 at 10:51 AM, it was revealed by observation and staff interview, that the delayed egress door located in the 200 Wing did not have a readily visible sign that read "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS."An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0222	Continued from page 3 The Maintenance Director or designee will audit all delayed-egress doors weekly for four weeks, then monthly for two months to ensure required signage remains present, visible, legible, and securely installed. Findings will be reviewed with the Administrator and reported through the facility's QAPI process as indicated. Any identified variance will be corrected immediately.		09/30/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2			K0324	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice The kitchen gas cooking appliance was reviewed following identification of the deficient condition. The		09/30/2026

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K0324 SS = E Bldg. 01	Continued from page 4 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3. and NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations section 12.1.2.3 and 12.1.2.3.1. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 08/24/2026 at 10:44 AM, it was revealed by observation and staff interview that the kitchen fire suppression system did not have an approved method to ensure that the appliance is returned to an approved design location. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	Continued from page 4 facility will establish and clearly identify the approved design location for the appliance so that the appliance can be returned to the appropriate location following movement. 2. 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 deficiencies involving the kitchen cooking equipment and fire suppression system. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur A visual marker/identification point will be established to clearly identify the approved location of the kitchen appliance. The maintenance director was educated regarding the importance of returning the appliance to the designated location after movement and ensuring the cooking equipment remains properly positioned in relation to the fire suppression system. Dietary staff were educated on notifying Maintenance if the appliance is moved or if the designated location/markings is no longer visible. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The Maintenance Director or designee will audit the kitchen cooking equipment weekly for four weeks, then monthly for two months to verify that the appliance remains in the approved design location and that the location marker remains visible and intact. Any variance will be corrected immediately and reported to the Administrator.		09/30/2026

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K0511 SS = E Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure gas appliances per NFPA 101 (2012 edition), Life Safety Code, section 9.1.1, and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.6.1.2. and 10.12.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/24/2026 at 10:44 AM, it was revealed by observation that the gas appliance in the kitchen was on casters and not secured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0511	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice The kitchen gas appliance was immediately reviewed following identification of the deficient condition. The facility secured the gas appliance in accordance with the Life Safety Code and NFPA requirements. 2. 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 an unsecured gas appliance. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur The kitchen gas appliance was secured to prevent unintended movement. The maintenance director was educated regarding securing gas appliances and the importance of verifying that gas equipment remains safely positioned. Gas appliances will be included in routine Life Safety inspections and preventive maintenance rounds. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The Maintenance Director or designee will audit gas appliances weekly for four weeks, then monthly for two months to verify that appliances remain properly secured and safely positioned. Any identified deficiency will be		09/30/2026

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K0511 SS = E Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on document review, observation, and staff interview, the facility failed to enforce smoking policies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.4. This deficient finding could have a patterned impact on the occupants within the facility. Findings include: On 08/24/2026 at 10:35 AM, it was revealed by observation that there were cigarettes discarded in the landscaping and not the approved ashtray. An interview with the Maintenance Director verified			K0511	Continued from page 6 corrected immediately and reported to the Administrator.		09/30/2026
K0741 SS = E Bldg. 01				K0741	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice The smoking patio area was immediately reviewed following identification of improperly discarded cigarettes and accumulated leaves. The affected area was cleaned and the discarded cigarette butts were removed. The facility educated smokers regarding the requirement that cigarette butts be disposed of only in the designated receptacles and will continue coordination with the Fire Marshal regarding an in-service on fire code requirements and smoking safety. 2. 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 deficiency due to fire hazards. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur The facility reviewed expectations related to smoking safety and proper disposal of cigarette butts. The smoking area will be routinely inspected for cigarette butts, combustible debris, and other fire hazards. Staff will address identified hazards immediately.		09/30/2026

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K0741 SS = E Bldg. 01	Continued from page 7 this deficient finding at the time of discovery.			K0741	Continued from page 7 The facility to work with the Fire Marshal to coordinate additional education for residents and staff regarding fire code and smoking safety expectations. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The Maintenance Director or designee will inspect the designated smoking area daily for four weeks, then three times weekly for four weeks, and weekly for two months to ensure cigarette butts are disposed of in approved receptacles and combustible debris does not accumulate in the area. The Administrator or designee will review smoking-area inspection results and resident education completion weekly during the monitoring period. Any identified concern will be corrected immediately.		09/30/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by:			K0920	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice The extension cord being used for the courtyard pellet smoker was immediately removed. The medical nebulizer identified as being plugged into a power strip was removed from the power strip and corrected. Staff education will be completed regarding appropriate use of electrical equipment, power strips, and extension cords. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/24/2026	
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE , MANKATO, Minnesota, 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
K0920 SS = E Bldg. 01	Continued from page 8 Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 08/24/2026 at 10:30 AM, it was revealed by observation that the grill in the courtyard was plugged in with an extension cord. 2. On 08/24/2026 at 10:37 AM, it was revealed by observation that a medical device was plugged into a power strip in room 504. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0920	Continued from page 8 All residents have the potential to be affected by improper use of electrical equipment, power strips, or extension cords. The Maintenance Director conducted a facility-wide review of resident rooms and common areas to identify inappropriate use of extension cords, power strips, or other electrical adaptive devices. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur Nursing and maintenance staff were educated regarding appropriate use of power strips, extension cords, and electrical equipment, including equipment located in resident care areas. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The Maintenance Director or designee will complete facility-wide electrical safety audits weekly for four weeks, then monthly for two months. Audits will include resident rooms, common areas, and other applicable locations to verify that extension cords and power strips are being used appropriately. Any identified concern will be corrected immediately. Audit findings will be reviewed with the Administrator and reported through QAPI as appropriate.		09/30/2026