DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2022

CMS Certification Number (CCN): 245507

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 31, 2022 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any 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

DEPARTMENT OF HEALTH

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April 12, 2022

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

RE: CCN: 245507
Cycle Start Date: February 18, 2022

Dear Administrator:

On March 8, 2022, we notified you a remedy was imposed. On March 31, 2022 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 31, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 23, 2022 be discontinued as of March 31, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 8, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 23, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Electronically delivered

April 12, 2022

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

Re: Reinspection Results
Event ID: 8UD512

Dear Administrator:

On March 31, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Electronically delivered
March 8, 2022

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

RE: CCN: 245507
Cycle Start Date: February 18, 2022

Dear Administrator:

On February 18, 2022, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 23, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 23, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 23, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Hillcrest Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 23, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 18, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at

https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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 02/18/2022

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 2/14/22, through 2/18/22, 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 2/14/22, through 2/18/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED H5507070C (MN80943), however NO deficiencies were cited due to actions implemented by the facility prior to survey: 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	F 000		

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

Electronically Signed | 03/18/2022

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 000	Continued From page 1 regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		3/18/22

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F 656	Continued From page 2 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R26) reviewed for smoking,1 of 2 residents (R4) reviewed for transmission based precautions. Findings include: R26's admission record printed 2/17/22, indicated R26 was admitted 9/19, diagnoses included nicotine dependence, diabetes, malignant neoplasm of mandible (jaw cancer), and squamous cell carcinoma (cancer) of skin of other parts of face. R26's quarterly Minimum Data Set (MDS) assessment dated 1/26/22, indicated R26 had intact cognition, no behavior symptoms, required two-person physical assist for activities of daily living, and mobility device of a wheelchair. On 2/14/22, the care plan dated 1/27/22, was reviewed and did not identify R26 smoked or any smoking interventions. The care plan was then updated on 2/14/22, interventions were added to the care plan and included R26 currently smoked, resident will smoke safely, educate on potential dangers of oxygen and cigarette smoking, and independent with smoking per evaluation. R26's smoking evaluation dated 10/8/21, and	F 656	Plan of Correction□656 Development of Care Plans 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 taken for those affected by the alleged deficient practice: R26□s care plan has been updated to reflect that he is able to smoke independently w/o an assistive devise. R4 is no longer on transmission based precautions and the care plan has been updated appropriately. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has updated all smoking and transmission based precaution care plans. The facility has re-educated the nurse	

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F 656	Continued From page 3 2/14/22, indicated R26 was deemed independent to smoke. On 2/14/22, at 5:45 p.m. R26 was outside in wheelchair, within one foot of facility door with cigarette lit and in his mouth. R26's black jacket was observed with ashes on the bottom of his jacket near his waist. R26 when asked, confirmed ashes dropped on the jacket while smoking. On 2/14/22, at 6:10 p.m. R26's jacket had one eraser size hole on the bottom of the jacket and R26 confirmed the hole was from a cigarette burn hole prior to admitted to the facility. R26 stated he had no burn holes in his jacket or clothing since he had been at the facility. R26 stated sometimes the ashes fell on his clothing, but he had never burned himself or burned his clothes and was able to flick the ashes off his clothing. On 2/15/22, at 9:30 a.m. the resident went outside to smoke independently. R26 independently lit the cigarette to smoke. The resident was observed smoking independently without any ashes dropping on his clothing. The resident flicked his ashes in the smoking container and when finished threw the remains of his cigarette into the container. On 2/15/22, at 2:06 p.m. licensed practice nurse (LPN)-C stated on the evening of 2/14/22, she evaluated R26's smoking and observed resident safely get in and out of the building, light cigarette safely, ashed cigarette appropriately, extinguished and placed cigarette in the receptacle. LPN-C stated R26 showed her the hole jacket and stated the hole happened a while ago. LPN-C indicated she did not witness concerns and did not implement any new	F 656	managers on the care plan process. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 656	Continued From page 4	F 656		

interventions or restrictions as R26 was evaluated with no concerns while he smoked. LPN stated R26's care plan was expected to identify smoking and confirmed the care plan had not included smoking prior to last night [2/14/22], and further indicated in October 2021, R26 restarted smoking.

On 2/15/22, at 2:21 p.m. interview with administrator stated on the evening of 2/14/22, R26 smoking evaluation occurred and R26 was deemed to smoke independently. The administrator stated he expected resident care plans to be thorough, and confirmed R26's care plan was not comprehensive without smoking included.

On 2/15/22, at 3:48 p.m. R26 was seated in wheelchair outside smoking no ashes observed on resident.

On 2/16/22, at 2:18 p.m. interview with DON stated she expected that smoking resident's care plans would identify the resident smoked and smoking interventions included in the care plan.

Facility policy titled Resident Smoking Policy dated 11/18, indicated:
It is the intent of this policy to outline the procedure for safe resident smoking including evaluation of residents to determine those who are capable of smoking independently, and to provide a designated smoking area for those residents who choose to smoke.
If a resident is identified as a current smoker the protocol below under smoking facility should be utilized.
b. All residents who smoke will be evaluated for the need of adaptive equipment.

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F 656	Continued From page 5 4. Residents who choose to smoke will be evaluated upon admission, significant change in condition/cognition, or exhibits inability to follow safe smoking practices or quarterly. 6. Residents requiring supervision will receive assistance with smoking, in accordance with facility and resident specific practices as identified on the individual resident care plans. 10. The facility must document in the care plan and/or progress notes other attempted interventions to manage and accommodate smoking needs before revoking smoking privileges. R4 R4's facesheet printed on 2/17/22, indicated diagnoses including enterocolitis (inflammation of digestive tract) due to recurrent clostridium difficile (c-diff; a bacteria in the bowel which causes diarrhea and fever and which can be spread by touching fecal matter or a contaminated surface). R4's quarterly Minimum Data Set (MDS) assessment dated 1/26/22, indicated R4 was cognitively intact, had adequate hearing and vision, clear speech, was understood and able to understand. R4 required assistance from staff for transferring in and out of bed and moving about in a wheelchair. R4 was occasionally incontinent of bladder and frequently incontinent of bowel. During an interview and observation on 2/14/22, at 2:09 p.m., contact precaution signs were noted on R4's door with instructions to wear gown and gloves when entering the room. R4 stated he had three different bouts of c-diff over the past year. "I have a ... [foul language] of a time washing my hands. They give me a wet wash cloth in the morning, but that's all." R4 added, he didn't wash	F 656		

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F 656	Continued From page 6	F 656		

his hands before meals and staff didn't offer to help him wash his hands.

R4's care plan printed on 2/17/22, failed to identify c-diff as a focus area. As a result, the care plan lacked interventions/tasks related to providing comprehensive care for management of c-diff and measures to take to prevent the spread of c-diff.

During an interview on 2/17/22, at 12:55 p.m., licensed practical nurse (LPN)-A stated she was responsible for updating R4's care plan, and acknowledged after looking through R4's electronic medical record, that c-diff was not a focus area on R4's care plan and hence there were no interventions related to the disease or to transmission based precautions (TBP's). LPN-A confirmed it would be expected for c-diff to be included on a care plan for a resident who had a diagnosis of c-diff, and acknowledged the importance of staff knowing measures to prevent the spread of c-diff to other residents. When asked how she determined what goes on a residents care plan, LPN-A stated she had a list she referred to, and stated she didn't know how she overlooked this on R4's care plan.

During an interview on 2/18/22, at 7:31 a.m., regional nurse consultant (RNC)-C stated she would expect c-diff to be a focus area on a care plan in order to ensure a resident received appropriate care related to c-diff, and to ensure TBP's were followed in order to prevent the spread of c-diff to other residents. RNC-C was unaware R4's care plan did not include c-diff and ensured it would be added.

Facility policy titled Clostridium Difficile, dated

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F 656	Continued From page 7 October 2018, indicated measures would be taken to prevent the occurrence of c-diff infections among residents. Precautions were taken while caring for residents with c-diff to prevent transmission to other residents. The primary reservoirs for c-diff were infected people and surfaces and described the steps for prevention and intervention: increase awareness of symptoms and risk factors, frequent hand washing with soap and water, wearing gloves when handling feces or contaminated items, and disinfecting items with bleach. Furthermore, the policy indicated when caring for residents with c-diff, staff were to maintain vigilant hand hygiene and washing hands with soap and water were superior to alcohol based hand sanitizer. Residents with diarrhea were to be monitored for signs and symptoms of dehydration. Facility policy titled Care Planning, dated 1/6/22, indicated: The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F 656		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced	F 678		3/18/22

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F 678	Continued From page 8 by: Based on interview and document review, the facility failed to update the code status for 1 of 1 resident (R18) reviewed for advanced directives. In addition, the facility failed to accurately document resident's code status throughout the medical record. Findings include: R18's quarterly Minimum Data Set (MDS) assessment dated 11/30/21, identified R18 had intact cognition. R18's face sheet, dated 8/23/21 and updated on 9/1/21, identified diagnoses of cerebral infarction (lack of oxygen to brain causing brain damage), aphasia (loss of ability to understand or express speech), diabetes mellitus- type 2, hemiplegia (paralysis of one side of the body), and malignant neoplasm of prostate (prostate cancer). R18's face sheet, dated 8/23/21, identified advance directive as cardiopulmonary resuscitation (CPR). R18's hospice admission consent form identified on 2/1/22, R18 had transitioned to hospice care. R18's Provider Orders for Life-Sustaining Treatment (POLST), dated 8/23/21, identified "Attempt Resuscitation/CPR (Full Treatment)." The POLST, dated 2/2/22, updated and signed by R18's spouse/ health care agent, and hospice physician; indicated code status changed to "Do not attempt resuscitation/DNR (Allow Natural Death)." R18's care plan, dated 8/24/21, identified code status as CPR and for staff to follow POLST guidelines.	F 678	Plan of Correction□678 CPR 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 taken for those affected by the alleged deficient practice: R18□s POLST status has been updated. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has completed a full facility audit, and all POLST orders are current and correct. The facility has re-educated the nurse managers that POLST status must be reviewed upon significant changes. The facility has started reviewing all POLST Changes daily during IDT meeting and insure updated orders in PCC and accurate care plans. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct	

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F 678	Continued From page 9 R18's order summary report and medication administration record (MAR) reviewed on 2/14/22, identified R18's advance directive as CPR. During an interview on 2/14/22, at 7:20 p.m. registered nurse (RN)-A indicated to her knowledge R18 was a full code. RN-A checked R18's current POLST status, dated 8/23/21, which indicated full code. Surveyor reviewed with RN-A hospice admission consent form signed by R18's health care agent and spouse, dated 2/1/22, indicating POLST completed and code status changed to DNR. RN-A indicated R18's spouse was having a difficult time changing status to DNR, but would contact hospice to confirm the new change. During an interview with RN-A on 2/14/22, at 7:35 p.m. RN-A indicated she had confirmed with hospice agency R18 had changed code status from CPR to DNR. RN-A indicated hospice was going to fax the current POLST tomorrow morning on 2/15/22. During an interview on 2/15/22, at 1:13 p.m. social services (SS)-A indicated the facility process for when a resident goes onto hospice care, includes updating the POLST form when physician orders are received. SS-A indicated being unsure of where the breakdown in communication occurred with hospice orders, unclear if they were still waiting on physician signature at that point, as nurse manager on unit handles. Social services-A indicated being responsible for handling admission POLST only. During an interview on 2/15/22, at 1:18 p.m. licensed practical nurse (LPN)-A, who is also the	F 678	daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 678	Continued From page 10	F 678		

unit manager where R18 resided, indicated being familiar with R18 going onto hospice recently. LPN-A indicated when looking for code status, would refer to medication administration record (MAR), treatment administration record (TAR), or face sheet/admission record through the electronic medical record (EMR) system. LPN-A verified R18's current code status as CPR per EMR, indicated if R18 was found unresponsive, would've initiated CPR. LPN-A indicated relying on hospice to update code status.

During an interview on 2/15/22, at 1:35 p.m. director of nursing (DON), indicated the social worker completes advance directives at time of admission, the DON and nurse unit manager then reviews. The DON indicated code status is reviewed by nurse manager on unit quarterly and any changes needing to be updated is completed by that nurse. The DON indicated it is her expectation when updating code status; changes are reflected on POLST form, admission record, MAR/TAR, and care plan. The DON admitted the error of code status not being updated from CPR to DNR for R18, indicated facility staff were unaware of new hospice orders written and signed by physician on 2/2/22, but will be fixed immediately. The DON indicated they have spoken to hospice staff regarding incident; going forward hospice nurse to report directly to facility nurse on unit after hospice visit, then any new progress notes/orders written at visit are to be given directly to facility nurse instead of placing in hospice binder. The DON indicated it is her expectation for facility nurse to place any new orders/care plan changes in EMR, nurse unit manager then reviews for finalization.

Facility policy titled Cardiopulmonary

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F 678	Continued From page 11 Resuscitation, revised 11/19, included: A POLST form will be completed upon admission by the nurse manager or designee and (REVIEWED) upon readmission, quarterly, and as needed (such as when a resident is transferred from one care setting or level of care to another; when there is a substantial change in the resident ' s health status; when the resident ' s treatment preferences change; or when a primary medical care provider changes). A POLST form is a medical order, which means it must be signed by a medical provider to be valid. If the resident is admitted without a valid code status order or the admitting orders are different than the resident preferences, the facility must notify the provider immediately to get an accurate, valid code status order.	F 678		
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 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 comprehensively assess and monitor the progress of finger lesions for 1 of 1 resident (R28) with non-pressure related skin concerns. Findings include:	F 684	Plan of Correction□684 Quality of care 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.	3/18/22

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F 684	Continued From page 12 R28 was admitted to the facility on 7/31/18, with diagnoses (identified on the diagnosis report sheet) dated 1/5/22, included; actinic keratosis (rough scaly skin caused by the sun) congestive heart failure (CHF) (a chronic condition in which the heart does not pump blood as well as it should), fibromyalgia (widespread muscle pain and tenderness) osteoarthritis (when bone protective tissue wears down), spinal stenosis (narrowing of the spinal canal), history of pressure ulcer (PU) on coccyx and buttocks, dehydration and joint pain. Observation and interview on 2/14/22 1:40 p.m. R28 was in her room sitting in her wheelchair. R28 noted to have 3 bandaids on her thumb, 2nd and 3rd fingers of her left hand. The bandaids were partially on the lesions. The lesions looked crusty and cracked around the edges and whitish colored in the center. The center noted to be moist. R28 stated that she has had sores on her fingers for several weeks and that they were not getting any better. R28 stated that they caused her discomfort because she does utilize her wheelchair independently. R28 did not know what caused the lesions. R28's quarterly minimum data set (MDS) assessment dated 12/15/21, identified R28 as having a baseline interview for mental status (BIMS) of "14" (cognitively intact). R28 required extensive assistance with activities of daily living (ADL's) that included mobility. R28 utilizes a wheelchair. The MDS identified R28 as being at risk for PU's and identified one stage 2 PU (partial thickness skin loss of the dermis). Interventions; pressure reducing device on chair and bed, turning and repositioning program, PU	F 684	How corrective action will be taken for those affected by the alleged deficient practice: ¿R28 has wound care orders for the identified figner lesions, and will complete BID and PRN. R28 has been added to routine wound provider rounds for assessment and monitoring. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk related to the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has completed a facility wide audit of resident hands with no additional findings. The facility has educated nursing staff on reporting skin conditions to the provider and getting appropriate interventions in place. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 684	Continued From page 13 care and nutritional intervention. The MDS did not include any other skin conditions. Review of the care plan dated 2/16/22, identified R28 as having a risk alteration in skin integrity related to history of venous statis ulcer (open sores on the skin that occur when the valves in the veins don ' t work properly and there is ongoing high pressure in the veins)., skin keratosis, cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) and open area to right buttock (resolved on 3/17/21). Interventions listed; do not use perfume soaps, wheelchair cushion on wheelchair, weekly pressure would assessments, keep skin clean and dry, encourage mobility, inspect skin daily and report concerns to charge nurse, weekly skin assessments by licensed staff and treatment cream interventions as needed (PRN). The care plan indicated R28 has alteration in mobility related to osteoarthritis, left knee pain, CHF and fibromyalgia. Interventions listed; independent with bed mobility, monitor skin integrity, routine preventive skin cares with lotion and powder, ultrafoam pressure redistribution mattress to bed and wheelchair, encourage adequate fluids and monitor skin integrity. -The comprehensive care plan did not include R28's non-pressure related skin lesions on the tips of the fingers of the left hand. Review of the current physicians orders dated 2/16/22, included an order to soak the resdient's right 2nd finger in warm water for 3-6 minutes and apply a generous amount of Vaseline and cover finger with a dressing to keep moisture in fingertip twice a day (BID) until resolved. There were no orders for the treatment to the thumb and 3rd finger lesions.	F 684		

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F 684	Continued From page 14 Review of the progress notes and weekly wound assessments from 1/5/22 (since onset of the finger lesion identified on the physicians orders) to 2/16/22, included 1 entry on 1/11/22, related to R28's finger lesion. The note indicated R28 left index finger was noted to be dry and scaly. The nurse practitioner (NP) will evaluate today. The progress notes did not include any further documentation related to the description of the finger lesion nor did it include when R28 obtained the other 2 lesions noted on her thumb and 3rd finger. Review of a physicians visit progress note dated 1/5/22, indicated R28 was seen for wound care evaluation and treatment of re-occurring ulcers to buttocks. The note indicated R28's had a right 2nd finger fissure. Treatment to soak finger in warm water for 3-5 minutes and apply a generous amount of Vaseline. Cover with a gauze dressing to keep moisture on the lesions. Implement treatment BID until resolved. There were no other progress notes in the medical record indicating the progress of the finger lesions, nor did it address the additional lesions on the thumb and 3rd finger. Observation and interview on 2/16/22 1:45 p.m. R28 was sitting in the hallway next to her room. R28 noted to have 3 bandaids on her thumb, 2nd and 3rd fingers of her left hand. The bandaids were only partially on the lesions and exposing the wounds. The lesions continued to look crusty and cracked around the edges and whitish colored in the center. The center noted to be moist. R28 stated she continued to have soreness in her affected fingers and did not feel like they were getting any better.	F 684		

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F 684	Continued From page 15 Interview on 2/16/22, at 10:30 a.m. registered nurse (RN)-D stated R28 has had the skin lesions on all 3 fingers of the left hand (identified above) for several weeks. RN-D indicated the lesions should have been updated to include in the plan of care. RN-D indicated she did not think the lesions were improving. Interview on 2/16/22, at 3:00 p.m. the facility nurse consultant (NC)-A and director of nursing (DON) confirmed R28's plan of care should have been updated to include R28's non-pressure skin lesions on her fingers. NC-A stated the facility nursing staff had been trained on how to manage non-pressure related skin concerns as well as updating the care plan when they are changes in a residents status. Interview on 2/16/22, at 3:22 p.m. nurse manager (NM)-D stated she had failed to comprehensively assess R28's skin lesions of the fingers and should have. NM-D stated she was unsure exactly when R28 obtained all 3 of the finger lesions. NM-D indicated the R28 has had dry lesions on her fingers for a few months that would wax and wane. that. MN-D confirmed staff had not been documenting the progress of the finger lesions and unsure if they were improving or not. MD-A added the facility NP reviews skin concerns every 2 weeks, but was unable to find documentation related to the lesions other than on 1/5/22. Review of the facility policy Skin Assessment and Wound Management dated 7/2018, included upon a significant change in a residents skin such as a development of a non-pressure related skin impairment the following actions will be taken;	F 684		

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F 684	Continued From page 16 notify the provider and resident representative, complete education with the resident/resident representative including risk/benefits, update care plan, update care lists. Document skin condition weekly until healed, update the provider as needed, review skin concerns with the interdisciplinary team (IDT) at least monthly and update care plan as needed (PRN).	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to prevent worsening and prevent additional pressure ulcers (PU)'s from developing for 1 of 1 resident (R28) who had two unstageable PU's (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) and one stage 2 PU (partial thickness skin loss of the dermis) This failure resulted in actual harm when	F 686	Plan of Correction□686 Treatment/Svcs to prevent/Heal Pressure ulcers 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 taken for those affected by the alleged deficient practice:	3/18/22

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F 686	Continued From page 17 R28's pressure ulcers worsened and additional PU's were acquired. Findings include: R28 was admitted to the facility on 7/31/18, with diagnoses (identified on the diagnosis report sheet) dated 1/5/22, including; congestive heart failure (CHF) (a chronic condition in which the heart does not pump blood as well as it should), fibromyalgia (widespread muscle pain and tenderness) osteoarthritis (when bone protective tissue wears down), spinal stenosis (narrowing of the spinal canal), history of PU on coccyx and buttocks, dehydration, diarrhea, and joint pain. Observation and interview on 2/14/22, at 1:38 p.m. R28 reported to the surveyor she had a "sore" bottom. R28 was sitting in her wheelchair in her room. R28 stated she had a PU on her buttocks that was not healing and she was unsure why. R28 thought she had the sore for a month but was unsure. R28 indicated she she did not recall being repositioned every 2 hours. R28's quarterly minimum data set (MDS) assessment dated 12/15/21, identified R28 as having a baseline interview for mental status (BIMS) of "14" (cognitively intact). R28 required extensive assistance with activities of daily living (ADL's) that included mobility. R28 required extensive assistance with toileting and repositioning. The MDS identified R28 as being at risk for PU's and identified one stage 2 PU. Interventions; pressure reducing device on chair and bed, turning and repositioning program, PU care and nutritional intervention. The MDS indicated R28 did not exhibit any behaviors. R28 utilized a wheelchair for mobility.	F 686	¿R28 has been reassessed for her alteration in skin care plan. R28 continues to refuse repositioning. Reviewed risk and benefits of this choice with the resident. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk related to the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has completed an audit of all resident□s interventions with skin breakdown to insure that they are correct. All residents have appropriate interventions in place with updated plans of care. The facility has re-educated the nursing staff on the importance of turning and repositioning residents Q2 hours. The facility has provided education to all nurses on the facility wound process and implemented the WOund process checklist for areas of significant alteration in skin integrity. initiated a weekly wounds meeting until 100 percent compliant with pressure ulcer prevention interventions. The meeting will go to weekly X 4 weeks then monthly for surveillance. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits as noted above in the wound management	

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F 686	Continued From page 18 Review of the Braden scale dated 12/15/21, indicated R28's risk factor was mild for skin breakdown. The assessment indicated R28 continues to have an open area on the right buttock as well as a new area that is dry near the open area, that looks like it may open. Triad hydrophilic treatment dressing applied as ordered. Encourage the resident to avoid sitting no longer than 1 hour in the wheelchair without repositioning. Repositioning at least every 2 hours in bed/chair to prevent skin breakdown. Limit chair sitting to 2 hours. Avoid the resident falling asleep on the toilet. Wheelchair cushion on chair from pressure applying, staff to monitor skin daily with cares and weekly with skin inspection. Review of the Weekly Pressure Wound Evaluations; -10/20/21- right buttock measures 0.3 centimeter (cm) in length by 0.3 cm. width. The center of the wound is slightly orange in color and surrounded by whitish skin. Unstageable. -12/1/21-right buttock measures 0.1 cm length by 0.1 cm width. The wound bed is dry with no drainage. Unstageable. -12/15/21-right buttock measures 1.3 cm length by 1.5 cm width with 100% granulation tissue(new connective tissue for healing of wounds). Unstageable. -12/29/21-right buttock measures 1.5 cm length by 1.3 cm width. The wound bed had a scant amount of serous (thin and clear) drainage. Unstageable. -2/2/22-right buttock (distal) measures 0.5 cm length by 0.5 cm width. 100% granulation tissue. Pain with treatment. Unstageable (newly acquired PU on 12/29/22 and measured 0.5 cm length by 0.6 cm width)	F 686	meeting. Completion date: 3/18/2022	

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F 686	Continued From page 19 right buttock (proximal) measures 1.7 cm length by 1.2 cm width. 100% slough slough (necrotic/dead) tissue. Pain with treatment. Unstageable. left buttock measures 1.2 cm length by 0.5 cm width. 100% slough tissue. Pain with treatment. Unstageable. (newly acquired on 1/2/22 with measurements of 0.7 cm length by 1.0 cm in width) 2/9/22-right buttock (proximal) measures 1.0 cm length by 1.4 cm width. 100% slough tissue. Unstageable right buttock (distal) 0.8 cm length by 0.6 cm width. 100% slough tissue. Unstageable. left buttock measures 1.8 cm length by 0.9 cm width. 100% slough tissue. Unstageable. The weekly Pressure Wound Evaluation from 10/20/21 to 2/9/22, indicated R28 obtained a new unstageable PU to the right distal buttocks and a newly unstageable PU to the left buttock during this time. The right buttock (proximal) PU went from granulation tissue to slough tissue and increased in size from 0.3 centimeter (cm) length by 0.3 cm. width to 1.0 cm length by 1.4 cm width. The right buttock (distal) PU increase in size from 0.5 cm length by 0.6 cm width to 0.8 cm length by 0.6 cm width. The left buttock increased in size from 0.7 cm length by 1.0 cm in width to 1.8 cm length and no change in width During review of the weekly wound assessments, it was noted the above PU's were not thoroughly being completed. Review of the current physicians orders dated 2/16/22, included an order to encourage R28 to avoid sitting for longer than 1 hour in the wheelchair without repositioning every shift (order date 2/9/22). The physicians orders also included	F 686		

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F 686	Continued From page 20 an order to reposition R28 at least every 2 hours in bed/chair to prevent pressure to bottom. Limit chair sitting to 2 hours. Review of the care plan dated 2/16/22, identified R28 as having at risk alteration in skin integrity related to history of venous statis ulcer, skin keratosis, cellulitis and open area to right buttock (resolved on 3/17/21). Interventions listed; do not use perfume soaps, wheelchair cushion on wheelchair, weekly pressure would assessments, keep skin clean and dry, encourage mobility, inspect skin daily and report concerns to charge nurse, weekly skin assessments by licensed staff and treatment cream interventions as needed (PRN). The care plan indicated R28 has alteration in mobility related to osteoarthritis, left knee pain, CHF and fibromyalgia. Interventions listed; independent with bed mobility, monitor skin integrity, routine preventive skin cares with lotion and powder, ultrafoam pressure redistribution mattress to bed and wheelchair. The care plan indicated R28 is independent with toileting and transfers and continent of bowel and bladder. R28 has a history of sitting on the toilet for hours. Staff to remind R28 every 15 minutes to finish. Interventions listed; resident was educated to call for assist when transferring to toilet, encourage good peri cares, encourage adequate fluids and monitor skin integrity. -The comprehensive care plan did not include R28's PU's on the buttocks nor the repositioning interventions per physicians order Review of the nursing assistant (NA) care sheet dated 2/9/22, indicated R28 is assisted to bed and with all transfers. Offer toileting and repositioning every 2-3 hours PRN and peri-cares PRN. Offer R28 to sit in the recliner at night, if	F 686		

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F 686	Continued From page 21	F 686		

refuses to sleep in bed. When finding R28 in the bathroom stay with her until finished. Check R28 for safety (related to fall risk) every 1 hour to make sure the resident is sleeping during the hours of 10:00 p.m. to 6:00 a.m.
-The NA care sheet did not reflect the current physicians orders for repositioning.

Review of the NA hourly safety checks from 1/1/22 to 2/15/22, (10:00 p.m. to 6:00 a.m.) for R28, did not include repositioning. The checks only included the whereabouts of where R28 was during this time.

Continuous observations on 2/15/22 and 2/16/22, from 8:00 a.m. to 10:30 a.m. (2 1/2 hrs) and from 1:00 p.m. to 3:30 p.m. (2 1/2 hrs). R28 was not offered repositioning or off-loading. During this time, staff were observed to walk by the residents room.

Observation on 2/16/22, at 10:30 a.m. R28's PU treatment was done by registered nurse (RN)-D. R28's wound dressings were removed with saline. There was a scant amount of brownish drainage on the dressings. R28 was observed to have 2 PU's on the right buttock and 1 PU on the left buttock. When RN-D cleansed the wounds R28 flinched and complained of pain. The PU's were measured by RN-D, at this time.
Measurements:
Right buttock-(proximal) 1.1 cm length by 1.7 cm width by 0.1 cm depth (increase in size from most recent measurements on 2/9/22)
Right buttock (distal) 1.3 cm length by 0.7 cm width by 0.2 cm depth (increase in size from most recent measurements on 2/9/22)
Left buttock- 1.2 cm length by 1.2 cm width by 0.1 cm depth (increased in length and depth from

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F 686	Continued From page 22 most recent measurements on 2/9/22. The skin around all 3 pressure ulcers was slightly reddened. Triad hydrophilic (absorbs wound exudate) wound dressing was applied to all 3 PU's R28 stated she tries to off-load, lay down during the day and stay off of her bottom as much as she can. R28 had a pressure reduction mattress on her bed and a pressure reduction cushion on her chair. Interview during this time with RN-D, stated she usually does not provide wound care for R28 and was unsure if the wounds had improved or not, but did indicate the nurse practitioner provides wound care every 2 weeks. Continued observations on 2/17/22, from 9:00 a.m. to 12:15 p.m. R28 was not repositioned or off-loaded. R28 remained in her room and slouched in her wheelchair. Facility staff were observed to go in and out of her room administering medications, delivering dinner tray, answering call lite and putting clothing away. The staff also walked by her room several times without offering to reposition or off-load. Review of a physicians visit progress note dated 1/5/22, indicated R28 was seen for wound care evaluation and treatment of re-occurring ulcers to buttocks. The note indicated there was a new small area starting to open on the left buttocks, which is new from last visit. R28 expresses frustration that wounds are not healing. R28 is having pain with wound care. R28 is compliant with treatments. The right buttock wound measures 1.2 cm by 1.5 cm by 0.1 cm with a smaller area next to it that measures 0.4 cm by 0.3 cm by 0.1 cm. The wound has increased in size with a scant amount of drainage. 100%	F 686		

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F 686	Continued From page 23 slough and unstageable The left buttocks measures 1.0 cm by 0.6 cm. No drainage. Unstageable The progress note indicated to encourage R28 to avoid sitting for longer than 1 hour in the wheelchair without repositioning and to encourage increased protein at meals and multivitamin. Occupational therapy (OT) for wheelchair positioning and overlay to bed. Review of a physicians visit progress note dated 2/9/22, indicated R28 was seen for wound care evaluation and treatment of re-occurring ulcers to buttocks. The note indicated R28 is reporting there has been no improvement in the wounds on her bottom and continues to have pain when sitting. The progress note indicated R28 continues to have a dressing application over her buttock wounds, but the resident indicates they do not stay on. The right proximal buttocks ulceration measures 1.0 cm by 1.4 cm by 0.1 cm. The wound has increased in size, no odor or drainage. 100% slough and unstageable. Surrounding skin is tender. Right distal buttocks ulceration measures 0.8 cm by 0.6 cm by 0.1 cm. The wound has increased in size. There is no odor and scant drainage. Unstageable and surrounding skin is tender. The left buttocks ulceration measures 1.8 cm by 0.9 cm by 0.1 cm. Wound has increased in size. No odor or drainage. 100% slough and unstageable. Surrounding skin is tender Treatment of medicine gel to wound bed twice a day (BID) and as needed (PRN) until healed. Make sure resident is receiving peri care. Padded toilet seat is recommended and encourage resident to avoid sitting for more than an hour without repositioning.	F 686		

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F 686	Continued From page 24 Interview on 2/16/22, at 11:15 a.m., RN-D indicated R28's PU's were re-occurring and do not seem to get better. RN-D stated R28 should be turned and repositioned every 2 hours, but confirmed she was not aware of any order for repositioning or off-loading the resident every 1 hour. RN-D further indicated R28 requires assistance with repositioning and transferring, but will often attempt to transfer self. Interview on 2/16/22, at 11:30 a.m. NA-D stated R28 will at times refuse to off-load or lay down when offered. NA-D indicated R28 should be repositioned or off-loaded every 2 hours. NA-D stated he was not aware of R28 being off-loaded or repositioned every 1 hour. NA-D further indicated when staff get busy, it is difficult to get residents repositioned timely. Interview on 2/16/22, at 1:30 p.m. trained medication assistant (TMA)-A indicated she follows the NA's care sheet for repositioning and off-loading R28. TMA-A confirmed the NA plan of care directed staff to reposition R28 every 2-3 hours PRN. TMA-A further indicated R28 will independently transfer self, but verified R28 requires assistance. Interview on 2/16/22, at 3:30 p.m. nurse manager (NM)-D indicated R28's care plan should have been updated to reflect the current physician orders for repositioning. NM-D indicated she thought the NA's were repositioning R28 while providing hourly safety checks, but later verified the staff were just visualizing R28's whereabouts. NM-D also confirmed weekly skin assessments were not always complete by the licensed nursing staff. NM-D indicated the NP was monitoring and providing treatment for R28's PU's.	F 686		

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F 686	Continued From page 25 Interview on 2/16/22, at 3:00 p.m. the facility nurse consultant (NC)-A and director of nursing (DON) confirmed R28's plan of care should have been updated to reflect the current physicians orders of repositioning (at least every 2 hours and to encourage sitting for no more than an 1 hour). NC-A stated the facility nursing staff had been trained on how to manage PU's and implement interventions per individualized care plan Review of the facility policy Skin Assessment and Wound Management dated 7/2018, included upon a significant change in a residents skin such as a development of a pressure related skin impairment, the following actions will be taken;; a tissue tolerance observation and evaluation will be completed, to determine skin tolerance and implement interventions to prevent breakdown and to promote healing, update the plan of care, update the NA care sheets and complete education with the resident including risk/benefits. Document refusals in the medical record.	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		3/18/22

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F 755	Continued From page 26 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for routine reconciliation of controlled substances medication for 1 of 1 emergency kit (E-Kit) to prevent potential loss/diversion. Findings include: On 2/16/22, at 2:30 p.m., a tour of the North medication storage room with nurse manager (NM)-D. Located within the medication storage room was a portable refrigerator that contained the facility E-Kit. The E-Kit consisted of a small tackle box that was secured with a pull away colored tab. The tackle box contained 2 vials of injectable lorazepam (an anti-anxiety medication/controlled substance). Review of the documentation count in the Narcotic bound	F 755	Plan of Correction—755 Pharmacy 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 taken for those affected by the alleged deficient practice: ¿The facility has initiated a count between each shift for E-Kit Ativan. How will the facility 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 the same alleged deficient practice.	

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F 755	Continued From page 27 book,did not identify lorazepam had ever been reconciled by facility staff, to identify or account for any missing medication. Interview with NM-D on 5/12/21, at 11:00 a.m. confirmed staff were not periodically reconciling the E-Kit controlled substances. NM-D indicated she did not understand why reconciling of the E-Kit needed to be done, because only licensed staff had access to the medication room. Interview with NM-E on 5/12/21, at 11:00 a.m. confirmed staff were not reconciling the E-Kit controlled substances. Interview on 2/16/22, at 12:00 p.m. with the facility nurse consultant (NC)-A indicated all staff had been trained on the policy for reconciliation of the E-Kit and should be aware of the process. Review of the facility Controlled Drug Count Process (undated) indicates it is the expectation that all controlled substances must be counted every shift, including the cubix and refrigerator E-Kit (contains vials of lorazepam) The E-Kit must remain under double lock plus have a numbered tag on it. A visual check to ensure count is correct must take place each shift, and sign the controlled drug count log acknowledging meds have been counted with cubex, refrigerator and E-kit.	F 755	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nurses and TMAs on the new Emergency Kit process. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor för compliance.	
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.	F 756		3/18/22

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F 756	Continued From page 28 §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 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 acted upon, addressed, and documented in the medical record for 1 of 5	F 756	Plan of Correction□755 Pharmacy Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not	

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F 756	Continued From page 29 residents (R17) reviewed for unnecessary medication use. Findings include: R17's admission Minimum Data Set (MDS) assessment dated 12/1/21, identified R17 had moderate cognitive impairment, mild depression, required extensive assist with bed mobility, transfers, dressing, toilet use, and personal hygiene. Diagnoses included Parkinson's disease (chronic and progressive movement disorder causes stiffness or slowing of movement), diabetes, anxiety disorder, depression, and age-related physical disability. The MDS indicated R17 received scheduled pain medication, non-medication interventions for pain, insulin, antidepressant, and opioids. R17's care plan dated 2/16/22, indicated potential for psychotropic drug ADR's [adverse drug reaction] r/t [related to] daily use of psychotropic medication related to diagnosis of depression with daily Cymbalta (medication used for depression) use, interventions included administer medication as ordered monitoring for ADR's, report suspected ADR's to MD/PA [medical doctor/physician assistant], medications reviewed by MD/PA and pharmacist, be alert to mood and behavioral changes, and monitor and document mood state/behaviors upon occurrence. R17's Medication Review Report printed 2/18/22, indicated an order for buspirone 10 mg tablet for anxiety and sertraline 100 mg related to major depressive disorder. R17's Consultant Pharmacist's Medication	F 756	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 taken for those affected by the alleged deficient practice: ¿The facility has reviewed the pharmacy recommendations from the pharmacy with R17□s provider, and updated the resident's care plan to align with the current provider reccomendations How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nurse managers on reviewing pharmacy recommendations with the provider per facility policy The facility has completed all of the outstanding pharmacy recommendations and updated care plans. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 756	Continued From page 30	F 756		

Regimen Review document dated 12/14/21, identified R17's medication regimen had been reviewed by the consulting pharmacist (CP), and indicated R17 continued on sertraline and buspirone, ensure the following was completed: PCC [point click care] orders for behavior monitoring. The corresponding Consultant Pharmacist's Medication Review dated 1/11/22, and 2/15/22, indicated recommendations were reissued from 12/21, and the CP indicated R17 continued on sertraline and buspirone, and again indicated to ensure the following was completed: PCC [point click care] orders for behavior monitoring.

R17's medical record was reviewed and lacked evidence nursing reviewed and/or acted upon the CP recommendations dated 12/14/21, 1/11/22, or 2/15/22, for behavior monitoring.

On 2/18/22, at 10:49 a.m. an interview via telephone with the CP indicated a monthly medication chart review was completed of all residents residing at the facility. The CP indicated recommendations were sent monthly via email to the director of nursing (DON) and administrator. The CP indicated the recommendations were expected to be addressed within the timeframe outlined on the report or within a month . The CP stated the following month he reviewed the status of the recommendations and verified completion, and recommendations were reissued if not addressed. The CP confirmed R17's last recommendation for behavior monitoring had not been implemented, and indicated daily target behavior monitoring was expected. The CP further stated monthly the residents pending recommendations were discussed with the DON. The CP stated November through December,

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F 756	Continued From page 31	F 756		

pharmacy recommendation completion rate was low at 25%, and indicated 75% was the completion goal rate.

On 2/18/22, at 10:58 a.m. the director of nursing (DON), stated she received a monthly email from the CP with resident's pharmacy recommendations and the DON indicated monthly she distributed the CP pharmacy nursing recommendations to the nurse managers. The DON verified the facility received R17's CP recommendations on 12/14/21, 1/11/22, and 12/15/22, and the recommendations had not been addressed. The DON indicated she expected the nurse managers to have addressed and acted upon the CP monthly recommendations. The DON further indicated she was aware of the 25%, pharmacy completion rate last month and further indicated she expected 100%, of the recommendations acted upon.

On 2/18/22, at 11:00 a.m. the administrator confirmed the nurse managers received the CP recommendations and verified the consultant pharmacist's recommendations had not been addressed.

Facility policy titled Gradual Dose Reductions, dated 12/19, indicated:
1. Behavioral symptoms related to dementia:
The GDR may be considered clinically contraindicated if the:
· Resident ' s target symptoms returned or worsened after the most recent attempt at a GDR within the facility AND
· Physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the

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F 756	Continued From page 32 resident ' s function or increase distressed behavior. A policy and procedure was requested regarding pharmacy recommendations and not received.	F 756		
F 880 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 §483.70(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;	F 880		3/18/22

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F 880	Continued From page 33 (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. §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, interview, and document review the facility failed to follow transmission-based precautions by ensuring closure of room doors for 2 of 3 residents (R14,	F 880	Plan of Correction□F880 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not	

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F 880	Continued From page 34 R50) symptomatic and known to be positive with COVID-19. The facility's failure to ensure implementation of proper precautions to prevent or mitigate the risk of COVID-19 outbreak had the potential to affect all other 63 residents and staff within the facility. Findings include: During entrance conference on 2/14/22 at 12:47 p.m., the administrator identified three residents (R14, R50, R38) confirmed to have COVID-19 and were on droplet/contact precautions, all three residents resided on 500 unit of facility. R14's medical diagnosis listed on admission face sheet, printed on 2/18/22, identified dementia with Lewy body (brain disease causing problems in thinking, movement, behavior, and mood). R14 was diagnosed with positive COVID-19 on 2/7/22, remained asymptomatic throughout isolation period, off precautions on 2/18/22. R50's medical diagnosis listed on admission face sheet, printed on 2/18/22, identified admission from acute care hospital. Further review of R50's care plan, dated 12/29/21, revealed R50 had a history of kidney failure and receives outpatient dialysis 3x/week, congestive heart failure (CHF- a chronic condition in which the heart cannot pump blood effectively), and pneumonia (infection of the lungs). R50 was diagnosed with positive COVID-19 on 2/7/22; became symptomatic with cough, nausea vomiting on 2/9/22-2/14/22. Isolation precautions removed 2/18/22, as R50 no longer experiencing symptoms. During initial observation on 2/14/22 at 2:27 p.m. two of the three residents with confirmed	F 880	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 taken for those affected by the alleged deficient practice: ¿No residents are currently on transmission based precautions. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nursing and dietary staff on Donning/Doffing PPE and having the door closed for Covid + residents. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Directed Plan of Correction 1. Address how corrective action will be accomplished for those residents found to be affected by the deficient practice. a. The facility currently does not have any residents on transmission based precautions. Therefore no additional residents are currently being affected by the deficient practice. 2. Address how the facility will identify	

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F 880	Continued From page 35 COVID-19 virus, (R14 and R50), had their room doors open wide. R14 and R50's room doors had droplet/contact precautions signs posted outside. Multiple observations of room doors being open for R41 and R50 while on droplet/contact precautions was observed during survey. The duration of time room doors were open was unknown, staff not observed to be in and/or coming out of rooms at the following times; R14 2/14/22 at 6:41 p.m. 2/15/22 at 7:19 a.m. 2/15/22 at 2:51 p.m. 2/16/22 at 7:40 a.m. 2/16/22 at 8:42 a.m. 2/16/22 at 11:13 a.m. 2/16/22 at 12:53 p.m. R50 2/14/22 at 6:42 p.m. prior to unknown nurse aide applying personal protective equipment (PPE) and entering room to deliver meal tray 2/15/22 at 2:55 p.m. 02/16/22 at 7:20 a.m. 02/16/22 at 8:42 a.m. During interview on 2/16/22, at 7:20 a.m. registered nurse (RN)-C was asked about residents with COVID-19 and room doors being open. RN-C indicated doors should be kept closed. During interview on 2/16/22, at 7:37 a.m. RN-B indicated residents with COVID-19 and on isolation, should have rooms doors closed. RN-B indicated difficulty with keeping R14's door closed as he was a fall risk and was known to try	F 880	other resident having the potential to be affected by the same practice. a. Re-education of staff as noted above. Root cause analysis□See attachment 1. IP/DON shall complete the following. " Grouping of residents, or cohorting, should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices. " Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents). " Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask. " Provide dedicated equipment for areas, as able. All noted above are currently part of the facility□s policies and procedures. Staff will be re-educated on Covid 19 policy/procedure. The facility will provide education to the residents regarding Transmission based precautions.	

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F 880	Continued From page 36 to open door frequently to come out of room. RN-B indicated she has provided verbal re-education to staff on keeping doors to isolation rooms closed at all times. Facility policy titled Infection Prevention and Control Program, dated 8/17, indicated: Important facets of infection prevention include; identifying possible infections or potential complications of existing infections, instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, implementing appropriate isolation precautions when necessary. Policy did not indicate anything specific related to COVID-19 infection control and prevention.	F 880	Completion date: 3/18/2022 Date Resident Covid Vaccine Current Action Notes Initial Audit for POC is uploaded under docs as Audit 880	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		3/18/22

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F 883	Continued From page 37 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide evidence pneumococcal	F 883	Plan of Correction□F883 Please accept the following as the	

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F 883	Continued From page 38 vaccinations were up to date for 1 of 5 residents (R51) reviewed for vaccinations. Findings include: R51's admission Minimum Data Set (MDS) assessment dated 1/22, indicated an admission date of 1/13/22. The MDS further indicated R51 had intact cognition, was 68 years of age, had medically complex health conditions, and was not assessed for pneumococcal vaccination status. R51's admission MDS assessment, dated 1/20/22, identified diagnoses to include; cancer, anemia (a condition of lack of red blood cells), renal insufficiency (a condition that causes poor function of kidneys), cerebrovascular accident (CVA; a condition that causes damage to the brain/stroke), and respiratory failure (a condition that causes poor function of the lungs). When interviewed on 2/17/22, at approximately 1:45 p.m. the regional nurse consultant (RNC) confirmed R51's medical record did not include evidence of pneumococcal vaccinations had been completed. RNC contacted R51's spouse to further discuss vaccination status. RNC received verbal consent from R51's spouse to administer pneumococcal vaccine upon completion of interview on 2/17/22. Facility policy titled Pneumococcal Vaccine, revised 11/4/19, included: Upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine, and within 30 days of admission, will be offered the vaccine, when	F 883	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 taken for those affected by the alleged deficient practice: ¿R51 has received the pneumococcal vaccine. How will the facility 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 the same alleged deficient practice. The facility completed a facility wide audit of any residents who did not receive the pneumo vaccine. All residents who qualify, and had not received the vaccine have been offered the vaccine. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nurse managers the pneumococcal vaccine policy. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 883	Continued From page 39 indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. Pneumococcal vaccination will be administered to residents and will be documented in the resident's medical record.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19	F 887		3/18/22

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(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 887	Continued From page 40 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure COVID-19 vaccination doses were offered to 3 of 5 residents (R41, R49, R51) reviewed for COVID-19 vaccination status. Findings include:	F 887	Plan of Correction□F887 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.	

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	245507	A. BUILDING _____ B. WING _____	C 02/18/2022

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F 887	Continued From page 41 R41's admission Minimum Data Set (MDS) assessment dated 7/1/21, indicated R41 was admitted to the facility on 7/1/21. Reviewed R41's "Resident Vaccine Administration Consent Form," signed by R41, her representative, and facility nursing staff on 7/2/21, did not address COVID-19 vaccination. Furthermore, R41's medical record lacked documentation R41 and/or her representative were offered the COVID-19 vaccine upon and/or after admission, nor were provided education related to the risk and/or benefits of the vaccine. R41's medical record lacked documentation that COVID-19 vaccine was administered or contraindicated. R49 R49's admission MDS assessment dated 1/12/22, indicated R49 was admitted to the facility on 1/12/22. Reviewed R49's "Resident Vaccine Administration Consent Form," unsigned and undated by R49, his representative, and facility nursing staff; did not address COVID-19 vaccination. Furthermore, R49's medical record lacked documentation R49 and/or his representative were offered the COVID-19 vaccine upon and/or after admission, nor that he and/or his representative were provided education related to the risk and/or benefits of the vaccine. R49's medical record lacked documentation that COVID-19 vaccine was administered or contraindicated. When interviewed on 2/17/22, at approximately 2:28 p.m. the regional nurse consultant (RNC) indicated when residents are admitted to facility, the resident and/or representative are provided	F 887	How corrective action will be taken for those affected by the alleged deficient practice: ¿All residents have been reassessed and re-offered the Covid 19 vaccine if they have not received. It. How will the facility identify other residents having the potential to be affected by the same deficient practice? Any unvaccinated residents are at risk r/t the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nurse managers on offering the Covid 19 vaccine to all new admissions Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 887	Continued From page 42	F 887		

facility "Resident Vaccine Administration Consent Form." RNC indicated it is her expectation that the admission nurse goes through the consent form with resident and/or representative, offering immunizations which included tetanus, diphtheria, and pertussis (Tdap), pneumococcal, influenza, and COVID-19, provide education regarding vaccines, sign and date forms consenting to or declining of vaccinations, and then administer vaccinations consented.

When interviewed on 2/17/22 at approximately 2:28 p.m. RNC indicated being unaware if R41 and R49 and/or their representatives had been offered COVID-19 vaccine during admission and needed to check into this further. RNC indicated later in day after interview, R41 and R49 had not received nor had been offered COVID-19 vaccination. RNC indicated nursing staff will contact R41 and R49's representative for consent/declination of COVID-19 vaccine.

R51
R51's MDS admission assessment dated 1/13/22, indicated R51 admitted to the facility on 1/13/22.

R51's medical record lacked documentation of follow-up for R51's second dose of COVID-19 vaccination. Review of R51's Minnesota immunization information connection (MIIC) form indicated he had received first dose on 1/12/22. Review of facility's "Resident Vaccine Administration Consent Form," unsigned and undated by R51, his representative, and facility nursing staff; did not address follow-up of second dose for COVID-19 vaccination. Furthermore, R51's medical record lacked documentation R51 and/or his representative had any follow-up for

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F 887	Continued From page 43 second dose for COVID-19 vaccine upon and/or after admission nor that he and/or his representative were provided education related to the risk and/or benefits of the vaccine. R51's medical record lacked documentation of COVID-19 vaccine contraindications. When interviewed on 2/17/22, at approximately 2:28 p.m. RNC indicated being unaware if R51 and/or his representative had any follow-up for second dose of COVID-19 vaccine during admission or thereafter and needed to check into further. RNC indicated later on 2/17/22, following interview, R51 had not had any follow-up nor had been offered second dose of COVID-19 vaccination. RNC indicated nursing staff will contact R51's representative for consent/declination of second dose for COVID-19 vaccine. Facility COVID-19 vaccination policy dated 12/28/21, received, however only addressed staff.	F 887		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 8 of 71 rooms (rooms 101, 103, 111, 112, 113, 115, 201, 216) were maintained in good repair and in sanitary conditions, impacting 11 residents (R21, R264, R1, R55, R46, R57, R13, R213, R59, R9, R4). In addition, the facility failed to ensure fans used in resident resident	F 921	Plan of Correction□Home like Environment 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	3/18/22

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F 921	Continued From page 44 rooms (rooms 401 and 417), impacting residents (R3, R32) were kept in a clean and sanitary manner; free of dust and debris. Findings include: During resident screening on 2/14/22, from 12:30 p.m. to 4 p.m., the following observations were made: --Room 216, occupied by R21: The white toilet bowl was heavily stained with a dark gold, rusty color. --Room 101, occupied by R1 and R264: An excessive amount of gray dust and debris resembling thick dryer lint was observed in the return air vent on the floor under the window; three ceiling tiles near the window were stained with a gold-colored splatter pattern; the white toilet bowl was heavily stained with a dark gold, rusty color; and the return air vent in the bathroom ceiling had gray fuzzy material on the slats. --Room 103, occupied by R55: The wall-mount hand sanitizer dispenser was empty. --Room 111, occupied by R46 and R57: The paper towel dispenser in the bathroom was empty. The return air vent in the bathroom ceiling was rusty and had a significant amount of gray fuzzy material on the slats. --Room 112, occupied by R13: The return air vent in the bathroom ceiling was rusty and had a significant amount of gray fuzzy material on the slats. --Room 113, occupied by R59 and R213: The return air vent in the bathroom ceiling had a significant amount of gray fuzzy material on the slats. --Room 115, occupied by R9: The white toilet bowl was heavily stained with a dark gold, rusty	F 921	response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: Housekeeping has deep cleaned all of the effected rooms and done a facility audit and cleaned any dirty fans, ceiling tiles and repainted rusted vents. Maintenance has either replaced or cleaned all of the effected toilets. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Housekeeping has established a new checklist, and received training for cleaning rooms to ensure all rooms are kept appropriately Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits of identified areas for 2 weeks as needed to monitor f¿r compliance, and spot check as part of the QAPI process Completion date: 3/18/2022	

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F 921	Continued From page 45	F 921		

color. The return air vent in the bathroom ceiling was rusty and had a significant amount of gray fuzzy material on the slats.
--In the shower room on the memory care unit, the return air vent in the ceiling was rusty and had a significant amount of gray fuzzy material on the slats. There were five tiles, approximately two inches by two inches, missing from around the drain, causing an irregular surface with sharp edges.
--Room 201, occupied by R4: An excessive amount of gray dust and debris resembling thick dryer lint was observed in the return air vent on the floor under the window.
--Utility room on 200 wing: The wall-mounted soap dispenser at the sink was empty; the return air vent in the ceiling was heavily soiled with gray fuzzy material; the rim around the hopper (a large toilet-type unit for disposal of clinical waste) and the wall behind the hopper was splattered with brown material that had the appearance of fecal matter.

During an interview and observation on 2/14/22, from 1:51 p.m. to 2:22 p.m., R4 in room 201 stated when housekeeping cleaned his floor, they only mopped down the middle of the room, they didn't move furniture or mop under the bed. Dead bugs, mouse droppings, and "helicopter" leaves from trees were observed on R4's window sill and near the small window air conditioning unit. There was also a fine layer of dirt and dust on the window sill. Mouse droppings were observed on the closet floor. In addition, the return air vent in the bathroom ceiling had a significant amount of gray fuzzy material on the slats.

During an observation on 2/16/22, at 8:21 a.m., R3 in room 401 was asleep in a broda chair about

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F 921	Continued From page 46	F 921		

5 feet in front of a small fan that was blowing directly toward him. Observed strands of dust approximately 4 - 5 inches in length blowing out from the fan toward R3; the blades of the fan were heavily soiled with gray fuzzy material.

During a telephone interview on 2/16/22, at 9:06 a.m., family member (FM)-E stated when she visited R4 on 2/13/22, she moved the recliner away from the wall to sit in it and noticed mouse droppings and dirt under it; adding it was obvious the chair had not been pulled out and mopped under for awhile. FE-E stated she had been disappointed in how housekeepers mopped the floor -- just going down the center of the room with a mop and not mopping under furniture or under R4's bed. FM-E stated R4 often dropped things that would land under his bed and no one picked it up.

During an interview and observation on 2/16/22, at 12:50 p.m., with the assistant director of nursing (ADON), together observed the above environmental concerns by going to each room. In addition, in room 103, the wall mount hand sanitizer dispenser was still empty, and in room 111 the paper towel dispenser in the bathroom was still empty, both initially observed on 2/14/22. The ADON asked staff to notify housekeeping to refill them. With permission from R4 in room 201, looked through drawers and closet for evidence of mice. Observed mouse droppings in a drawer, on the window sill and the floor of the closet. Observed a return air vent on the floor below the window with an excessive/heavy amount of gray dust/debris in it. The ADON admitted the mouse droppings and excessive dust posed a health risk to residents and staff, and stated she would have housekeeping thoroughly clean R4's room and

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F 921	Continued From page 47 follow up with maintenance and housekeeping. During an interview and observation on 2/16/22, at 1:36 p.m., together with the administrator and environmental services director (ESD)-A, observed the above environmental concerns by going to each room. ESD-A stated she had started a list on 2/14/22, of stained toilets that needed to be replaced. Went into R4's room (room 201) to look at areas where mouse droppings had been seen; the window sill which had been cleaned, the return air vent on the floor below the window which was heavily soiled with dust and debris, and the mouse droppings on the closet floor. During an interview on 2/16/22, at 1:49 p.m., following the tour of resident rooms, the administrator stated the condition of the resident rooms came as somewhat of a surprise, particularly the condition of the toilets, adding the facility had problems with rusty water. The administrator stated what he observed was not acceptable, and admitted it was not providing residents a sanitary and home-like environment, adding "we will take care of it." During an interview on 2/18/22, at 9:52 a.m., housekeeping supervisor (HS)-C stated he was aware of return air vents in the ceiling in resident bathrooms and the floor air returns vents in some resident rooms, but was not aware if they had ever been cleaned. HS-C stated he had not trained housekeepers to look at them, clean them or tell him about them, but that housekeepers usually mentioned things like that. HS-C stated he showed new housekeepers what to do, then they worked with another housekeeper 4 - 5 times before starting on their own. When	F 921		

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F 921	Continued From page 48	F 921		

informed that a resident stated housekeepers only mopped down the center of the room, HS-C stated he had recently talked to a housekeeper about that, adding he wanted to trust that the housekeepers did a thorough job, but didn't follow them around to make sure. HS-C was shown personal fans in rooms 401 occupied by R3, and room 417 occupied by R32, both which had a heavy amount of fuzzy gray material on them. In room 401, the fan was small, and blowing directly on R3 from about 5 feet away. In room 417, a large fan on top of a dorm size refrigerator was not in operation. HS-C stated he expected housekeepers to notice when fans needed to be cleaned and take them to maintenance to have them cleaned, adding it wasn't good for fans to blow dust on residents. Together looked at the floor vent in room 101, as well as the stained ceiling tile, bathroom vent and rusty toilet bowl; HS-C stated the facility was planning to replace some of the stained toilets, and he would take care of the replacing the ceiling tiles and cleaning the return air vents.

During an interview on 2/18/22, at 1:46 p.m., discussed environmental findings with ESD-A, maintenance assistant (MA)-B, and HS-C. ESD-A stated the facility was old and acknowledged some things needed to replaced such as toilets, adding that the condition of some toilets was embarrassing and not what should be found in a nursing home. HS-C stated staffing housekeepers had been a challenge given they were short staffed, but admitted some of the findings had been going on for a long time (e.g., dust and debris build up in vents) and could not be attributed to a recent shortage of staff. ESD-A admitted they had work to do.

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F 921	Continued From page 49 During an interview on 2/18/22, at 2 p.m., housekeeper (H)-A stated no one had hold her to mop under beds or move and mop under furniture. H-A stated they were short housekeepers and the job was stressful. H-A had a clipboard with resident rooms listed that she checked off when done cleaning a room. The list did not include prompts to ensure specific tasks were done each day, such as replacing paper towels. When asked how she remembered to do everything, H-A admitted there was a lot to remember and did her best. Facility policy titled Cleaning and Disinfecting Residents' rooms, dated August 2013, indicated housekeeping would clean surfaces such as floors and tabletops on a regular basis. Personnel would remain alert for evidence of rodent activity (droppings) and report such findings to the Environmental Services Director. The policy outlined step by step process for cleaning resident rooms. The policy did not specify how to mop the floors, e.g. move furniture and/or to mop under the bed.	F 921		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an effective pest control program to eliminate mice in the building. This failure affected R4, and had the potential to affect all 66 residents who resided in the facility.	F 925	Plan of Correction□Pest free environment 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	3/18/22

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F 925	Continued From page 50 Findings include: R4's diagnoses included diabetes, end stage renal disease (renal failure) requiring dialysis (the process of removing toxins from the body), and transmission based precautions for recurrent clostridium difficile (a bacteria in the bowel which causes diarrhea and fever). R4's quarterly Minimum Data Set (MDS) assessment dated 1/26/22, indicated R4 was cognitively intact, had adequate hearing and vision, clear speech, was understood and able to understand. R4 required assistance from staff for transferring in and out of bed and moving about in a wheelchair. R4 did not walk. During an interview on 2/14/22, at 1:51 p.m., R4 who resided in room 201, reported he had mice in his room, "I hear them in the ceiling and I've seen them on the floor. Heard them in the ceiling yesterday." R4 added that there had been mice droppings on his floor and in his dresser drawers. R4 stated maintenace staff put live traps in his room and had caught five mice over several months. No traps were observed in visible areas of the room. R4 stated his wife had been there on 2/13/22, and cleaned mice droppings out of his dresser drawers. R4 stated his wife brought a nursing assistant (NA) into the room to show her, then housekeeping scoured the entire room and put some kind of peppermint repellent in the room. R4 stated maintenance and housekeeping were aware of mice in his room. R4 didn't know if the facility used a professional exterminator. On 2/14/22, at 2:22 p.m., observed dead bugs, mouse droppings and "helicopter" leaves from	F 925	by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: Guardian pest control reviewed the entire facility for pest hazards with new interventions for effected rooms, but no additional findings. Per guardian's recommendations, the facility has resealed the windows in 201 and 118. Pest repellants are also being utilized. Guardian will continue to round at the facility on a monthly basis, and upon facility need. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Housekeeping staff will be educated on identifying and reporting signs of pests in the facility. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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F 925	Continued From page 51	F 925		

trees on R4's wide and deep window sill. Observed a small air-conditioning unit in the lower left corner of the large window. Silver duct tape placed around the opening of the air conditioner was loose in some spots.

During an interview on 2/16/22, at 8:16 a.m., housekeeper (H)-B admitted to seeing evidence of mice in the facility and in rooms 201 and 401. "I've seen mouse droppings in room 401 and clothing chewed on in room 201." When this occurred, H-B stated she told her boss, housekeeping supervisor (HS)-C, then her and another housekeeper deep-cleaned room 401. H-B could not recall when that was, but stated it was a few months ago.

During an observation on 2/16/22, at 8:21 a.m., no mice droppings were observed in room 401. R3 was asleep in a broda chair about 5 feet in front of a small fan that was blowing directly toward him. Noticed two strands of dust approximately 4 - 5 inches in length blowing out from the fan; the blades of the fan were heavily soiled with gray fuzzy material.

During an interview on 2/16/22, at 8:26 a.m., with nursing assistant (NA)-A and (H)-A, when asked if either had seen evidence of mice in resident rooms, H-A stated "not often." NA-A stated she had not, but had been told some residents had seen mice in their rooms. H-A stated she had seen droppings, "not everywhere, just one or two rooms." When asked which rooms, stated R4's room (201) and someone on the northwest wing, but couldn't recall which room or which resident. H-A stated if she saw droppings, she informed her boss HS-C, and cleaned the room well.

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	245507	A. BUILDING _____ B. WING _____	C 02/18/2022

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 925	Continued From page 52	F 925		

During a telephone interview on 2/16/22, at 9:06 p.m., family member (FM)-E stated she was aware of mice in R4's room, adding she had observed holes in one of his shirts and suspected it was from mice. FM-E stated while visiting on 2/13/22, she cleaned a small chest of drawers and saw mouse droppings in it and also noticed mice had eaten through a bag of Cheetos. FM-E stated she noticed a lot of mouse droppings on 2/13/22, when she pulled R4's recliner away from the wall to sit in it. Furthermore, FM-E stated the recliner had obviously not been pulled out and cleaned under for a while as there were many mice droppings and dirt under it. FM-E stated she told a staff member who then came in and cleaned the floor well. FM-E stated she cleaned R4's dresser drawers of mice droppings and put fabric softener sheets in the drawers and closet to repel mice. FM-E stated she had never seen mice in R4's room, but had seen plenty of droppings, adding there had been a trap behind R4's recliner at one time.

Facility policy titled Pest Control, dated May 2008, was reviewed and indicated the facility would maintain an on-going pest control program to ensure the building would be kept free of rodents.

A service report from Guardian Pest Solutions dated 1/24/22, was received from the administrator and reviewed. The following was documented by the service technician (ST)-F: Performed inspections of door entrances, common space, hallways and there were no activities. I expected [sic] dining room area and kitchen, talk with food service director (FSD)-A, she still has issues with mice in her (kitchen) drawers. I expected [sic] area again here is a big hole in wall behind ice machine (in resident dining

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F 925	Continued From page 53 room), talk with the environmental services director (ESD)-A about sealing that hole in the wall, but she said can't move the ice machine and that she would try to find a way to seal up that hole. I find that the whole [sic] pedometry [sic] the point of entry for mice that are getting in to kitchen drawers. I mentioned this last time I was here. No other activities found. During an interview on 2/16/22, at 10:50 a.m., FSD-A stated they used to have problems with mice, but not anymore. Mice droppings had been found in kitchen drawers in the past. FSD-A stated they speculated mice were coming from the basement via a pipe that comes into the building to the ice machine. FSD-A stated that hole had been sealed and denied further evidence of mice. During kitchen tour, did not observe mouse droppings in drawers, on surfaces, or floors. During an interview on 2/16/22, at 11:57 a.m., HS-C stated he had not heard anything from staff about mice in a while. If staff tell him about mice, he puts a tube trap in the residents room -- mice can go in, but they can't get out. HS-C stated Guardian Pest Control came to the facility once a month; the technician checked in with housekeeping and maintenance when he arrived and informed them of his findings before he left. When asked if he knew where mice where coming in, HS-C stated he did not, adding "numerous places, such an old building." HS-C stated there was a hole behind the ice machine; maintenance would know more about that. Once identified, staff cleaned droppings, disinfected the room and he placed a trap. HS-C stated he also placed packets of peppermint under dressers to repel mice.	F 925		

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F 925	Continued From page 54 On 2/16/22, at 12:50 p.m., with assistant director of nursing (ADON), donned PPE (personal protective equipment) and with permission from R4, looked through drawers and closet for evidence of mice. There were two, identical three drawer dressers against one wall; all 6 drawers were looked through and mice droppings were found in the underwear drawer. Noticed the dryer sheets that FM-E placed in the drawers on 2/13/22. Observed mouse droppings on window sill and the floor of the closet. Observed a return air vent on the floor below the window which had an excessive/heavy amount of gray dust/debris in it. This was pointed out to the ADON. The ADON stated she was aware of mice in the facility, but reports of mice had not been brought to her attention recently. The ADON acknowledged mice and mice droppings could spread germs and could pose a health risk to residents and staff, and stated she would have housekeeping thoroughly clean R4's room and follow up with ESD-A. On 2/16/22, at 1:36 p.m., with the administrator and ESD-A, went into R4's room to look at areas where mouse droppings had been seen; the window sill which had since been cleaned, the air conditioner with lose duct tape, the return air vent on the floor below the window which was heavily soiled with dust and debris, and the mice droppings on the closet floor. R4 informed the administrator and ESD-A that FM-E had spent most of 2/13/22, cleaning drawers of mice droppings and put dryer sheets in them to repel mice. During an interview on 2/16/22, at 1:49 p.m., the administrator acknowledged he had been aware	F 925		

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F 925	Continued From page 55	F 925		

of mice in R4's room, adding "he brings in a lot of outside food, which is a food source for mice." The administrator stated he did not know how mice were getting into R4's room and would have the pest exterminator come back today or tomorrow to address it. The administrator acknowledged mice in a residents room was not acceptable, nor was it a sanitary and home-like environment, adding "we will take care of it."

During a telephone interview on 2/18/22, at 1:30 p.m., ST-F stated he was called to come to the facility on 2/17/22. ST-F stated he believed the main problem with mice was related to the hole in the wall behind the ice machine in the dining room adjacent to the kitchen. ST-F stated he had told maintenance assistant (MA)-B and ESD-A about this in the past. "I told MA-B what he could do; I don't know if it is completely sealed up -- I didn't look at it." While there, ST-F stated he looked in room 118 where there had been reports of mice, adding there was a heat duct that went down to the floor and not sealed up because it would cause the pipe to freeze. ST-F suggested to MA-B he could use wire mesh. ST-F checked an office near the kitchen where there had been reports of mice in the ceiling. ST-F stated he did not go into R4's room.

During an observation on 2/18/22, at 1:43 p.m., observed the area behind the ice machine in the dining room adjacent to the kitchen. The tall, square, floor-model ice machine dispenser was positioned at an angle to the corner of the room, approximately 10 feet from a door leading into the kitchen. Behind the ice machine was an area of pipe-work, with multiple pipes going into the floor and into the wall. Observed steel wool sticking out from hole around pipe-work going into the wall.

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F 925	Continued From page 56 Multiple penetrations were noted going into the floor and wall. During an interview on 2/18/22, at 1:46 p.m., with ESD-A, MA-B and HS-C, ESD-A stated the hole in the wall behind the ice machine in the dining room had been sealed with steel wool around the pipes after the ST-F had been at the facility on 1/24/22, and there had been no more mice noted in kitchen drawers. Not able to say if continued evidence of mice indicated mice were getting into the building by other means. ESD-A stated based on recommendations from ST-F on 2/17/22, for room 118, MA-B went to a hardware store and purchased a floor vent; put steel wool over the pipe, and the vent over steel wool and caulked around it. Regarding R4's room, caulking was placed around the outside of window in his room. ESD-A, MA-B and HS-C acknowledged mice should not be inside the building; it wasn't good for the health of residents and it did not create a home-like environment. ESD-A stated they took mice in the building very seriously; that's why they had an exterminator come monthly. Facility policy titled Pest Control, dated May 2008, indicated the facility would maintain an effective pest control program; that the facility maintained an on-going pest control program to ensure that the building was kept free of insects and rodents. Additionally, maintenance, when appropriate and necessary, assisted in providing pest control services. Facility policy titled Cleaning and Disinfecting Residents' rooms, dated August 2013, indicated personnel would remain alert for evidence of rodent activity (droppings) and report such findings to the Environmental Services Director.	F 925		

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 8, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 8UD511

Dear Administrator:

The above facility was surveyed on February 14, 2022 through February 18, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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, 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

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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
	00031	A. BUILDING: _____ B. WING _____	C 02/18/2022

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2 000	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 2/14/22, through 2/18/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5507070C (MN80943) however 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 surveyors 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R26) reviewed for smoking,1 of 2 residents (R4) reviewed for transmission based precautions. Findings include: R26's admission record printed 2/17/22, indicated R26 was admitted 9/19, diagnoses included nicotine dependence, diabetes, malignant neoplasm of mandible (jaw cancer), and squamous cell carcinoma (cancer) of skin of other parts of face. R26's quarterly Minimum Data Set (MDS) assessment dated 1/26/22, indicated R26 had intact cognition, no behavior symptoms, required	2 565	Plan of Correction□656 Development of Care Plans 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 taken for those affected by the alleged deficient practice: R26□s care plan has been updated to reflect that he is able to smoke independently w/o an assistive devise. R4 is no longer on transmission based precautions and the care plan has been updated appropriately. How will the facility identify other residents	3/18/22

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2 565	Continued From page 3 two-person physical assist for activities of daily living, and mobility device of a wheelchair. On 2/14/22, the care plan dated 1/27/22, was reviewed and did not identify R26 smoked or any smoking interventions. The care plan was then updated on 2/14/22, interventions were added to the care plan and included R26 currently smoked, resident will smoke safely, educate on potential dangers of oxygen and cigarette smoking, and independent with smoking per evaluation. R26's smoking evaluation dated 10/8/21, and 2/14/22, indicated R26 was deemed independent to smoke. On 2/14/22, at 5:45 p.m. R26 was outside in wheelchair, within one foot of facility door with cigarette lit and in his mouth. R26's black jacket was observed with ashes on the bottom of his jacket near his waist. R26 when asked, confirmed ashes dropped on the jacket while smoking. On 2/14/22, at 6:10 p.m. R26's jacket had one eraser size hole on the bottom of the jacket and R26 confirmed the hole was from a cigarette burn hole prior to admitted to the facility. R26 stated he had no burn holes in his jacket or clothing since he had been at the facility. R26 stated sometimes the ashes fell on his clothing, but he had never burned himself or burned his clothes and was able to flick the ashes off his clothing. On 2/15/22, at 9:30 a.m. the resident went outside to smoke independently. R26 independently lit the cigarette to smoke. The resident was observed smoking independently without any ashes dropping on his clothing. The resident flicked his ashes in the smoking container and when finished threw the remains of	2 565	having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has updated all smoking and transmission based precaution care plans. The facility has re-educated the nurse managers on the care plan process. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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2 565	Continued From page 4 his cigarette into the container. On 2/15/22, at 2:06 p.m. licensed practice nurse (LPN)-C stated on the evening of 2/14/22, she evaluated R26's smoking and observed resident safely get in and out of the building, light cigarette safely, ashed cigarette appropriately, extinguished and placed cigarette in the receptacle. LPN-C stated R26 showed her the hole jacket and stated the hole happened a while ago. LPN-C indicated she did not witness concerns and did not implement any new interventions or restrictions as R26 was evaluated with no concerns while he smoked. LPN stated R26's care plan was expected to identify smoking and confirmed the care plan had not included smoking prior to last night [2/14/22], and further indicated in October 2021, R26 restarted smoking. On 2/15/22, at 2:21 p.m. interview with administrator stated on the evening of 2/14/22, R26 smoking evaluation occurred and R26 was deemed to smoke independently. The administrator stated he expected resident care plans to be thorough, and confirmed R26's care plan was not comprehensive without smoking included. On 2/15/22, at 3:48 p.m. R26 was seated in wheelchair outside smoking no ashes observed on resident. On 2/16/22, at 2:18 p.m. interview with DON stated she expected that smoking resident's care plans would identify the resident smoked and smoking interventions included in the care plan. Facility policy titled Resident Smoking Policy dated 11/18, indicated:	2 565		

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2 565	Continued From page 5 It is the intent of this policy to outline the procedure for safe resident smoking including evaluation of residents to determine those who are capable of smoking independently, and to provide a designated smoking area for those residents who choose to smoke. If a resident is identified as a current smoker the protocol below under smoking facility should be utilized. b. All residents who smoke will be evaluated for the need of adaptive equipment. 4. Residents who choose to smoke will be evaluated upon admission, significant change in condition/cognition, or exhibits inability to follow safe smoking practices or quarterly. 6. Residents requiring supervision will receive assistance with smoking, in accordance with facility and resident specific practices as identified on the individual resident care plans. 10. The facility must document in the care plan and/or progress notes other attempted interventions to manage and accommodate smoking needs before revoking smoking privileges. R4 R4's facesheet printed on 2/17/22, indicated diagnoses including enterocolitis (inflammation of digestive tract) due to recurrent clostridium difficile (c-diff; a bacteria in the bowel which causes diarrhea and fever and which can be spread by touching fecal matter or a contaminated surface). R4's quarterly Minimum Data Set (MDS) assessment dated 1/26/22, indicated R4 was cognitively intact, had adequate hearing and vision, clear speech, was understood and able to understand. R4 required assistance from staff for transferring in and out of bed and moving about in	2 565		

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2 565	Continued From page 6 a wheelchair. R4 was occasionally incontinent of bladder and frequently incontinent of bowel. During an interview and observation on 2/14/22, at 2:09 p.m., contact precaution signs were noted on R4's door with instructions to wear gown and gloves when entering the room. R4 stated he had three different bouts of c-diff over the past year. "I have a ... [foul language] of a time washing my hands. They give me a wet wash cloth in the morning, but that's all." R4 added, he didn't wash his hands before meals and staff didn't offer to help him wash his hands. R4's care plan printed on 2/17/22, failed to identify c-diff as a focus area. As a result, the care plan lacked interventions/tasks related to providing comprehensive care for management of c-diff and measures to take to prevent the spread of c-diff. During an interview on 2/17/22, at 12:55 p.m., licensed practical nurse (LPN)-A stated she was responsible for updating R4's care plan, and acknowledged after looking through R4's electronic medical record, that c-diff was not a focus area on R4's care plan and hence there were no interventions related to the disease or to transmission based precautions (TBP's). LPN-A confirmed it would be expected for c-diff to be included on a care plan for a resident who had a diagnosis of c-diff, and acknowledged the importance of staff knowing measures to prevent the spread of c-diff to other residents. When asked how she determined what goes on a residents care plan, LPN-A stated she had a list she referred to, and stated she didn't know how she overlooked this on R4's care plan. During an interview on 2/18/22, at 7:31 a.m.,	2 565		

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2 565	Continued From page 7	2 565		

regional nurse consultant (RNC)-C stated she would expect c-diff to be a focus area on a care plan in order to ensure a resident received appropriate care related to c-diff, and to ensure TBP's were followed in order to prevent the spread of c-diff to other residents. RNC-C was unaware R4's care plan did not include c-diff and ensured it would be added.

Facility policy titled Clostridium Difficile, dated October 2018, indicated measures would be taken to prevent the occurrence of c-diff infections among residents. Precautions were taken while caring for residents with c-diff to prevent transmission to other residents. The primary reservoirs for c-diff were infected people and surfaces and described the steps for prevention and intervention: increase awareness of symptoms and risk factors, frequent hand washing with soap and water, wearing gloves when handling feces or contaminated items, and disinfecting items with bleach. Furthermore, the policy indicated when caring for residents with c-diff, staff were to maintain vigilant hand hygiene and washing hands with soap and water were superior to alcohol based hand sanitizer. Residents with diarrhea were to be monitored for signs and symptoms of dehydration.

Facility policy titled Care Planning, dated 1/6/22, indicated: The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.

SUGGESTED METHOD OF CORRECTION:

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2 565	Continued From page 8 The director of nursing or designee could educate nursing staff on the development and implementation of comprehensive resident care plans, and then audit to ensure compliance. The director of nursing or designee could report findings of the audits to the Quality Assurance and Performance Improvement (QAPI) committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to prevent	2 900	Plan of Correction 686 Treatment/Svcs to prevent/Heal Pressure ulcers Please accept the following as the facility's	3/18/22

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2 900	Continued From page 9 worsening and prevent additional pressure ulcers (PU)'s from developing for 1 of 1 resident (R28) who had two unstageable PU's (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) and one stage 2 PU (partial thickness skin loss of the dermis) This failure resulted in actual harm when R28's pressure ulcers worsened and additional PU's were acquired. Findings include: R28 was admitted to the facility on 7/31/18, with diagnoses (identified on the diagnosis report sheet) dated 1/5/22, including; congestive heart failure (CHF) (a chronic condition in which the heart does not pump blood as well as it should), fibromyalgia (widespread muscle pain and tenderness) osteoarthritis (when bone protective tissue wears down), spinal stenosis (narrowing of the spinal canal), history of PU on coccyx and buttocks, dehydration, diarrhea, and joint pain. Observation and interview on 2/14/22, at 1:38 p.m. R28 reported to the surveyor she had a "sore" bottom. R28 was sitting in her wheelchair in her room. R28 stated she had a PU on her buttocks that was not healing and she was unsure why. R28 thought she had the sore for a month but was unsure. R28 indicated she she did not recall being repositioned every 2 hours. R28's quarterly minimum data set (MDS) assessment dated 12/15/21, identified R28 as having a baseline interview for mental status (BIMS) of "14" (cognitively intact). R28 required extensive assistance with activities of daily living (ADL's) that included mobility. R28 required extensive assistance with toileting and	2 900	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 taken for those affected by the alleged deficient practice: ¿R28 has been reassessed for her alteration in skin care plan. R28 continues to refuse repositioning. Reviewed risk and benefits of this choice with the resident. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk related to the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has completed an audit of all resident□s interventions with skin breakdown to insure that they are correct. The facility has re-educated the nursing staff on the importance of turning and repositioning residents Q2 hours. The facility has initiated a weekly wounds meeting until 100 percent compliant with pressure ulcer prevention interventions. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits as noted above in the wound management meeting. Completion date: 3/18/2022	

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2 900	Continued From page 10 repositioning. The MDS identified R28 as being at risk for PU's and identified one stage 2 PU. Interventions; pressure reducing device on chair and bed, turning and repositioning program, PU care and nutritional intervention. The MDS indicated R28 did not exhibit any behaviors. R28 utilized a wheelchair for mobility. Review of the Braden scale dated 12/15/21, indicated R28's risk factor was mild for skin breakdown. The assessment indicated R28 continues to have an open area on the right buttock as well as a new area that is dry near the open area, that looks like it may open. Triad hydrophilic treatment dressing applied as ordered. Encourage the resident to avoid sitting no longer than 1 hour in the wheelchair without repositioning. Repositioning at least every 2 hours in bed/chair to prevent skin breakdown. Limit chair sitting to 2 hours. Avoid the resident falling asleep on the toilet. Wheelchair cushion on chair from pressure applying, staff to monitor skin daily with cares and weekly with skin inspection. Review of the Weekly Pressure Wound Evaluations; -10/20/21- right buttock measures 0.3 centimeter (cm) in length by 0.3 cm. width. The center of the wound is slightly orange in color and surrounded by whitish skin. Unstageable. -12/1/21-right buttock measures 0.1 cm length by 0.1 cm width. The wound bed is dry with no drainage. Unstageable. -12/15/21-right buttock measures 1.3 cm length by 1.5 cm width with 100% granulation tissue(new connective tissue for healing of wounds). Unstageable. -12/29/21-right buttock measures 1.5 cm length by 1.3 cm width. The wound bed had a scant amount of serous (thin and clear) drainage.	2 900		

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2 900	Continued From page 11 Unstageable. -2/2/22-right buttock (distal) measures 0.5 cm length by 0.5 cm width. 100% granulation tissue. Pain with treatment. Unstageable (newly acquired PU on 12/29/22 and measured 0.5 cm length by 0.6 cm width) right buttock (proximal) measures 1.7 cm length by 1.2 cm width. 100% slough slough (necrotic/dead) tissue. Pain with treatment. Unstageable. left buttock measures 1.2 cm length by 0.5 cm width. 100% slough tissue. Pain with treatment. Unstageable. (newly acquired on 1/2/22 with measurements of 0.7 cm length by 1.0 cm in width) 2/9/22-right buttock (proximal) measures 1.0 cm length by 1.4 cm width. 100% slough tissue. Unstageable right buttock (distal) 0.8 cm length by 0.6 cm width. 100% slough tissue. Unstageable. left buttock measures 1.8 cm length by 0.9 cm width. 100% slough tissue. Unstageable. The weekly Pressure Wound Evaluation from 10/20/21 to 2/9/22, indicated R28 obtained a new unstageable PU to the right distal buttocks and a newly unstageable PU to the left buttock during this time. The right buttock (proximal) PU went from granulation tissue to slough tissue and increased in size from 0.3 centimeter (cm) length by 0.3 cm. width to 1.0 cm length by 1.4 cm width. The right buttock (distal) PU increase in size from 0.5 cm length by 0.6 cm width to 0.8 cm length by 0.6 cm width. The left buttock increased in size from 0.7 cm length by 1.0 cm in width to 1.8 cm length and no change in width During review of the weekly wound assessments, it was noted the above PU's were not thoroughly being completed.	2 900		

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2 900	Continued From page 12 Review of the current physicians orders dated 2/16/22, included an order to encourage R28 to avoid sitting for longer than 1 hour in the wheelchair without repositioning every shift (order date 2/9/22). The physicians orders also included an order to reposition R28 at least every 2 hours in bed/chair to prevent pressure to bottom. Limit chair sitting to 2 hours. Review of the care plan dated 2/16/22, identified R28 as having at risk alteration in skin integrity related to history of venous statis ulcer, skin keratosis, cellulitis and open area to right buttock (resolved on 3/17/21). Interventions listed; do not use perfume soaps, wheelchair cushion on wheelchair, weekly pressure would assessments, keep skin clean and dry, encourage mobility, inspect skin daily and report concerns to charge nurse, weekly skin assessments by licensed staff and treatment cream interventions as needed (PRN). The care plan indicated R28 has alteration in mobility related to osteoarthritis, left knee pain, CHF and fibromyalgia. Interventions listed; independent with bed mobility, monitor skin integrity, routine preventive skin cares with lotion and powder, ultrafoam pressure redistribution mattress to bed and wheelchair. The care plan indicated R28 is independent with toileting and transfers and continent of bowel and bladder. R28 has a history of sitting on the toilet for hours. Staff to remind R28 every 15 minutes to finish. Interventions listed; resident was educated to call for assist when transferring to toilet, encourage good peri cares, encourage adequate fluids and monitor skin integrity. -The comprehensive care plan did not include R28's PU's on the buttocks nor the repositioning interventions per physicians order Review of the nursing assistant (NA) care sheet	2 900		

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dated 2/9/22, indicated R28 is assisted to bed and with all transfers. Offer toileting and repositioning every 2-3 hours PRN and peri-cares PRN. Offer R28 to sit in the recliner at night, if refuses to sleep in bed. When finding R28 in the bathroom stay with her until finished. Check R28 for safety (related to fall risk) every 1 hour to make sure the resident is sleeping during the hours of 10:00 p.m. to 6:00 a.m.
-The NA care sheet did not reflect the current physicians orders for repositioning.

Review of the NA hourly safety checks from 1/1/22 to 2/15/22, (10:00 p.m. to 6:00 a.m.) for R28, did not include repositioning. The checks only included the whereabouts of where R28 was during this time.

Continuous observations on 2/15/22 and 2/16/22, from 8:00 a.m. to 10:30 a.m. (2 1/2 hrs) and from 1:00 p.m. to 3:30 p.m. (2 1/2 hrs). R28 was not offered repositioning or off-loading. During this time, staff were observed to walk by the residents room.

Observation on 2/16/22, at 10:30 a.m. R28's PU treatment was done by registered nurse (RN)-D. R28's wound dressings were removed with saline. There was a scant amount of brownish drainage on the dressings. R28 was observed to have 2 PU's on the right buttock and 1 PU on the left buttock. When RN-D cleansed the wounds R28 flinched and complained of pain. The PU's were measured by RN-D, at this time.
Measurements:
Right buttock-(proximal) 1.1 cm length by 1.7 cm width by 0.1 cm depth (increase in size from most recent measurements on 2/9/22)
Right buttock (distal) 1.3 cm length by 0.7 cm width by 0.2 cm depth (increase in size from

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most recent measurements on 2/9/22)
Left buttock- 1.2 cm length by 1.2 cm width by 0.1 cm depth (increased in length and depth from most recent measurements on 2/9/22.

The skin around all 3 pressure ulcers was slightly reddened. Triad hydrophilic (absorbs wound exudate) wound dressing was applied to all 3 PU's R28 stated she tries to off-load, lay down during the day and stay off of her bottom as much as she can. R28 had a pressure reduction mattress on her bed and a pressure reduction cushion on her chair. Interview during this time with RN-D, stated she usually does not provide wound care for R28 and was unsure if the wounds had improved or not, but did indicate the nurse practitioner provides wound care every 2 weeks.

Continued observations on 2/17/22, from 9:00 a.m. to 12:15 p.m. R28 was not repositioned or off-loaded. R28 remained in her room and slouched in her wheelchair. Facility staff were observed to go in and out of her room administering medications, delivering dinner tray, answering call lite and putting clothing away. The staff also walked by her room several times without offering to reposition or off-load.

Review of a physicians visit progress note dated 1/5/22, indicated R28 was seen for wound care evaluation and treatment of re-occurring ulcers to buttocks. The note indicated there was a new small area starting to open on the left buttocks, which is new from last visit. R28 expresses frustration that wounds are not healing. R28 is having pain with wound care. R28 is compliant with treatments. The right buttock wound measures 1.2 cm by 1.5 cm by 0.1 cm with a smaller area next to it that measures 0.4 cm by

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2 900	Continued From page 15 0.3 cm by 0.1 cm. The wound has increased in size with a scant amount of drainage. 100% slough and unstageable The left buttocks measures 1.0 cm by 0.6 cm. No drainage. Unstageable The progress note indicated to encourage R28 to avoid sitting for longer than 1 hour in the wheelchair without repositioning and to encourage increased protein at meals and multivitamin. Occupational therapy (OT) for wheelchair positioning and overlay to bed. Review of a physicians visit progress note dated 2/9/22, indicated R28 was seen for wound care evaluation and treatment of re-occurring ulcers to buttocks. The note indicated R28 is reporting there has been no improvement in the wounds on her bottom and continues to have pain when sitting. The progress note indicated R28 continues to have a dressing application over her buttock wounds, but the resident indicates they do not stay on. The right proximal buttocks ulceration measures 1.0 cm by 1.4 cm by 0.1 cm. The wound has increased in size, no odor or drainage. 100% slough and unstageable. Surrounding skin is tender. Right distal buttocks ulceration measures 0.8 cm by 0.6 cm by 0.1 cm. The wound has increased in size. There is no odor and scant drainage. Unstageable and surrounding skin is tender. The left buttocks ulceration measures 1.8 cm by 0.9 cm by 0.1 cm. Wound has increased in size. No odor or drainage. 100% slough and unstageable. Surrounding skin is tender Treatment of medicine gel to wound bed twice a day (BID) and as needed (PRN) until healed. Make sure resident is receiving peri care. Padded toilet seat is recommended and encourage resident to avoid sitting for more than an hour without repositioning.	2 900		

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2 900	Continued From page 16 Interview on 2/16/22, at 11:15 a.m., RN-D indicated R28's PU's were re-occurring and do not seem to get better. RN-D stated R28 should be turned and repositioned every 2 hours, but confirmed she was not aware of any order for repositioning or off-loading the resident every 1 hour. RN-D further indicated R28 requires assistance with repositioning and transferring, but will often attempt to transfer self. Interview on 2/16/22, at 11:30 a.m. NA-D stated R28 will at times refuse to off-load or lay down when offered. NA-D indicated R28 should be repositioned or off-loaded every 2 hours. NA-D stated he was not aware of R28 being off-loaded or repositioned every 1 hour. NA-D further indicated when staff get busy, it is difficult to get residents repositioned timely. Interview on 2/16/22, at 1:30 p.m. trained medication assistant (TMA)-A indicated she follows the NA's care sheet for repositioning and off-loading R28. TMA-A confirmed the NA plan of care directed staff to reposition R28 every 2-3 hours PRN. TMA-A further indicated R28 will independently transfer self, but verified R28 requires assistance. Interview on 2/16/22, at 3:30 p.m. nurse manager (NM)-D indicated R28's care plan should have been updated to reflect the current physician orders for repositioning. NM-D indicated she thought the NA's were repositioning R28 while providing hourly safety checks, but later verified the staff were just visualizing R28's whereabouts. NM-D also confirmed weekly skin assessments were not always complete by the licensed nursing staff. NM-D indicated the NP was monitoring and providing treatment for R28's PU's.	2 900		

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2 900	Continued From page 17 Interview on 2/16/22, at 3:00 p.m. the facility nurse consultant (NC)-A and director of nursing (DON) confirmed R28's plan of care should have been updated to reflect the current physicians orders of repositioning (at least every 2 hours and to encourage sitting for no more than an 1 hour). NC-A stated the facility nursing staff had been trained on how to manage PU's and implement interventions per individualized care plan Review of the facility policy Skin Assessment and Wound Management dated 7/2018, included upon a significant change in a residents skin such as a development of a pressure related skin impairment, the following actions will be taken;; a tissue tolerance observation and evaluation will be completed, to determine skin tolerance and implement interventions to prevent breakdown and to promote healing, update the plan of care, update the NA care sheets and complete education with the resident including risk/benefits. Document refusals in the medical record. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care and services are provided to prevent worsening or development of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the facility Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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21375	Continued From page 18	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow transmission-based precautions by ensuring closure of room doors for 2 of 3 residents (R14, R50) symptomatic and known to be positive with COVID-19. The facility's failure to ensure implementation of proper precautions to prevent or mitigate the risk of COVID-19 outbreak had the potential to affect all other 63 residents and staff within the facility. Findings include: During entrance conference on 2/14/22 at 12:47 p.m., the administrator identified three residents (R14, R50, R38) confirmed to have COVID-19 and were on droplet/contact precautions, all three residents resided on 500 unit of facility. R14's medical diagnosis listed on admission face sheet, printed on 2/18/22, identified dementia with Lewy body (brain disease causing problems in thinking, movement, behavior, and mood). R14 was diagnosed with positive COVID-19 on 2/7/22, remained asymptomatic throughout isolation period, off precautions on 2/18/22. R50's medical diagnosis listed on admission face	21375	Plan of Correction F880 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 taken for those affected by the alleged deficient practice: ¿No residents are currently on transmission based precautions. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nursing and dietary staff on Donning/Doffing PPE and having the door closed for Covid + residents. Quality Assurance plans to monitor facility performance to make sure that corrections	3/18/22

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21375	Continued From page 19 sheet, printed on 2/18/22, identified admission from acute care hospital. Further review of R50's care plan, dated 12/29/21, revealed R50 had a history of kidney failure and receives outpatient dialysis 3x/week, congestive heart failure (CHF- a chronic condition in which the heart cannot pump blood effectively), and pneumonia (infection of the lungs). R50 was diagnosed with positive COVID-19 on 2/7/22; became symptomatic with cough, nausea vomiting on 2/9/22-2/14/22. Isolation precautions removed 2/18/22, as R50 no longer experiencing symptoms. During initial observation on 2/14/22 at 2:27 p.m. two of the three residents with confirmed COVID-19 virus, (R14 and R50), had their room doors open wide. R14 and R50's room doors had droplet/contact precautions signs posted outside. Multiple observations of room doors being open for R41 and R50 while on droplet/contact precautions was observed during survey. The duration of time room doors were open was unknown, staff not observed to be in and/or coming out of rooms at the following times; R14 2/14/22 at 6:41 p.m. 2/15/22 at 7:19 a.m. 2/15/22 at 2:51 p.m. 2/16/22 at 7:40 a.m. 2/16/22 at 8:42 a.m. 2/16/22 at 11:13 a.m. 2/16/22 at 12:53 p.m. R50 2/14/22 at 6:42 p.m. prior to unknown nurse aide applying personal protective equipment (PPE) and entering room to deliver meal tray 2/15/22 at 2:55 p.m.	21375	are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Directed Plan of Correction 1. Address how corrective action will be accomplished for those residents found to be affected by the deficient practice. a. The facility currently does not have any residents on transmission based precautions. Therefore no additional residents are currently being affected by the deficient practice. 2. Address how the facility will identify other resident having the potential to be affected by the same practice. a. Re-education of staff as noted above. Root cause analysis See attachment 1. IP/DON shall complete the following. " Grouping of residents, or cohorting, should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices. " Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents). " Confine symptomatic residents and exposed roommates to their rooms. If they	

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21375	Continued From page 20 02/16/22 at 7:20 a.m. 02/16/22 at 8:42 a.m. During interview on 2/16/22, at 7:20 a.m. registered nurse (RN)-C was asked about residents with COVID-19 and room doors being open. RN-C indicated doors should be kept closed. During interview on 2/16/22, at 7:37 a.m. RN-B indicated residents with COVID-19 and on isolation, should have rooms doors closed. RN-B indicated difficulty with keeping R14's door closed as he was a fall risk and was known to try to open door frequently to come out of room. RN-B indicated she has provided verbal re-education to staff on keeping doors to isolation rooms closed at all times. Facility policy titled Infection Prevention and Control Program, dated 8/17, indicated: Important facets of infection prevention include; identifying possible infections or potential complications of existing infections, instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, implementing appropriate isolation precautions when necessary. Policy did not indicate anything specific related to COVID-19 infection control and prevention. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's infection control program related to Covid-19. The administrator or designee could provide education to all facility staff on infection control. The administrator or designee could do weekly/monthly audits for	21375	must leave their room, ensure the resident is wearing a mask. " Provide dedicated equipment for areas, as able. All noted above are currently part of the facility□s policies and procedures. Staff will be re-educated on Covid 19 policy/procedure. The facility will provide education to the residents regarding Transmission based precautions. Completion date: 3/18/2022 Date Resident Covid Vaccine Current Action Notes Initial	

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21375	Continued From page 21 compliance. The director of nursing or designee could report findings of the audits to the Quality Assurance and Performance Improvement (QAPI) committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending	21530		3/18/22

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21530	Continued From page 22 physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 1 of 5 residents (R17) reviewed for unnecessary medication use. Findings include: R17's admission Minimum Data Set (MDS) assessment dated 12/1/21, identified R17 had moderate cognitive impairment, mild depression, required extensive assist with bed mobility, transfers, dressing, toilet use, and personal hygiene. Diagnoses included Parkinson's disease (chronic and progressive movement disorder causes stiffness or slowing of movement), diabetes, anxiety disorder, depression, and age-related physical disability. The MDS indicated R17 received scheduled pain medication, non-medication interventions for pain, insulin, antidepressant, and opioids. R17's care plan dated 2/16/22, indicated potential for psychotropic drug ADR's [adverse drug reaction] r/t [related to] daily use of psychotropic	21530	Plan of Correction□755 Pharmacy 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 taken for those affected by the alleged deficient practice: ¿The facility has reviewed the pharmacy recommendations from the pharmacy with R17□s provider. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nurse managers on reviewing pharmacy recommendations with the provider per	

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21530	Continued From page 23 medication related to diagnosis of depression with daily Cymbalta (medication used for depression) use, interventions included administer medication as ordered monitoring for ADR's, report suspected ADR's to MD/PA [medical doctor/physician assistant], medications reviewed by MD/PA and pharmacist, be alert to mood and behavioral changes, and monitor and document mood state/behaviors upon occurrence. R17's Medication Review Report printed 2/18/22, indicated an order for buspirone 10 mg tablet for anxiety and sertraline 100 mg related to major depressive disorder. R17's Consultant Pharmacist's Medication Regimen Review document dated 12/14/21, identified R17's medication regimen had been reviewed by the consulting pharmacist (CP), and indicated R17 continued on sertraline and buspirone, ensure the following was completed: PCC [point click care] orders for behavior monitoring. The corresponding Consultant Pharmacist's Medication Review dated 1/11/22, and 2/15/22, indicated recommendations were reissued from 12/21, and the CP indicated R17 continued on sertraline and buspirone, and again indicated to ensure the following was completed: PCC [point click care] orders for behavior monitoring. R17's medical record was reviewed and lacked evidence nursing reviewed and/or acted upon the CP recommendations dated 12/14/21, 1/11/22, or 2/15/22, for behavior monitoring. On 2/18/22, at 10:49 a.m. an interview via telephone with the CP indicated a monthly medication chart review was completed of all	21530	facility policy Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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21530	Continued From page 24	21530		

residents residing at the facility. The CP indicated recommendations were sent monthly via email to the director of nursing (DON) and administrator. The CP indicated the recommendations were expected to be addressed within the timeframe outlined on the report or within a month . The CP stated the following month he reviewed the status of the recommendations and verified completion, and recommendations were reissued if not addressed. The CP confirmed R17's last recommendation for behavior monitoring had not been implemented, and indicated daily target behavior monitoring was expected. The CP further stated monthly the residents pending recommendations were discussed with the DON. The CP stated November through December, pharmacy recommendation completion rate was low at 25%, and indicated 75% was the completion goal rate.

On 2/18/22, at 10:58 a.m. the director of nursing (DON), stated she received a monthly email from the CP with resident's pharmacy recommendations and the DON indicated monthly she distributed the CP pharmacy nursing recommendations to the nurse managers. The DON verified the facility received R17's CP recommendations on 12/14/21, 1/11/22, and 12/15/22, and the recommendations had not been addressed. The DON indicated she expected the nurse managers to have addressed and acted upon the CP monthly recommendations. The DON further indicated she was aware of the 25%, pharmacy completion rate last month and further indicated she expected 100%, of the recommendations acted upon.

On 2/18/22, at 11:00 a.m. the administrator confirmed the nurse managers received the CP

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21530	Continued From page 25 recommendations and verified the consultant pharmacist's recommendations had not been addressed. Facility policy titled Gradual Dose Reductions, dated 12/19, indicated: 1. Behavioral symptoms related to dementia: The GDR may be considered clinically contraindicated if the: · Resident ' s target symptoms returned or worsened after the most recent attempt at a GDR within the facility AND · Physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident ' s function or increase distressed behavior. A policy and procedure was requested regarding pharmacy recommendations and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to pharmacy reviews. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21530		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance,	21600		3/18/22

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21600	Continued From page 26 and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for routine reconciliation of controlled substances medication for 1 of 1 emergency kit (E-Kit) to prevent potential loss/diversion. Findings include: On 2/16/22, at 2:30 p.m., a tour of the North medication storage room with nurse manager (NM)-D. Located within the medication storage room was a portable refrigerator that contained the facility E-Kit. The E-Kit consisted of a small tackle box that was secured with a pull away colored tab. The tackle box contained 2 vials of injectable lorazepam (an anti-anxiety medication/controlled substance). Review of the documentation count in the Narcotic bound book,did not identify lorazepam had ever been reconciled by facility staff, to identify or account for any missing medication. Interview with NM-D on 5/12/21, at 11:00 a.m. confirmed staff were not periodically reconciling the E-Kit controlled substances. NM-D indicated she did not understand why reconciling of the E-Kit needed to be done, because only licensed staff had access to the medication room. Interview with NM-E on 5/12/21, at 11:00 a.m. confirmed staff were not reconciling the E-Kit controlled substance. Interview on 2/16/22, at 12:00 p.m. with the facility nurse consultant (NC)-A indicated all staff	21600	Plan of Correction 755 Pharmacy 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 taken for those affected by the alleged deficient practice: ¿The facility has initiated a count between each shift for E-Kit Ativan. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated nurses and TMAs on the new Emergency Kit process. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance.	

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21600	Continued From page 27 had been trained on the policy for reconciliation of the E-Kit and should be aware of the process. Review of the facility Controlled Drug Count Process (undated) indicates it is the expectation that all controlled substances must be counted every shift, including the cubix and refrigerator E-Kit (contains vials of lorazepam) The E-Kit must remain under double lock plus have a numbered tag on it. A visual check to ensure count is correct must take place each shift, and sign the controlled drug count log acknowledging meds have been counted with cubex, refrigerator and E-kit. SUGGESTED METHOD OF CORRECTION: The administrator, consultant pharmacist or designee could review and revise policies and procedures to include processes for monitoring controlled substances stored in the E-Kit. The administrator, consultant pharmacist or designee could perform random observational audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure 8 of 71 rooms (rooms 101, 103,	21665	Plan of Correction□Home like Environment	3/18/22

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(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) COMPLETE DATE
21665	Continued From page 28 111, 112, 113, 115, 201, 216) were maintained in good repair and in sanitary conditions, impacting 11 residents (R21, R264, R1, R55, R46, R57, R13, R213, R59, R9, R4). In addition, the facility failed to ensure fans used in resident resident rooms (rooms 401 and 417), impacting residents (R3, R32) were kept in a clean and sanitary manner; free of dust and debris. Findings include: During resident screening on 2/14/22, from 12:30 p.m. to 4 p.m., the following observations were made: --Room 216, occupied by R21: The white toilet bowl was heavily stained with a dark gold, rusty color. --Room 101, occupied by R1 and R264: An excessive amount of gray dust and debris resembling thick dryer lint was observed in the return air vent on the floor under the window; three ceiling tiles near the window were stained with a gold-colored splatter pattern; the white toilet bowl was heavily stained with a dark gold, rusty color; and the return air vent in the bathroom ceiling had gray fuzzy material on the slats. --Room 103, occupied by R55: The wall-mount hand sanitizer dispenser was empty. --Room 111, occupied by R46 and R57: The paper towel dispenser in the bathroom was empty. The return air vent in the bathroom ceiling was rusty and had a significant amount of gray fuzzy material on the slats. --Room 112, occupied by R13: The return air vent in the bathroom ceiling was rusty and had a significant amount of gray fuzzy material on the slats. --Room 113, occupied by R59 and R213: The return air vent in the bathroom ceiling had a	21665	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 taken for those affected by the alleged deficient practice: Housekeeping has deep cleaned all of the effected rooms. Maintenance has either replaced or cleaned all of the effected toilets. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Housekeeping has established a new checklist for cleaning rooms to ensure all rooms are kept appropriately Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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	00031	A. BUILDING: _____ B. WING _____	C 02/18/2022

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significant amount of gray fuzzy material on the slats.
--Room 115, occupied by R9: The white toilet bowl was heavily stained with a dark gold, rusty color. The return air vent in the bathroom ceiling was rusty and had a significant amount of gray fuzzy material on the slats.
--In the shower room on the memory care unit, the return air vent in the ceiling was rusty and had a significant amount of gray fuzzy material on the slats. There were five tiles, approximately two inches by two inches, missing from around the drain, causing an irregular surface with sharp edges.
--Room 201, occupied by R4: An excessive amount of gray dust and debris resembling thick dryer lint was observed in the return air vent on the floor under the window.
--Utility room on 200 wing: The wall-mounted soap dispenser at the sink was empty; the return air vent in the ceiling was heavily soiled with gray fuzzy material; the rim around the hopper (a large toilet-type unit for disposal of clinical waste) and the wall behind the hopper was splattered with brown material that had the appearance of fecal matter.

During an interview and observation on 2/14/22, from 1:51 p.m. to 2:22 p.m., R4 in room 201 stated when housekeeping cleaned his floor, they only mopped down the middle of the room, they didn't move furniture or mop under the bed. Dead bugs, mouse droppings, and "helicopter" leaves from trees were observed on R4's window sill and near the small window air conditioning unit. There was also a fine layer of dirt and dust on the window sill. Mouse droppings were observed on the closet floor. In addition, the return air vent in the bathroom ceiling had a significant amount of gray fuzzy material on the slats.

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21665	Continued From page 30 During an observation on 2/16/22, at 8:21 a.m., R3 in room 401 was asleep in a broda chair about 5 feet in front of a small fan that was blowing directly toward him. Observed strands of dust approximately 4 - 5 inches in length blowing out from the fan toward R3; the blades of the fan were heavily soiled with gray fuzzy material. During a telephone interview on 2/16/22, at 9:06 a.m., family member (FM)-E stated when she visited R4 on 2/13/22, she moved the recliner away from the wall to sit in it and noticed mouse droppings and dirt under it; adding it was obvious the chair had not been pulled out and mopped under for awhile. FE-E stated she had been disappointed in how housekeepers mopped the floor -- just going down the center of the room with a mop and not mopping under furniture or under R4's bed. FM-E stated R4 often dropped things that would land under his bed and no one picked it up. During an interview and observation on 2/16/22, at 12:50 p.m., with the assistant director of nursing (ADON), together observed the above environmental concerns by going to each room. In addition, in room 103, the wall mount hand sanitizer dispenser was still empty, and in room 111 the paper towel dispenser in the bathroom was still empty, both initially observed on 2/14/22. The ADON asked staff to notify housekeeping to refill them. With permission from R4 in room 201, looked through drawers and closet for evidence of mice. Observed mouse droppings in a drawer, on the window sill and the floor of the closet. Observed a return air vent on the floor below the window with an excessive/heavy amount of gray dust/debris in it. The ADON admitted the mouse droppings and excessive dust posed a health risk	21665		

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to residents and staff, and stated she would have housekeeping thoroughly clean R4's room and follow up with maintenance and housekeeping.

During an interview and observation on 2/16/22, at 1:36 p.m., together with the administrator and environmental services director (ESD)-A, observed the above environmental concerns by going to each room. ESD-A stated she had started a list on 2/14/22, of stained toilets that needed to be replaced. Went into R4's room (room 201) to look at areas where mouse droppings had been seen; the window sill which had been cleaned, the return air vent on the floor below the window which was heavily soiled with dust and debris, and the mouse droppings on the closet floor.

During an interview on 2/16/22, at 1:49 p.m., following the tour of resident rooms, the administrator stated the condition of the resident rooms came as somewhat of a surprise, particularly the condition of the toilets, adding the facility had problems with rusty water. The administrator stated what he observed was not acceptable, and admitted it was not providing residents a sanitary and home-like environment, adding "we will take care of it."

During an interview on 2/18/22, at 9:52 a.m., housekeeping supervisor (HS)-C stated he was aware of return air vents in the ceiling in resident bathrooms and the floor air returns vents in some resident rooms, but was not aware if they had ever been cleaned. HS-C stated he had not trained housekeepers to look at them, clean them or tell him about them, but that housekeepers usually mentioned things like that. HS-C stated he showed new housekeepers what to do, then they worked with another housekeeper 4 - 5

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times before starting on their own. When informed that a resident stated housekeepers only mopped down the center of the room, HS-C stated he had recently talked to a housekeeper about that, adding he wanted to trust that the housekeepers did a thorough job, but didn't follow them around to make sure. HS-C was shown personal fans in rooms 401 occupied by R3, and room 417 occupied by R32, both which had a heavy amount of fuzzy gray material on them. In room 401, the fan was small, and blowing directly on R3 from about 5 feet away. In room 417, a large fan on top of a dorm size refrigerator was not in operation. HS-C stated he expected housekeepers to notice when fans needed to be cleaned and take them to maintenance to have them cleaned, adding it wasn't good for fans to blow dust on residents. Together looked at the floor vent in room 101, as well as the stained ceiling tile, bathroom vent and rusty toilet bowl; HS-C stated the facility was planning to replace some of the stained toilets, and he would take care of the replacing the ceiling tiles and cleaning the return air vents.

During an interview on 2/18/22, at 1:46 p.m., discussed environmental findings with ESD-A, maintenance assistant (MA)-B, and HS-C. ESD-A stated the facility was old and acknowledged some things needed to replaced such as toilets, adding that the condition of some toilets was embarrassing and not what should be found in a nursing home. HS-C stated staffing housekeepers had been a challenge given they were short staffed, but admitted some of the findings had been going on for a long time (e.g., dust and debris build up in vents) and could not be attributed to a recent shortage of staff. ESD-A admitted they had work to do.

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21665	Continued From page 33 During an interview on 2/18/22, at 2 p.m., housekeeper (H)-A stated no one had hold her to mop under beds or move and mop under furniture. H-A stated they were short housekeepers and the job was stressful. H-A had a clipboard with resident rooms listed that she checked off when done cleaning a room. The list did not include prompts to ensure specific tasks were done each day, such as replacing paper towels. When asked how she remembered to do everything, H-A admitted there was a lot to remember and did her best. Facility policy titled Cleaning and Disinfecting Residents' rooms, dated August 2013, indicated housekeeping would clean surfaces such as floors and tabletops on a regular basis. Personnel would remain alert for evidence of rodent activity (droppings) and report such findings to the Environmental Services Director. The policy outlined step by step process for cleaning resident rooms. The policy did not specify how to mop the floors, e.g. move furniture and/or to mop under the bed. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate maintenance and housekeeping staff on the importance of maintaining a safe, clean, functional and homelike environment. The administrator or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of resident rooms to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an effective pest control program to eliminate mice in the building. This failure affected R4, and had the potential to affect all 66 residents who resided in the facility. Findings include: R4's diagnoses included diabetes, end stage renal disease (renal failure) requiring dialysis (the process of removing toxins from the body), and transmission based precautions for recurrent clostridium difficile (a bacteria in the bowel which causes diarrhea and fever). R4's quarterly Minimum Data Set (MDS) assessment dated 1/26/22, indicated R4 was cognitively intact, had adequate hearing and vision, clear speech, was understood and able to understand. R4 required assistance from staff for transferring in and out of bed and moving about in a wheelchair. R4 did not walk. During an interview on 2/14/22, at 1:51 p.m., R4 who resided in room 201, reported he had mice in his room, "I hear them in the ceiling and I've seen	21730	Plan of Correction□Home like Environment 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 taken for those affected by the alleged deficient practice: Housekeeping has deep cleaned all of the effected rooms. Maintenance has either replaced or cleaned all of the effected toilets. How will the facility 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 the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Housekeeping has established a new checklist for cleaning rooms to ensure all	3/18/22

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21730	Continued From page 35 them on the floor. Heard them in the ceiling yesterday." R4 added that there had been mice droppings on his floor and in his dresser drawers. R4 stated maintenace staff put live traps in his room and had caught five mice over several months. No traps were observed in visible areas of the room. R4 stated his wife had been there on 2/13/22, and cleaned mice droppings out of his dresser drawers. R4 stated his wife brought a nursing assistant (NA) into the room to show her, then housekeeping scoured the entire room and put some kind of peppermint repellent in the room. R4 stated maintenance and housekeeping were aware of mice in his room. R4 didn't know if the facility used a professional exterminator. On 2/14/22, at 2:22 p.m., observed dead bugs, mouse droppings and "helicopter" leaves from trees on R4's wide and deep window sill. Observed a small air-conditioning unit in the lower left corner of the large window. Silver duct tape placed around the opening of the air conditioner was loose in some spots. During an interview on 2/16/22, at 8:16 a.m., housekeeper (H)-B admitted to seeing evidence of mice in the facility and in rooms 201 and 401. "I've seen mouse droppings in room 401 and clothing chewed on in room 201." When this occurred, H-B stated she told her boss, housekeeping supervisor (HS)-C, then her and another housekeeper deep-cleaned room 401. H-B could not recall when that was, but stated it was a few months ago. During an observation on 2/16/22, at 8:21 a.m., no mice droppings were observed in room 401. R3 was asleep in a broda chair about 5 feet in front of a small fan that was blowing directly toward him. Noticed two strands of dust	21730	rooms are kept appropriately Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 3/18/2022	

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21730	Continued From page 36 approximately 4 - 5 inches in length blowing out from the fan; the blades of the fan were heavily soiled with gray fuzzy material. During an interview on 2/16/22, at 8:26 a.m., with nursing assistant (NA)-A and (H)-A, when asked if either had seen evidence of mice in resident rooms, H-A stated "not often." NA-A stated she had not, but had been told some residents had seen mice in their rooms. H-A stated she had seen droppings, "not everywhere, just one or two rooms." When asked which rooms, stated R4's room (201) and someone on the northwest wing, but couldn't recall which room or which resident. H-A stated if she saw droppings, she informed her boss HS-C, and cleaned the room well. During a telephone interview on 2/16/22, at 9:06 p.m., family member (FM)-E stated she was aware of mice in R4's room, adding she had observed holes in one of his shirts and suspected it was from mice. FM-E stated while visiting on 2/13/22, she cleaned a small chest of drawers and saw mouse droppings in it and also noticed mice had eaten through a bag of Cheetos. FM-E stated she noticed a lot of mouse droppings on 2/13/22, when she pulled R4's recliner away from the wall to sit in it. Furthermore, FM-E stated the recliner had obviously not been pulled out and cleaned under for a while as there were many mice droppings and dirt under it. FM-E stated she told a staff member who then came in and cleaned the floor well. FM-E stated she cleaned R4's dresser drawers of mice droppings and put fabric softener sheets in the drawers and closet to repel mice. FM-E stated she had never seen mice in R4's room, but had seen plenty of droppings, adding there had been a trap behind R4's recliner at one time.	21730		

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21730	Continued From page 37 Facility policy titled Pest Control, dated May 2008, was reviewed and indicated the facility would maintain an on-going pest control program to ensure the building would be kept free of rodents. A service report from Guardian Pest Solutions dated 1/24/22, was received from the administrator and reviewed. The following was documented by the service technician (ST)-F: Performed inspections of door entrances, common space, hallways and there were no activities. I expected [sic] dining room area and kitchen, talk with food service director (FSD)-A, she still has issues with mice in her (kitchen) drawers. I expected [sic] area again here is a big hole in wall behind ice machine (in resident dining room), talk with the environmental services director (ESD)-A about sealing that hole in the wall, but she said can't move the ice machine and that she would try to find a way to seal up that hole. I find that the whole [sic] pedometry [sic] the point of entry for mice that are getting in to kitchen drawers. I mentioned this last time I was here. No other activities found. During an interview on 2/16/22, at 10:50 a.m., FSD-A stated they used to have problems with mice, but not anymore. Mice droppings had been found in kitchen drawers in the past. FSD-A stated they speculated mice were coming from the basement via a pipe that comes into the building to the ice machine. FSD-A stated that hole had been sealed and denied further evidence of mice. During kitchen tour, did not observe mouse droppings in drawers, on surfaces, or floors. During an interview on 2/16/22, at 11:57 a.m., HS-C stated he had not heard anything from staff about mice in a while. If staff tell him about mice,	21730		

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he puts a tube trap in the residents room -- mice can go in, but they can't get out. HS-C stated Guardian Pest Control came to the facility once a month; the technician checked in with housekeeping and maintenance when he arrived and informed them of his findings before he left. When asked if he knew where mice where coming in, HS-C stated he did not, adding "numerous places, such an old building." HS-C stated there was a hole behind the ice machine; maintenance would know more about that. Once identified, staff cleaned droppings, disinfected the room and he placed a trap. HS-C stated he also placed packets of peppermint under dressers to repel mice.

On 2/16/22, at 12:50 p.m., with assistant director of nursing (ADON), donned PPE (personal protective equipment) and with permission from R4, looked through drawers and closet for evidence of mice. There were two, identical three drawer dressers against one wall; all 6 drawers were looked through and mice droppings were found in the underwear drawer. Noticed the dryer sheets that FM-E placed in the drawers on 2/13/22. Observed mouse droppings on window sill and the floor of the closet. Observed a return air vent on the floor below the window which had an excessive/heavy amount of gray dust/debris in it. This was pointed out to the ADON. The ADON stated she was aware of mice in the facility, but reports of mice had not been brought to her attention recently. The ADON acknowledged mice and mice droppings could spread germs and could pose a health risk to residents and staff, and stated she would have housekeeping thoroughly clean R4's room and follow up with ESD-A.

On 2/16/22, at 1:36 p.m., with the administrator

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and ESD-A, went into R4's room to look at areas where mouse droppings had been seen; the window sill which had since been cleaned, the air conditioner with lose duct tape, the return air vent on the floor below the window which was heavily soiled with dust and debris, and the mice droppings on the closet floor. R4 informed the administrator and ESD-A that FM-E had spent most of 2/13/22, cleaning drawers of mice droppings and put dryer sheets in them to repel mice.

During an interview on 2/16/22, at 1:49 p.m., the administrator acknowledged he had been aware of mice in R4's room, adding "he brings in a lot of outside food, which is a food source for mice." The administrator stated he did not know how mice were getting into R4's room and would have the pest exterminator come back today or tomorrow to address it. The administrator acknowledged mice in a residents room was not acceptable, nor was it a sanitary and home-like environment, adding "we will take care of it."

During a telephone interview on 2/18/22, at 1:30 p.m., ST-F stated he was called to come to the facility on 2/17/22. ST-F stated he believed the main problem with mice was related to the hole in the wall behind the ice machine in the dining room adjacent to the kitchen. ST-F stated he had told maintenance assistant (MA)-B and ESD-A about this in the past. "I told MA-B what he could do; I don't know if it is completely sealed up -- I didn't look at it." While there, ST-F stated he looked in room 118 where there had been reports of mice, adding there was a heat duct that went down to the floor and not sealed up because it would cause the pipe to freeze. ST-F suggested to MA-B he could use wire mesh. ST-F checked an office near the kitchen where there had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	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) COMPLETE DATE
21730	Continued From page 40 reports of mice in the ceiling. ST-F stated he did not go into R4's room. During an observation on 2/18/22, at 1:43 p.m., observed the area behind the ice machine in the dining room adjacent to the kitchen. The tall, square, floor-model ice machine dispenser was positioned at an angle to the corner of the room, approximately 10 feet from a door leading into the kitchen. Behind the ice machine was an area of pipe-work, with multiple pipes going into the floor and into the wall. Observed steel wool sticking out from hole around pipe-work going into the wall. Multiple penetrations were noted going into the floor and wall. During an interview on 2/18/22, at 1:46 p.m., with ESD-A, MA-B and HS-C, ESD-A stated the hole in the wall behind the ice machine in the dining room had been sealed with steel wool around the pipes after the ST-F had been at the facility on 1/24/22, and there had been no more mice noted in kitchen drawers. Not able to say if continued evidence of mice indicated mice were getting into the building by other means. ESD-A stated based on recommendations from ST-F on 2/17/22, for room 118, MA-B went to a hardware store and purchased a floor vent; put steel wool over the pipe, and the vent over steel wool and caulked around it. Regarding R4's room, caulking was placed around the outside of window in his room. ESD-A, MA-B and HS-C acknowledged mice should not be inside the building; it wasn't good for the health of residents and it did not create a home-like environment. ESD-A stated they took mice in the building very seriously; that's why they had an exterminator come monthly. Facility policy titled Pest Control, dated May 2008, indicated the facility would maintain an effective	21730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	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) COMPLETE DATE
21730	Continued From page 41 pest control program; that the facility maintained an on-going pest control program to ensure that the building was kept free of insects and rodents. Additionally, maintenance, when appropriate and necessary, assisted in providing pest control services. Facility policy titled Cleaning and Disinfecting Residents' rooms, dated August 2013, indicated personnel would remain alert for evidence of rodent activity (droppings) and report such findings to the Environmental Services Director. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure a preventative pest/rodent control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest/rodent control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		

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 _____	**02/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	**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 fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/16/2022. At the time of this survey, Hillcrest Care & Reahbilitation 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. Hillcrest Care & Rehabilitation Center is a one-story with a partial basement. The 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 fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 67 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	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.