

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

Mighing

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered 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

M. Jaio

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



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

M. Ping

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



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

Hillcrest Care & Rehabilitation Center March 8, 2022 Page 2 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

Hillcrest Care & Rehabilitation Center March 8, 2022 Page 3

(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 \S 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR \S 488.412 and \S 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

Hillcrest Care & Rehabilitation Center March 8, 2022 Page 4

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

Hillcrest Care & Rehabilitation Center March 8, 2022 Page 5

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

M. Pais

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

PRINTED: 03/30/2022 FORM APPROVED OMB NO. 0938-0391

| C 02/18/2022 NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 PROVIDER'S PLAN OF CORRECTION (X5) | | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|-----------|---|--|---|-----|---|-----|------------|
| NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (M4) ID PRETEX (EACH DEFICIENCY WINST BE PRECEDED BY FULL RECOLD ENGINE FLOW OR LSC DENTIFYING INFORMATION) E 000 Initial Comments C 0n 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. INITIAL COMMENTS The following complaint was found to be NOT1 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. Nour electronic submission of the POC will | | | 245507 | | | | | |
| HILLCREST CARE & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments E 000 Initial Comments E 000 Initial Comments F 000 Initial Comments 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 survey was conducted during a standard recertification survey was conducted at your facility. A complaint investigation was also conducted, Tacility and Stound 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 (MM80943), 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 | | | 245507 | D. WING | | | 02/ | 18/2022 |
| HILLCREST CARE & REHABILITATION CENTER (A4) ID (A4) ID (ACA) ID (| NAME OF F | PROVIDER OR SUPPLIER | | | | | | |
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| | | as your allegation of Departments acception enrolled in ePOC, yat the bottom of the form. Your electron | of compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 ic submission of the POC will | | | | | |
| Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE | LABORATOR | onsite revisit of you validate substantial | r facility may be conducted to compliance with the | IATURE | | TITLE | | (V6) 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.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | NG | | E SURVEY IPLETED |
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| | | 245507 | B. WING _ | | | C 18/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | • | |
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| F 000 | Continued From pa | ge 1 | F 00 | 00 | | |
| | | Comprehensive Care Plan | F 6 | 56 | | 3/18/22 |
| | §483.21(b)(1) The fimplement a compression care plan for each resident rights set ff §483.10(c)(3), that objectives and time medical, nursing, an needs that are ident assessment. The codescribe the followi (i) The services that or maintain the resiphysical, mental, arrequired under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclute at ment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's codesired outcomes. (B) The resident's putture discharge. Fawhether the resider | t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) PROVIDER/SUPPLIER/CLIA

| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | G | | PLETED |
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| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | , 02. | |
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| F 656 | local contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEI by: Based on observative review, the facility for comprehensive car reviewed for smoking reviewed for transman Findings include: R26's admission rerection reviewed for transman for the reviewed for the | pose. s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced tion, interview, and document | F 65 | Plan of Correction 656 Developmed Care Plans Please accept the following as the facility's credible allegation of common This Plan of Correction does not constitute any admission of guilt on by the facility and is submitted only response to the regulatory require. How corrective action will be taken those affected by the alleged deficiply practice: R26 care plan has been up reflect that he is able to smoke independently w/o an assistive derign to longer on transmission based precautions and the care plan has updated appropriately. How will the facility identify other report having the potential to be affected 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 alter to ensist the problem will be corrected and occur: The facility has updated all smand transmission based precaution plans. The facility has re-educated the | pliance. r liability y in ments. n for sient dated to vise. R4 d been esidents by the ne ne or sure that will not noking n care | |

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| F 656 | to smoke. On 2/14/22, at 5:45 wheelchair, within or cigarette lit and in him was observed with jacket near his wais ashes dropped on the conference of the | p.m. R26 was outside in one foot of facility door with his mouth. R26's black jacket ashes on the bottom of his st. R26 when asked, confirmed the jacket while smoking. p.m. R26's jacket had one the bottom of the jacket and hole was from a cigarette burned to the facility. R26 stated hen his jacket or clothing since facility. R26 stated sometimes is clothing, but he had never burned his clothes and was les off his clothing. a.m. the resident went independently. R26 et cigarette to smoke. The wed smoking independently dropping on his clothing. The ashes in the smoking in finished threw the remains of et container. p.m. licensed practice nurse the evening of 2/14/22, she noking and observed resident at of the building, light cigarette | F 656 | managers on the care plan proces Quality Assurance plans to monito performance to make sure that corrections are achieved and are permanent: Administrator or Designee will condaily audits for 2 weeks as needed monitor for compliance. Completion date: 3/18/2022 | r facility | |

| PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 4 interventions or restrictions as R26 was evaluated interventions. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 Interventions or restrictions as R26 was evaluated | | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | IPLE CONSTRUCTION IG | | E SURVEY PLETED |
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| NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 4 interventions or restrictions as R26 was evaluated | | | 245507 | B. WING | | | |
| HILLCREST CARE & REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (ACCOMPLETED TO THE APPROPRIATE DEFICIENCY) (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (BACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (BACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (BACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | NAME OF | PROVIDER OR SUPPLIER | 210001 | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 4 interventions or restrictions as R26 was evaluated (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 F 656 | HILLCRI | EST CARE & REHABI | LITATION CENTER | | | | |
| interventions or restrictions as R26 was evaluated | PRÉFIX | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | (X5) COMPLETION DATE |
| 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 residents moking 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 smoke will be evaluated for the need of adaptive equipment. | F 656 | interventions or reswith no concerns w R26's care plan wa and confirmed the smoking prior to last indicated in October smoking. On 2/15/22, at 2:2's administrator stated R26 smoking evaluated to smoke it administrator stated plans to be thorough plan was not comprincluded. On 2/15/22, at 3:48 wheelchair outside on resident. On 2/16/22, at 2:18 stated she expected plans would identify smoking intervention. Facility policy titled dated 11/18, indicated 11/18, indicated the intent of this procedure for safe evaluation of residents who choosed in a resident is identicated. b. All residents who choosed in the sidents who choosed in th | trictions as R26 was evaluated hile he smoked. LPN stated is expected to identify smoking care plan had not included it night [2/14/22], and further r 2021, R26 restarted I p.m. interview with don the evening of 2/14/22, ation occurred and R26 was independently. The diple he expected resident care he, and confirmed R26's care rehensive without smoking p.m. R26 was seated in smoking no ashes observed p.m. interview with DON do that smoking resident's care of the resident smoked and in sincluded in the care plan. Resident Smoking Policy ted: Is policy to outline the resident smoking including tents to determine those who king independently, and to be seen to smoke. It is smoked to smoking area for those the resmoking facility should be a smoke will be evaluated for | F 65 | 56 | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | TIPLE CONSTRUCTION NG | COM | E SURVEY IPLETED |
|--------------------------|--|--|---------------------|---|-------|----------------------------|
| | | 245507 | B. WING _ | | 1 | C 18/2022 |
| | PROVIDER OR SUPPLIER EST CARE & REHABI | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 656 | 4. Residents who cevaluated upon adrondition/cognition, safe smoking pract 6. Residents require assistance with small facility and resident on the individual resident interventions to massmoking needs before indiagnoses including digestive tract) due difficile (c-diff; a baccauses diarrhea an spread by touching contaminated surfactured by touching contaminated surfactured by touching contaminated surfactured in the individual resident indiagnoses including digestive tract) due difficile (c-diff; a baccauses diarrhea an spread by touching contaminated surfactured by touching contaminated surfactured by touching contaminated surfactured in the individual resident | hoose to smoke will be mission, significant change in or exhibits inability to follow ices or quarterly. In gare supervision will receive oking, in accordance with a specific practices as identified sident care plans. It document in the care plan tes other attempted mage and accommodate ore revoking smoking ted on 2/17/22, indicated genterocolitis (inflammation of to recurrent clostridium cteria in the bowel which difever and which can be fecal matter or a | F 6 | 56 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | PLE CONSTRUCTION 3 | | E SURVEY PLETED |
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| | | 245507 | B. WING | | | C 18/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 656 | help him wash his help him wash his help him wash his help R4's care plan printidentify c-diff as a focare plan lacked into providing comprehenced from the configuration of c-diff. During an interview licensed practical nesponsible for updacknowledged after electronic medical responsible for updacknowledged after electronic medical responsion based confirmed it would help the confirmed it would help the spread of c-diff, a simportance of staff the spread of c-diff asked how she deteresidents care planshe referred to, and she overlooked this during an interview regional nurse consistency would expect c-diff plan in order to ensappropriate care responsible for confirmed it would be spread of c-diff to ounaware R4's care ensured it would be | eals and staff didn't offer to hands. ed on 2/17/22, failed to book area. As a result, the reventions/tasks related to ensive care for management of a to take to prevent the spread. on 2/17/22, at 12:55 p.m., urse (LPN)-A stated she was ating R4's care plan, and looking through R4's record, that c-diff was not a care plan and hence there has related to the disease or to precautions (TBP's). LPN-A be expected for c-diff to be plan for a resident who had a land acknowledged the knowing measures to prevent to other residents. When ermined what goes on a plan LPN-A stated she had a list of stated she didn't know how are no R4's care plan. on 2/18/22, at 7:31 a.m., sultant (RNC)-C stated she to be a focus area on a care ure a resident received lated to c-diff, and to ensure did in order to prevent the ther residents. RNC-C was plan did not include c-diff and | F 65 | 6 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | TIPLE CONSTRUCTION NG | | E SURVEY IPLETED |
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| | | 245507 | B. WING | | 1 | C 18/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 656 | October 2018, indictaken to prevent the infections among retaken while caring for prevent transmission primary reservoirs for and surfaces and doprevention and interest of symptoms and riswashing with soaps when handling fece disinfecting items would prove the policy indicated when country indicated when country indicated when the policy indicated when the policy indicated when country indicated when the policy indicated when the | atted measures would be e occurrence of c-diff esidents. Precautions were for residents with c-diff to on to other residents. The for c-diff were infected people escribed the steps for revention: increase awareness sk factors, frequent hand and water, wearing gloves s or contaminated items, and with bleach. Furthermore, the en caring for residents with maintain vigilant hand hygiene with soap and water were based hand sanitizer. | F 6 | 56 | | |
| F 678 SS=D | indicated: The care developing the resident will be utilized by stoof providing care or plan of care will be resident. The care pupdated as the conresident changes. Cardio-Pulmonary FCFR(s): 483.24(a)(3) Personal Support, including Country and the support of the care pupdated as the conresident changes. Cardio-Pulmonary FCFR(s): 483.24(a)(3) Personal Support, including Country and the care pupdated physician or advance directives. | Care Planning, dated 1/6/22, plan shall be used in dent's daily care routines and aff personnel for the purposes services to the resident. The utilized to provide care to the plan is to be modified and dition and care needs of the Resuscitation (CPR) 3) connel provide basic life CPR, to a resident requiring are prior to the arrival of I personnel and subject to orders and the resident's | F 6 | 78 | | 3/18/22 |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | SURVEY PLETED |
|---------------|---------------------------------|--|---------------|----|--|-----------|--------------------|
| | | 245507 | B. WING | | | (| |
| NAME OF E | PROVIDER OR SUPPLIER | 243307 | J | | REET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 18/2022 |
| NAME OF F | NOVIDEN ON SUFFEIEN | | | | 4 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | | ANKATO, MN 56001 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | N I | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI) TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | COMPLÉTION DATE |
| F 678 | Continued From pa | ige 8 | , F6 | 78 | | | |
| | by: | | | | | | |
| | | and document review, the | | | Plan of Correction ☐ 678 CPR | | |
| | | ate the code status for 1 of 1 | | | Please accept the following as the | | |
| | | ewed for advanced directives. | | | facility's credible allegation of comp | oliance. | |
| | | lity failed to accurately s code status throughout the | | | This Plan of Correction does not constitute any admission of guilt or | liability | |
| | medical record. | o dode status till odgriodt tile | | | by the facility and is submitted only | | |
| | | | | | response to the regulatory requiren | nents. | |
| | Findings include: | | | | How corrective action will be taken | | |
| | R18's quarterly Min | imum Data Set (MDS) | | | those affected by the alleged defici practice: | ent | |
| | | 11/30/21, identified R18 had | | | R18□s POLST status has beer | n | |
| | intact cognition. | , | | | updated. | | |
| | | | | | How will the facility identify other re | | |
| | | ated 8/23/21 and updated on | | | having the potential to be affected I | by the | |
| | | iagnoses of cerebral infarction brain causing brain damage), | | | same deficient practice? All residents of the facility have the | ے ا | |
| | | ility to understand or express | | | potential to be affected by the same | | |
| | | nellitus- type 2, hemiplegia | | | alleged deficient practice. | | |
| | | de of the body), and malignant | | | The measures the facility will take | | |
| | | te (prostate cancer). R18's | | | systems the facility will alter to ensu | | |
| | | /23/21, identified advance oulmonary resuscitation (CPR). | | | the problem will be corrected and voccur: | viii not | |
| | unective as cardiop | difficitally resuscitation (CFK). | | | The facility has completed a ful | . | |
| | R18's hospice adm | nission consent form identified | | | facility audit, and all POLST orders | | |
| | on 2/1/22, R18 had | transitioned to hospice care. | | | current and correct. | | |
| | | | | | The facility has re-educated the | | |
| | | ers for Life-Sustaining | | | managers that POLST status must | | |
| | |), dated 8/23/21, identified tion/CPR (Full Treatment)." | | | reviewed upon significant changes. The facility has started reviewing al | | |
| | | 2/2/22, updated and signed by | | | POLST Changes daily during IDT r | | |
| | R18's spouse/ heal | th care agent, and hospice | | | and insure updated orders in PCC | | |
| | | I code status changed to "Do | | | accurate care plans. | | |
| | | tation/DNR (Allow Natural | | | Quality Assurance where to me == it- | fooilibe | |
| | Death)." | | | | Quality Assurance plans to monitor performance to make sure that | iacility | |
| | R18's care plan da | ited 8/24/21, identified code | | | corrections are achieved and are | | |
| | | for staff to follow POLST | | | permanent: | | |
| | guidelines. | | | | Administrator or Designee will cor | duct | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | E CONSTRUCTION | | SURVEY PLETED |
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| | | 245507 | B. WING | | | | 0 |
| NAME OF F | PROVIDER OR SUPPLIER | 243307 | 5 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 18/2022 |
| NAME OF I | NOVIDEN ON SOIT EIEN | | | | 14 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | | ANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 678 | F 678 Continued From page 9 | | F 6 | 78 | | | |
| | administration reco | ary report and medication rd (MAR) reviewed on 2/14/22, vance directive as CPR. | | | daily audits for 2 weeks as needed monitor f¿r compliance. Completion date: 3/18/2022 | το | |
| | registered nurse (R knowledge R18 was R18's current POLS which indicated full with RN-A hospice a signed by R18's he dated 2/1/22, indicated code status change R18's spouse was I | on 2/14/22, at 7:20 p.m. N)-A indicated to her s a full code. RN-A checked ST status, dated 8/23/21, I code. Surveyor reviewed admission consent form alth care agent and spouse, ating POLST completed and ed to DNR. RN-A indicated having a difficult time changing would contact hospice to ange. | | | | | |
| | p.m. RN-A indicated hospice agency R1 from CPR to DNR. going to fax the cur morning on 2/15/22 During an interview | on 2/15/22, at 1:13 p.m. | | | | | |
| | process for when a care, includes update physician orders are being unsure of who communication occurred if they were signature at that potentials. Social seroesponsible for han |)-A indicated the facility resident goes onto hospice ating the POLST form when the received. SS-A indicated ere the breakdown in curred with hospice orders, estill waiting on physician int, as nurse manager on unit rvices-A indicated being dling admission POLST only. | | | | | |
| | | urse (LPN)-A, who is also the | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | TIPLE CONSTRUCTION ING | | E SURVEY MPLETED |
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| | | 245507 | B. WING | | 1 | C |
| NAME OF E | PROVIDER OR SUPPLIER | 240001 | | STREET ADDRESS, CITY, STATE, ZIP CODE | | /18/2022 |
| TO WILL OF T | TO VIDER OR GOLF EIER | | | 714 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABI | LITATION CENTER | | MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 678 | unit manager where familiar with R18 go LPN-A indicated wh would refer to medic (MAR), treatment a face sheet/admission electronic medical inverified R18's current EMR, indicated if Richard would've initiated Coon hospice to upda. During an interview director of nursing of worker completes a admission, the DON reviewed by nurse any changes needing by that nurse. The expectation when unare reflected on POMAR/TAR, and carrerror of code status to DNR for R18, incunaware of new hosigned by physician immediately. The Expoken to hospice in forward hospice nunurse on unit after progress notes/ordigiven directly to face hospice binder. The expectation for facility would recommend the status of the st | e R18 resided, indicated being bing onto hospice recently. Hen looking for code status, cation administration record dministration record (TAR), or on record through the record (EMR) system. LPN-A and code status as CPR per 18 was found unresponsive, PR. LPN-A indicated relying the code status. If on 2/15/22, at 1:35 p.m. (DON), indicated the social advance directives at time of N and nurse unit manager then indicated code status is manager on unit quarterly and the properties of the properti | F 6 | 778 | | |

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---|---|---|
| | 245507 | | | 1 | 0 |
| PROVIDER OR SUPPLIER | 243007 | | STREET ADDRESS CITY STATE ZIP CODE | 02/ | 18/2022 |
| | LITATION CENTER | | 714 SOUTHBEND AVENUE | | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD | BE | (X5) COMPLETION DATE |
| Resuscitation, revisal A POLST form will by the nurse manage (REVIEWED) upon as needed (such as transferred from onto another; when the resident 's heads treatment prefere primary medical care POLST form is a manust be signed by a lifthe resident is adstatus order or the attaction the resident protify the provider invalid code status or Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of Care is a applies to all treatmateriality residents. Basessment of a resident sreceivaccordance with propractice, the compresses and the resident facility factorial treatmaterial treatmate | ded 11/19, included: de completed upon admission der or designee and readmission, quarterly, and de when a resident is de care setting or level of care dere is a substantial change in th status; when the resident ' de provider changes). A dedical order, which means it de medical provider to be valid. Mitted without a valid code deadmitting orders are different deferences, the facility must deferences, the facility must deference in accurate, der. Care fundamental principle that deferent and care provided to desed on the comprehensive desident, the facility must ensure detered treatment and care in defensive person-centered desidents' choices. No is not met as evidenced dion, interview and document dailed to comprehensively derever the progress of finger desident (R28) with | | Plan of Correction □684 Quality of Please accept the following as the facility's credible allegation of comparties Plan of Correction does not constitute any admission of guilt or by the facility and is submitted only | oliance. liability | 3/18/22 |
| . manigo moidae. | | | . sopones to the regulatory requirem | | |
| | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Resuscitation, revis A POLST form will I by the nurse manag (REVIEWED) upon as needed (such as transferred from on to another; when th the resident 's heal s treatment prefere primary medical can POLST form is a m must be signed by a If the resident is ad status order or the a than the resident pr notify the provider in valid code status or Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents receiv accordance with pro practice, the compre care plan, and the re This REQUIREMEN by: Based on observat review, the facility fa assess and monito lesions for 1 of 1 re | PROVIDER OR SUPPLIER ST CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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. | PROVIDER OR SUPPLIER ST CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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WING COM 2714 SOUTHBEND AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 11 Resuscidation, 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. Quality of care is a fundamental principle that applies to all treatment and care provider changes in the resident's choices. F 684 F 684 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | IPLE CONSTRUCTION NG | (X3) DATE COM | E SURVEY PLETED |
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| | | 245507 | B. WING_ | | | C 18/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COI 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 684 | R28 was admitted diagnoses (identifies sheet) dated 1/5/22 rough scaly skin catheart failure (CHF) the heart does not should), fibromyalg and tenderness) or protective tissue we (narrowing of the spressure ulcer (PU dehydration and join Observation and in R28 was in her roo R28 noted to have and 3rd fingers of hwere partially on the crusty and cracked colored in the center moist. R28 stated the fingers for severally getting any better. The discomfort becoming any better, her discomfort becombeelchair independance of the lesions R28's quarterly minassessment dated having a baseline in (BIMS) of "14" (cogextensive assistant (ADL's) that include wheelchair. The Minisk for PU's and id (partial thickness senterventions; pressure in the state of the same of the lesions of the same | to the facility on 7/31/18, with ed on the diagnosis report 2, included; actinic keratosis (aused by the sun) congestive (a chronic condition in which pump blood as well as it his (widespread muscle pain steoarthritis (when bone lears down), spinal stenosis pinal canal), history of on coccyx and buttocks, int pain. Iterview on 2/14/22 1:40 p.m. m sitting in her wheelchair. 3 bandaids on her thumb, 2nd her left hand. The bandaids e lesions. The lesions looked around the edges and whitish er. The center noted to be hat she has had sores on her weeks and that they were not R28 stated that they caused ause she does utilize her hidently. R28 did not know what | F 68 | How corrective action will be those affected by the alleged practice: ¿R28 has wound care orders identified figner lesions, and war BID and PRN. R28 has been routine wound provider round assessment and monitoring. How will the facility identify oth having the potential to be affesame deficient practice? All residents are at risk related deficient practice. The measures the facility will systems the facility will alter to the problem will be corrected occur: The facility has completed wide audit of resident hands ward additional findings. The facility has educated on reporting skin conditions to provider and getting appropria interventions in place. Quality Assurance plans to make sure the corrections are achieved and permanent: DON or Designee will conducted audits for 2 weeks as needed for completion date: 3/18/2022 | for the will complete added to added to so for the residents exted by the ed to the take or consure that and will not do a facility with no nursing staff to the ate take or conitor facility at are lict daily | |

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| HILLCRE | EST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 | care and nutritional not include any other Review of the care R28 as having a ris related to history of sores on the skin the veins don't wo ongoing high pressi keratosis, cellulitis (causes redness, swarea of the skin) an (resolved on 3/17/2 use perfume soaps wheelchair, weekly keep skin clean and inspect skin daily an nurse, weekly skin and treatment creat (PRN). The care plaalteration in mobility knee pain, CHF and listed; independent integrity, routine preand powder, ultrafo mattress to bed and adequate fluids and The comprehensive R28's non-pressure tips of the fingers of Review of the curre 2/16/22, included at right 2nd finger in wand apply a genero cover finger with a cfingertip twice a day | intervention. The MDS dider skin conditions. plan dated 2/16/22, identified k alteration in skin integrity venous statis ulcer (open lat occur when the valves in rk properly and there is ure in the veins)., skin ibacterial skin infection that velling, and pain in the infected dopen area to right buttock 1). Interventions listed; do not wheelchair cushion on pressure would assessments, didry, encourage mobility, and report concerns to charge assessments by licensed staff in interventions as needed an indicated R28 has are related to osteoarthritis, left difibromyalgia. Interventions with bed mobility, monitor skin eventive skin cares with lotion am pressure redistribution di wheelchair, encourage I monitor skin integrity. The care plan did not include a related skin lesions on the fithe left hand. Int physicians orders dated in order to soak the resdient's varm water for 3-6 minutes us amount of Vaseline and dressing to keep moisture in are the treatment to the thumb | F 68 | 34 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| F 684 | assessments from finger lesion identifit to 2/16/22, included R28's finger lesion. index finger was no nurse practitioner (I progress notes did documentation relatinger lesion nor did the other 2 lesions finger. Review of a physici 1/5/22, indicated Fevaluation and treat buttocks. The note 2nd finger fissure. Warm water for 3-5 amount of Vaseline to keep moisture or treatment BID until progress notes in the progress of the address the additionard finger. Observation and interest was sitting in the R28 was sitting in the R28 was sitting in the R28 noted to have and 3rd fingers of hwere only partially of the wounds. The leand cracked around colored in the centere moist. R28 stated stated stated stated and stated s | ress notes and weekly wound 1/5/22 (since onset of the ed on the physicians orders) I 1 entry on 1/11/22, related to The note indicated R28 left ted to be dry and scaly. The NP) will evaluate today. The not include any further ted to the description of the I it include when R28 obtained noted on her thumb and 3rd ans visit progress note dated R28 was seen for wound care tment of re-occurring ulcers to indicated R28's had a right reatment to soak finger in minutes and apply a generous. Cover with a gauze dressing in the lesions. Implement resolved. There were no other he medical record indicating finger lesions, nor did it nal lesions on the thumb and serview on 2/16/22 1:45 p.m. The hallway next to her room. In a bandaids on her thumb, 2nd her left hand. The bandaids on the lesions and exposing sions continued to look crusty of the edges and whitish er. The center noted to be he continued to have exted fingers and did not feel | F 68 | 34 | | |

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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 684 | nurse (RN)-D stated on all 3 fingers of the for several weeks. It should have been used of care. RN-D indict lesions were improved interview on 2/16/2: nurse consultant (N (DON) confirmed R been updated to include include includes on her finger nursing staff had been updating the care paresidents status. Interview on 2/16/2: (NM)-D stated she assess R28's skin I should have. NM-D exactly when R28 collesions. NM-D indict lesions on her finger wax and wane. that not been document lesions and unsure MD-A added the face every 2 weeks, but documentation relation 1/5/22. Review of the facility Wound Management upon a significant cas a development of the form of the severy and the facility wound Management upon a significant cas a development of the facility wound management in the severy and the facility wound Management upon a significant cas a development of the facility wound management in the severy and the facility wound management upon a significant of the facility wound management upon a | 2, at 10:30 a.m. registered d R28 has had the skin lesions he left hand (identified above) RN-D indicated the lesions updated to include in the plan hated she did not think the ving. 2, at 3:00 p.m. the facility IC)-A and director of nursing 28's plan of care should have blude R28's non-pressure skin firs. NC-A stated the facility pen trained on how to manage and skin concerns as well as lan when they are changes in 2, at 3:22 p.m. nurse manager had failed to comprehensively esions of the fingers and stated she was unsure obtained all 3 of the finger atted the R28 has had dry firs for a few months that would ing the progress of the finger if they were improving or not. cility NP reviews skin concerns | F 68 | 4 | | |

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| TO WILL OF T | THO VIDER OR GOLF EIER | | | 714 SOUTHBEND AVENUE | | |
| HILLCRE | EST CARE & REHABII | LITATION CENTER | | MANKATO, MN 56001 | | |
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| F 684 | Continued From particles and complete education representative inclusive plan, update care list weekly until healed, needed, review skir interdisciplinary teat update care plan as Treatment/Svcs to CFR(s): 483.25(b)() §483.25(b)(1) Press Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that the (ii) A resident with professional standar pressure ulcers and ulcers unless the indemonstrates that the (iii) A resident with professional standar pressure ulcers and ulcers unless the indemonstrates that the (iii) A resident with professional standar pressure ulcers and ulcers unless the indemonstrates that the (iii) A resident with professional standar pressure ulcers from de This REQUIREMENT by: Based on observative review, the facility facility facility facility for the facility facility for the facility facility facility for the facility facil | ge 16 Ind resident representative, with the resident/resident ding risk/benefits, update care sts. Document skin condition update the provider as a concerns with the m (IDT) at least monthly and seneded (PRN). Prevent/Heal Pressure Ulcer 1)(i)(ii) Pegrity Sure ulcers. In rehensive assessment of a must ensure thates care, consistent with and so f practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent | F 6 | DEFICIENCY) | nt/Svcs pliance. | 3/18/22 |
| | one stage 2 PU (pa | red by slough or eschar) and rtial thickness skin loss of the resulted in actual harm when | | How corrective action will be taker those affected by the alleged defic practice: | | |

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| F 686 | R28's pressure ulcopul's were acquired. Findings include: R28 was admitted to diagnoses (identifies sheet) dated 1/5/22 failure (CHF) (a cheart does not pumplished by the properties of the art does not pumplished by the properties of the art does not pumplished by the properties of the art does not pumplished by the properties of the | ers worsened and additional l. To the facility on 7/31/18, with ad on the diagnosis report l., including; congestive heart ronic condition in which the lip blood as well as it should), pread muscle pain and rithritis (when bone protective lastory of PU on coccyx and lon, diarrhea, and joint pain. The view on 2/14/22, at 1:38 to the surveyor she had a lawas sitting in her wheelchair lated she had a PU on her lot healing and she was lought she had the sore for a lare. R28 indicated she she did lositioned every 2 hours. The view for mental status limitively intact). R28 required law with activities of daily living liv | F6 | 686 | ¿R28 has been reassessed for her alteration in skin care plan. R28 continues to refuse repositioning. Reviewed risk and benefits of this owith the resident. How will the facility identify other rehaving the potential to be affected be same deficient practice? All residents are at risk related to deficient practice. The measures the facility will take of systems the facility will alter to ensith the problem will be corrected and woccur: The facility has completed an all resident □s interventions with skibreakdown to insure that they are of All residents have appropriate interventions in place with updated of care. The facility has re-educated the nursing staff on the importance of the and repositioning residents Q2 hou. The facility has provided educated all nurses on the facility wound proceed all nurses on the facility wound proceed and implemented the WOund proceed and implemented the WOund proceed all nurses on the facility wound proceed and implemented the WOund proceed all nurses on the facility wo | choice sidents by the che or ure that vill not udit of n correct. plans e urning rs. tion to cess eration vounds t with cons. veeks facility | |

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| TVAIVIL OF I | NOVIDEN ON COLL FIELD | | | | 4 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | | ANKATO, MN 56001 | | |
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| F 686 | Review of the Brade indicated R28's risk breakdown. The as continues to have a buttock as well as a open area, that look hydrophilic treatmer ordered. Encourage no longer than 1 hor epositioning. Repoin bed/chair to previous in the toilet. It is in the toilet from pressure apply with cares and wee Review of the Weel Evaluations; -10/20/21- right butto (cm) in length by 0 wound is slightly or by whitish skin. Unsinger 12/15/21-right butto 0.1 cm width. The violation of the width in the word of the word of the width in the word of t | en scale dated 12/15/21, a factor was mild for skin sessment indicated R28 in open area on the right a new area that is dry near the as like it may open. Triad int dressing applied as a the resident to avoid sitting ur in the wheelchair without sitioning at least every 2 hours ent skin breakdown. Limit urs. Avoid the resident falling. Wheelchair cushion on chair ying, staff to monitor skin daily kly with skin inspection. kly Pressure Wound tock measures 0.3 centimeter .3 cm. width. The center of the lange in color and surrounded stageable. ck measures 0.1 cm length by wound bed is dry with no | F 6 | 86 | meeting. Completion date: 3/18/2022 | | |

| 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 night 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 | | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ' | TIPLE CONSTRUCTION NG | СОМ | E SURVEY IPLETED |
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| NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 19 | | | 245507 | B. WING | | | |
| MANKATO, MN 56001 | NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| 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 night buttock (proximal) measures 1.0 cm length by 1.4 cm width. 100% slough tissue. Unstageable or midth. 100% slough tissue. Unstageable left buttock (distal) 0.8 cm length by 0.5 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 1.3 cm length by 0.9 cm width. 100% slough tissue. Unstageable. left buttock measures 1.8 cm length by 0.9 cm width. 100% slough tissue. Unstageable. left buttock measures 1.8 cm length by 0.9 cm width. 100% slough tissue. Unstageable. left buttock measures 1.8 cm length by 0.9 cm width. 100% slough tissue. Unstageable. left buttock measures 1.8 cm length by 0.9 cm width. 100% slough tissue. Unstageable of the right distal buttock sand 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 | HILLCRE | EST CARE & REHABII | LITATION CENTER | | | | |
| 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 | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFI) | (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF |) BE | COMPLETION |
| 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 | F 686 | right buttook cm length by 1.2 cm (necrotic/dead) tiss. Unstageable. left buttook 0.5 cm width. 100% treatment. Unstage 1/2/22 with measur 1.0 cm in width) 2/9/22-right buttook length by 1.4 cm wi Unstageable right buttook cm width. 100% slo left buttook 0.9 cm width. 100% The weekly Pressur 10/20/21 to 2/9/22, unstageable PU to newly unstageable PU to newly unstageable this time. The right from granulation tis increased in size from unity length by 0.3 cm. where we width. The right in size from 0.5 cm cm length by 0.6 cm increased in size frow width to 1.8 cm lend During review of the it was noted the about the curren 2/16/22, included and the six of the six of the curren 2/16/22, included and the six of | ck (proximal) measures 1.7 In width. 100% slough slough tue. Pain with treatment. It measures 1.2 cm length by It slough tissue. Pain with lable. (newly acquired on rements of 0.7 cm length by It (proximal) measures 1.0 cm It (distal) 0.8 cm length by 0.6 It (distal) 0.8 cm length by 0.6 It (distal) 0.8 cm length by It ssue. Unstageable. In length by It slough tissue. Unstageable. In length distal buttocks and a It is left buttock during It buttock (proximal) PU went It is left buttock during It is left buttock during It is left buttock during It is left buttock (distal) PU increase It length by 0.6 cm width to 0.8 In width. The left buttock It is le | F 6 | 86 | | |

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| F 686 | an order to reposition bed/chair to previous chair sitting to 2 hours of the care R28 as having at ristered to history of keratosis, cellulitiss (resolved on 3/17/2 use perfume soaps wheelchair, weekly keep skin clean and inspect skin daily a nurse, weekly skin and treatment crea (PRN). The care plateration in mobility knee pain, CHF and listed; independent integrity, routine preand powder, ultraformattress to bed and indicated R28 is incompared to transfers and conting R28 has a history of Staff to remind R28 Interventions listed for assist when trar good peri cares, en monitor skin integrity. The comprehension R28's PU's on the binterventions per please of the nursical dated 2/9/22, indication and with all transfers and wit | on R28 at least every 2 hours ent pressure to bottom. Limit urs. plan dated 2/16/22, identified sk alteration in skin integrity venous statis ulcer, skin and open area to right buttock 1). Interventions listed; do not a, wheelchair cushion on pressure would assessments, d dry, encourage mobility, and report concerns to charge assessments by licensed staff in interventions as needed an indicated R28 has y related to osteoarthritis, left d fibromyalgia. Interventions with bed mobility, monitor skin eventive skin cares with lotion am pressure redistribution d wheelchair. The care plan dependent with toileting and nent of bowel and bladder. If sitting on the toilet for hours. If every 15 minutes to finish, is resident was educated to call insferring to toilet, encourage accourage adequate fluids and thy. The care plan did not include outtocks nor the repositioning | F | 686 | | | |

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| F 686 | bathroom stay with for safety (related to make sure the reside hours of 10:00 p.m.) The NA care sheet physicians orders for the NA has a street physicians or the NA has a street p | bed. When finding R28 in the her until finished. Check R28 of fall risk) every 1 hour to dent is sleeping during the to 6:00 a.m. it did not reflect the current or repositioning. ourly safety checks from 10:00 p.m. to 6:00 a.m.) for expositioning. The checks hereabouts of where R28 was ations on 2/15/22 and 2/16/22, 0:30 a.m. (2 1/2 hrs) and is 30 p.m. (2 1/2 hrs). R28 was oning or off-loading. During exposerved to walk by the exposerved to walk by the scant amount of brownish existings. R28 was observed to right buttock and 1 PU on the RN-D cleansed the wounds omplained of pain. The PU's RN-D, at this time. Imal) 1.1 cm length by 1.7 cm ofth (increase in size from most ints on 2/9/22) I) 1.3 cm length by 0.7 cm ofth (increase in size from most ints on 2/9/22) | F6 | 86 | | |

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| | | 245507 | B. WING | | | C 1 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| HILLCRE | EST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | reddened. Triad hydexudate) wound drepU's R28 stated siduring the day and as she can. R28 hamattress on her becushion on her chaiwith RN-D, stated swound care for R28 wounds had improven urse practitioner pweeks. Continued observationament a.m. to 12:15 p.m. In off-loaded. R28 remslouched in her who observed to go in a administering medicanswering call lite as staff also walked by without offering to revaluation and treat buttocks. The note small area starting which is new from lift frustration that wou having pain with wow with treatments. The measures 1.2 cm b smaller area next to 0.3 cm by 0.1 cm. The state of the sta | rements on 2/9/22. 3 pressure ulcers was slightly drophilic (absorbs wound essing was applied to all 3 he tries to off-load, lay down stay off of her bottom as much d a pressure reduction d and a pressure reduction ir. Interview during this time he usually does not provide and was unsure if the red or not, but did indicate the rovides wound care every 2 tions on 2/17/22, from 9:00 R28 was not repositioned or nained in her room and eelchair. Facility staff were | F 68 | 36 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | | E SURVEY PLETED |
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| | | 245507 | B. WING | | 1 | C 18/2022 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 021 | 10/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 686 | slough and unstage measures 1.0 cm b Unstageable The prencourage R28 to a hour in the wheelch to encourage increa multivitamin. Occup wheelchair position Review of a physici 2/9/22, indicated Fevaluation and trea buttocks. The note there has been no inher bottom and consitting. The progress continues to have a buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right proximal buttock wounds, but do not stay on. The right distal buttock by 0.6 cm by 0.1 cm size. There is no on Unstageable and surface and surface would be unstageable. Surror Treatment of medical day (BID) and as not Make sure resident toilet seat is recommended. | cable The left buttocks by 0.6 cm. No drainage. Togress note indicated to avoid sitting for longer than 1 air without repositioning and ased protein at meals and pational therapy (OT) for ing and overlay to bed. The wound care the the resident indicated R28 was seen for wound care the therapy and the resident in the wounds on tinues to have pain when so note indicated R28 and dressing application over here the resident indicates they buttocks ulceration measures by 0.1 cm. The wound has one odor or drainage. The wound has one odor or drainage. The wound has increased in lor and scant drainage. The wound has increased in lor and scant drainage. The wound has increased in lor and scant drainage. The wound has increased in lor and scant drainage. The wound has increased in lor and scant drainage. The wound has increased in size. The wound has increased in size where we wound has increased in size where we wound h | F 686 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245507 | B. WING | | 1 | C 18/2022 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 021 | 10/2022 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY) |) BE | (X5) COMPLETION DATE | |
| F 686 | Interview on 2/16/2: indicated R28's PU not seem to get bet be turned and report of seem to get bet be turned and report of seem to get bet be turned and report of seem to get bet under the was repositioning or off-hour. RN-D further assistance with repwill often attempt to linterview on 2/16/2: R28 will at times rewhen offered. NA-D repositioned or off-stated he was not a or repositioned eveindicated when staff residents reposition. Interview on 2/16/2 medication assistant follows the NA's calloff-loading R28. The care directed staff hours PRN. TMA-A independently transmedures assistance. Interview on 2/16/2: (NM)-D indicated Report of the providing hourly saft the staff were just whith NA's we providing hourly saft the staff were just whith NA's we providing hourly saft the staff were just whith NA's we providing hourly saft the staff were just whith NA's we providing hourly saft the staff were just whith NA's we providing hourly saft the staff were just whith NA's we provide the | 2, at 11:15 a.m., RN-D 's were re-occurring and do ter. RN-D stated R28 should sitioned every 2 hours, but not aware of any order for loading the resident every 1 indicated R28 requires ositioning and transferring, but o transfer self. 2, at 11:30 a.m. NA-D stated fuse to off-load or lay down o indicated R28 should be oaded every 2 hours. NA-D aware of R28 being off-loaded ry 1 hour. NA-D further if get busy, it is difficult to get ned timely. 22, at 1:30 p.m. trained ant (TMA)-A indicated she re sheet for repositioning and AA-A confirmed the NA plan of to reposition R28 every 2-3 afurther indicated R28 will after self, but verified R28 be. 2, at 3:30 p.m. nurse manager 28's care plan should have flect the current physician ning. NM-D indicated she ere repositioning R28 while fety checks, but later verified disualizing R28's whereabouts and weekly skin assessments mplete by the licensed nursing and the NP was monitoring and | F 68 | 36 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | | | COMPLETED | | | |
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| | | 245507 | B. WING _ | | 1 | C 18/2022 | |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | | |
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| F 686 | Interview on 2/16/2: nurse consultant (N (DON) confirmed R | ge 25 2, at 3:00 p.m. the facility IC)-A and director of nursing 28's plan of care should have flect the current physicians | F 68 | 36 | | | |
| | orders of reposition to encourage sitting NC-A stated the fa- trained on how to m | ing (at least every 2 hours and for no more than an 1 hour). cility nursing staff had been nanage PU's and implement dividualized care plan | | | | | |
| | Wound Manageme upon a significant of as a development of impairment, the follitissue tolerance obside completed, to dimplement intervent and to promote hear update the NA care education with the ropocument refusals | y policy Skin Assessment and nt dated 7/2018, included hange in a residents skin such of a pressure related skin owing actions will be taken;; a servation and evaluation will etermine skin tolerance and tions to prevent breakdown aling, update the plan of care, sheets and complete resident including risk/benefits. in the medical record. ocedures/Pharmacist/Records b)(1)-(3) | F 75 | 55 | | 3/18/22 | |
| | drugs and biologica them under an agre §483.70(g). The fa personnel to admin | ovide routine and emergency lls to its residents, or obtain | | | | | |
| | pharmaceutical ser | ures. A facility must provide vices (including procedures urate acquiring, receiving, | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| | | 245507 | B. WING | | C 02/18/2022 | |
| NAME OF E | PROVIDER OR SUPPLIER | 2.000. | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/10/2022 | |
| NAME OF F | -NOVIDEN ON SUFFLIEN | | | | | |
| HILLCRE | ST CARE & REHABII | ITATION CENTER | | 714 SOUTHBEND AVENUE | | |
| | | | | MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | BE COMPLÉTION | | |
| F 755 | | ge 26 ministering of all drugs and | F 7 | 55 | | |
| | | the needs of each resident. | | | | |
| | | Consultation. The facility ain the services of a licensed | | | | |
| | | des consultation on all ision of pharmacy services in | | | | |
| | | olishes a system of records of ion of all controlled drugs in nable an accurate | | | | |
| | order and that an acis maintained and p | rmines that drug records are in ecount of all controlled drugs eriodically reconciled. NT is not met as evidenced | | | | |
| | Based on observate review, the facility for routine reconciliation | ion, interview and document ailed to ensure a system for n of controlled substances 1 emergency kit (E-Kit) to ss/diversion. | | Plan of Correction—755 Pharmac Please accept the following as the facility's credible allegation of comp This Plan of Correction does not constitute any admission of guilt or by the facility and is submitted only | oliance. | |
| | Findings include: | | | response to the regulatory requirer How corrective action will be taken | nents. | |
| | medication storage (NM)-D. Located wi room was a portabl the facility E-Kit. Th tackle box that was colored tab. The tacinjectable lorazepar medication/controlled. | p.m., a tour of the North room with nurse manager thin the medication storage e refrigerator that contained e E-Kit consisted of a small secured with a pull away ckle box contained 2 vials of m (an anti-anxiety ed substance). Review of the nt in the Narcotic bound | | those affected by the alleged defici practice: ¿The facility has initiated a count be each shift for E-Kit Ativan. How will the facility identify other rehaving the potential to be affected same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. | ent etween sidents by the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245507 | B. WING | | l | 0 |
| NAME OF F | PROVIDER OR SUPPLIER | 243307 | D. WING_ | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 18/2022 |
| NAME OF F | ROVIDER OR SUPPLIER | | | | | |
| HILLCREST CARE & REHABILITATION CENTER | | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | | |
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| F 755 | Continued From pa | ge 27 | f 75 | 55 | | |
| | book,did not identify | / lorazepam had ever been / staff, to identify or account | | The measures the facility will take or systems the facility will alter to ensure the problem will be corrected and will no occur: | | |
| | confirmed staff were the E-Kit controlled she did not understa | on 5/12/21, at 11:00 a.m. e not periodically reconciling substances. NM-D indicated and why reconciling of the | | The facility has re-educated nu and TMAs on the new Emergency process. | Kit | |
| | staff had access to | done, because only licensed the medication room. | | Quality Assurance plans to monitor performance to make sure that corrections are achieved and are | facility | |
| | | e not reconciling the E-Kit es. | | permanent: DON or Designee will conduct dai audits for 2 weeks as needed to me för compliance. | | |
| | facility nurse consul had been trained or | 2, at 12:00 p.m. with the tant (NC)-A indicated all staff the policy for reconciliation of d be aware of the process. | | | | |
| | Process (undated) that all controlled suevery shift, including E-Kit (contains vials must remain under numbered tag on it. count is correct must sign the controlled of meds have been count and E-kit. | y Controlled Drug Count indicates it is the expectation ubstances must be counted g the cubix and refrigerator of lorazepam) The E-Kit double lock plus have a A visual check to ensure st take place each shift, and drug count log acknowledging bunted with cubex, refrigerator | | | | |
| | Drug Regimen Revi CFR(s): 483.45(c)(| iew, Report Irregular, Act On 1)(2)(4)(5) | F 7 | 56 | | 3/18/22 |
| | | drug regimen of each resident t least once a month by a | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l ` ′ | PLE CONSTRUCTION 3 | (X3) DATE SURVEY COMPLETED | | |
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| | | 245507 | B. WING | | C | |
| NAME OF I | PROVIDER OR SUPPLIER | 240007 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/18 | 8/2022 |
| NAIVIL OF F | -NOVIDEN ON SUFFLIEN | | | 714 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | Continued From pa | ge 28 | F 75 | 5 | | |
| | §483.45(c)(2) This of the resident's me | review must include a review edical chart. | | | | |
| | irregularities to the facility's medical dir and these reports in (i) Irregularities income drug that meets the (d) of this section for (ii) Any irregularities during this review in separate, written reattending physician director and director and director minimum, the resid and the irregularity (iii) The attending president's medical rirregularity has bee action has been take be no change in the | charmacist must report any attending physician and the ector and director of nursing, nust be acted upon. Itude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. It is noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a sent's name, the relevant drug, the pharmacist identified. The pharmacist identified on reviewed and what, if any, then to address it. If there is to be medication, the attending ocument his or her rationale in cal record. | | | | |
| | maintain policies ar drug regimen review limited to, time fram the process and stewhen he or she ide requires urgent action. This REQUIREMENT by: Based on interview facility failed to ensure recommendations with the process and stewhen he or she ide requires urgent actions. | facility must develop and and procedures for the monthly we that include, but are not ness for the different steps in the pharmacist must take not to protect the resident. In any or the different steps in the pharmacist must take not to protect the resident. In any or the different steps in the pharmacist were acted upon, addressed, the medical record for 1 of 5 | | Plan of Correction□755 Pharmacy Please accept the following as the facility's credible allegation of comp This Plan of Correction does not | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 245507 | B. WING | | | 02/° | 18/2022 |
| | PROVIDER OR SUPPLIER EST CARE & REHABII | LITATION CENTER | | 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTHBEND AVENUE IANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | residents (R17) rev medication use. Findings include: R17's admission Mi assessment dated moderate cognitive required extensive transfers, dressing, hygiene. Diagnose disease (chronic and disorder causes stiff movement), diabeted depression, and ag The MDS indicated medication, non-me insulin, antidepress R17's care plan dat for psychotropic drureaction] r/t [related medication related with daily Cymbalta depression) use, in administer medication administer medication reviewed by MD/PA mood and behavior document mood state occurrence. R17's Medication R indicated an order fanxiety and sertralin depressive disorder | inimum Data Set (MDS) 12/1/21, identified R17 had impairment, mild depression, assist with bed mobility, toilet use, and personal is included Parkinson's id progressive movement finess or slowing of es, anxiety disorder, e-related physical disability. R17 received scheduled pain edication interventions for pain, ant, and opioids. ed 2/16/22, indicated potential ag ADR's [adverse drug to] daily use of psychotropic to diagnosis of depression (medication used for terventions included ion as ordered monitoring for ected ADR's to MD/PA risician assistant], medications and pharmacist, be alert to all changes, and monitor and ate/behaviors upon eview Report printed 2/18/22, for buspirone 10 mg tablet for the 100 mg related to major | F 7 | 756 | constitute any admission of guilt or by the facility and is submitted only response to the regulatory requirem How corrective action will be taken those affected by the alleged deficie practice: ¿The facility has reviewed the pharman R17 sprovider, and updated the resident's care plan to align with the current provider recomendations. How will the facility identify other rehaving the potential to be affected by 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 alter to ensure the problem will be corrected and wo occur: The facility has re-educated numanagers on reviewing pharmacy recommendations with the provider facility policy The facility has completed all of the outstanding pharmacy recommendation and updated care plans. Quality Assurance plans to monitor performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct dai audits for 2 weeks as needed to more it is completed and are permanent. Completion date: 3/18/2022 | in hents. for ent macy acy with established by the established facility | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245507 | B. WING | | 1 | 0 |
| NAME OF F | PROVIDER OR SUPPLIER | 240001 | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 18/2022 |
| | | | | 714 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE . | (X5) COMPLETION DATE |
| F 756 | identified R17's me reviewed by the cor indicated R17 contil buspirone, ensure the PCC [point click car monitoring. The confidence of Pharmacist's Medicand 2/15/22, indicar reissued from 12/2 continued on sertral indicated to ensure PCC [point click car monitoring. R17's medical reconevidence nursing recommendation 2/15/22, for behavior 2/15/22, for behavior the director of nursing recommendations with the director of nursing recommendation of the recommendation of the recommendation for the recommendation for the penalty of | ocument dated 12/14/21, dication regimen had been resulting pharmacist (CP), and nued on sertraline and he following was completed: re] orders for behavior presponding Consultant reation Review dated 1/11/22, red recommendations were 1, and the CP indicated R17 line and buspirone, and again the following was completed: re] orders for behavior red was reviewed and lacked reviewed and/or acted upon the rest at a monthly view was completed of all at the facility. The CP indicated were sent monthly via email to respect to within a month. The CP month he reviewed the status at the status and verified completion, one were reissued if not processed within the timeframe or or within a month. The CP month he reviewed the status at the status and verified completion, one were reissued if not processed of the CP was expected. The CP was expected. The CP was expected. The CP was expected. | F 7 | , | | |
| | recommendations \ | hly the residents pending were discussed with the DON. ember through December, | | | | |

| NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER RAWS OF PROVIDER OR SUPPLIER MANKATO, MN 56001 C 02/18/2022 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE 714 SOUTHBEND AVENUE | | | 245507 | B. WING | | | |
| MANKATO, MN 56001 | | | | | | 021 | 10/2022 |
| | THELONE | LOT OAKE & KENADII | ENATION CENTER | | MANKATO, MN 56001 | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE | PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE | (X5) COMPLETION DATE |
| F 756 Continued From page 31 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 to the nurse managers. The DON werified 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' is 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 | F 756 | pharmacy recommelow at 25%, and incompletion goal rate On 2/18/22, at 10:5 (DON), stated she is the CP with resident recommendations a monthly she distributed mecommendations of 12/15/22, and the recommendations of 12/15/22, and the recommendations of 12/15/22, and the recommendations she was aware of the recommendations she was aware of the recommendations. She was aware of the recommendations of 12/18/22, at 11:0 confirmed the nurse recommendations of 13/18/22, at 11:0 confirmed the nurse recommendat | endation completion rate was dicated 75% was the e. 88 a.m. the director of nursing received a monthly email from at's pharmacy and the DON indicated uted the CP pharmacy nursing to the nurse managers. The icility received R17's CP on 12/14/21, 1/11/22, and ecommendations had not the DON indicated she managers to have addressed at CP monthly. The DON further indicated the 25%, pharmacy completion of further indicated she the recommendations acted. 10 a.m. the administrator are managers received the CP and verified the consultant animendations had not been. 11 Gradual Dose Reductions, ted: 12 toms related to dementia: considered clinically inconsidered clinically arget symptoms returned or most recent attempt at a GDR ND additional attempted dose | | 56 | | |

| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | , · | | LE CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | 240007 | D. WIING | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 18/2022 |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | | 14 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | behavior. | ge 32 or increase distressed dure was requested regarding | F 7 | 756 | | | |
| F 880 SS=D | pharmacy recomme Infection Prevention | endations and not received. n & Control | F 8 | 380 | | | 3/18/22 |
| | infection prevention designed to provide comfortable enviror | tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable | | | | | |
| | program. The facility must es | n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements: | | | | | |
| | reporting, investigate and communicable staff, volunteers, vis providing services userrangement based | I upon the facility assessment ng to §483.70(e) and following | | | | | |
| | procedures for the put are not limited to (i) A system of surversible communications. | eillance designed to identify able diseases or ey can spread to other | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | (X3) DATE SURVEY COMPLETED | |
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| | | 245507 | B. WING | | C 02/18/2022 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 02/10/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLÉTION |
| F 880 | (ii) When and to who communicable diserported; (iii) Standard and the to be followed to prediv) When and how it resident; including the involved, and (B) A requirement the least restrictive posticumstances. (v) The circumstance must prohibit employed in the involved in | ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. Indie, store, process, and the taken by the facility. | F 880 | Plan of Correction□F880 Please accept the following as the facility's credible allegation of comp This Plan of Correction does not | liance. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|--|----------------------------|
| | | 245507 | B. WING | | 02/1 |) 8/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 02/ | 012022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5) COMPLETION DATE |
| F 880 | R50) symptomatic COVID-19. The far implementation of por mitigate the risk potential to affect a within the facility. Findings include: During entrance cop.m., the administration of pormation of pormatical of por | and known to be positive with cility's failure to ensure proper precautions to prevent of COVID-19 outbreak had the II other 63 residents and staff after identified three residents (Infirmed to have COVID-19 and stact precautions, all three in 500 unit of facility. In positive COVID-19 on 2/7/22, identified dementia with isease causing problems in the positive COVID-19 on 2/7/22, matic throughout isolation ons on 2/18/22. In positive COVID-19 on 2/7/22, matic throughout isolation ons on 2/18/22. In positive COVID-19 on 2/7/22, matic throughout isolation on an admission face in the positive COVID-19 on 2/7/22, matic throughout isolation on an admission face in the positive content of the interpretation of 2/9/22-2/14/22. In second 2/18/22, as R50 no | F 880 | constitute any admission of guilt of by the facility and is submitted only response to the regulatory required. How corrective action will be taken those affected by the alleged defining practice: ¿No residents are currently on transmission based precautions. How will the facility identify other of the having the potential to be affected same deficient practice? All residents have the potential to affected by the deficient practice. The measures the facility will alter to ensure the problem will be corrected and occur: The facility has re-educated in and dietary staff on Donning/Doffi and having the door closed for Corresidents. Quality Assurance plans to monitor performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits for 2 weeks as needed to in fight compliance. Directed Plan of Correction 1. Address how corrective action accomplished for those residents be affected by the deficient practica. The facility currently does not any residents on transmission bas precautions. Therefore no addition residents are currently being affect the deficient practice. 2. Address how the facility will increase the deficient practice. | y in ments. In for cient sidents by the coresure that will not ursing ng PPE wid + or facility to daily nonitor in will be found to be, have seed analysted by | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------|--|-------------------------------|--------------------|
| | | 245507 | B. WING | | | С |
| | | 245507 | D. WING _ | | 02/ | 18/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HILL CRE | CT CADE O DELIADII | ITATION CENTER | | 714 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABIL | LITATION CENTER | | MANKATO, MN 56001 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPRO | | COMPLETION DATE |
| | | | | DEFICIENCY) | | |
| F 880 | Continued From pa | ge 35 | F 88 | 30 | | |
| | | 14 and R50), had their room | | other resident having the potentia | to be | |
| | doors open wide. R14 and R50's room doors had droplet/contact precautions signs posted outside. | | | affected by the same practice. | 10 00 | |
| | | | | a. Re-education of staff as noted | l above | |
| | a. op. oo oo | ramania algina pastan antanas. | | Root cause analysis □ See attachn | | |
| | Multiple observation | ns of room doors being open | | IP/DON shall complete the followi | | |
| | | nile on droplet/contact | | " Grouping of residents, or coh- | | |
| | precautions was ob | served during survey. The | | should be done when possible to | separate | |
| | duration of time roo | m doors were open was | | residents with an infectious diseas | se | |
| | | observed to be in and/or | | (positive residents) from residents | | |
| | coming out of room | s at the following times; | | are not affected. Plans to cohort s | | |
| | | | | be carefully established in advance | | |
| | R14 | | | should be centered on implement | ation of | |
| | 2/14/22 at 6:41 p.m. | | | infection control practices. | | |
| | 2/15/22 at 7:19 a.m | | | | | |
| | 2/15/22 at 2:51 p.m | | | " Dedicate a unit or part of a un | | |
| | 2/16/22 at 7:40 a.m | | | care location for residents with dis | | |
| | 2/16/22 at 8:42 a.m 2/16/22 at 11:13 a.r | | | including those with or without cur | | |
| | 2/16/22 at 11:13 a.i 2/16/22 at 12:53 p.r | | | symptoms of illness. Anticipate was close off units to prevent spread of | | |
| | 2/10/22 at 12.00 p.i | 11. | | from ill residents to non-ill residen | | |
| | R50 | | | for symptomatic COVID-19, recov | | |
| | | . prior to unknown nurse aide | | COVID-19 residents, non-COVID- | | |
| | | rotective equipment (PPE) | | suspected residents). | | |
| | and entering room t | | | | | |
| | 2/15/22 at 2:55 p.m | | | " Confine symptomatic resident | s and | |
| | 02/16/22 at 7:20 a.r | n. | | exposed roommates to their room | s. If | |
| | 02/16/22 at 8:42 a.r | n. | | they must leave their room, ensur | e the | |
| | | | | resident is wearing a mask. | | |
| | | 2/16/22, at 7:20 a.m. | | | | |
| | | N)-C was asked about | | " Provide dedicated equipment | for | |
| | | ID-19 and room doors being | | areas, as able. | | |
| | • | ted doors should be kept | | | | |
| | closed. | | | All noted above are currently part | | |
| | Desired : | 0/40/00 -1.7.07 | | facility □s policies and procedures | Staff | |
| | During interview on | 2/16/22, at 7:37 a.m. RN-B | | will be re-educated on Covid 19 | | |
| | | with COVID-19 and on | | policy/procedure. | 4 - 41 - | |
| | | ve rooms doors closed. | | The facility will provide education | | |
| | | culty with keeping R14's door fall risk and was known to try | | residents regarding Transmission precautions. | pased | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|-----|--|--------------------|---------|
| | | 0.45507 | D WING | | | | C |
| | | 245507 | B. WING | | | 02/ | 18/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | | 14 SOUTHBEND AVENUE IANKATO, MN 56001 | | |
| (V4) ID | SLIMMARY STA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL | | BE | COMPLETION DATE | |
| F 880 | Continued From pa | ge 36 | F 8 | 80 | | | |
| | RN-B indicated she | ently to come out of room. has provided verbal f on keeping doors to isolation times. | | | Completion date: 3/18/2022 | | |
| | Control Program, defacets of infection propossible infections, existing infections or disand ensuring that the techniques and proappropriate isolation necessary. Policy of | Infection Prevention and ated 8/17, indicated: Important prevention include; identifying or potential complications of instituting measures to avoid assemination, educating staff ney adhere to proper cedures, implementing in precautions when did not indicate anything COVID-19 infection control and | | | Date Resident Covid Vaccine Current Action Notes Initial Audit for POC is uploaded under de Audit 880 | | |
| F 883 SS=D | | mococcal Immunizations 1)(2) | F 8 | 883 | | | 3/18/22 |
| | immunizations §483.80(d)(1) Influe policies and proced (i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization Octobannually, unless the contraindicated or timmunized during the contraindicated or the timmunized for the contraindicated or the contraindicated or the timmunized during the contraindicated or the timmunized during the contraindicated or the timmunized during the timmunized during the time. | enza. The facility must develop ures to ensure that- ne influenza immunization, e resident's representative regarding the benefits and is of the immunization; offered an influenza per 1 through March 31 e immunization is medically the resident has already been this time period; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245507 | B. WING | | 1 | C 40/0000 |
| NAME OF F | DOMED OF CHERNIER | 243307 | B. WIII - | | 02/ | 18/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 883 | following: (A) That the resider was provided educated and potential side elimmunization; and (B) That the resider immunization or didifferent immunization due to refusal. §483.80(d)(2) Pneumust develop policit that- (i) Before offering the immunization, each representative recebenefits and potent immunization; (ii) Each resident is immunization, unless medically contrained already been immunization or that the opportunity (iv) The resident or has the opportunity (iv) The resident or has the opportunity (iv) The resident or has the opportunity (iv) That the resider was provided educated and potential side elimmunization; and (B) That the resider pneumococcal immunication or This REQUIREMENTS. | nt or resident's representative ation regarding the benefits offects of influenza at not receive the influenza at not receive the influenza at medical contraindications or a medical disease. The facility resident or the resident's ives education regarding the ial side effects of the a pneumococcal as the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and redical record includes indicates, at a minimum, the ant or resident's representative ation regarding the benefits affects of pneumococcal ant either received the nunization or did not receive immunization due to medical refusal. | F 8 | | | |
| | | and document review the vide evidence pneumococcal | | Plan of Correction ☐ F883 Please accept the following as the | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | | E CONSTRUCTION | | SURVEY PLETED |
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| | | | 71. 50125 | | | | |
| | | 245507 | B. WING | | | 02/1 | 18/2022 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HILLORI | EST CARE & REHABII | ITATION CENTER | | 7 | 14 SOUTHBEND AVENUE | | |
| HILLOIN | 231 CARL & REHADII | ENATION CENTER | | N | IANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 883 | vaccinations were u (R51) reviewed for Findings include: R51's admission M assessment dated date of 1/13/22. The MDS further in cognition, was 68 y complex health confor pneumococcal value (R51's admission M 1/20/22, identified canemia (a condition renal insufficiency (function of kidneys) (CVA; a condition the brain/stroke), and retain/stroke), and retain/stroke), and retain/stroke (R51's medianes poor full the properties of pneumocompleted. RNC of further discuss vace verbal consent from pneumococcal vace interview on 2/17/22. Facility policy titled revised 11/4/19, including policy titled revised 11/4 | inimum Data Set (MDS) 1/22, indicated an admission dicated R51 had intact ears of age, had medically iditions, and was not assessed vaccination status. DS assessment, dated diagnoses to include; cancer, n of lack of red blood cells), a condition that causes poor n, cerebrovascular accident hat causes damage to the espiratory failure (a condition nction of the lungs). Dn 2/17/22, at approximately hal nurse consultant (RNC) edical record did not include ococcal vaccinations had been ontacted R51's spouse to cination status. RNC received in R51's spouse to administer cine upon completion of 2. Pneumococcal Vaccine, cluded: the facility (within 5 days), all | F8 | 883 | facility's credible allegation of comp. This Plan of Correction does not constitute any admission of guilt or by the facility and is submitted only response to the regulatory requiren How corrective action will be taken those affected by the alleged deficipractice: ¿R51 has received the pneumocod vaccine. How will the facility identify other rehaving the potential to be affected by 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 of any residents who did not receive pneumo vaccine. All residents who qualify, and had not received the vacualify, and had not received the vacuality, and had not received the vaccine. The measures the facility will alter to ensure the problem will be corrected and voccur: The facility has re-educated numanagers the pneumococcal vaccipolicy. Quality Assurance plans to monitor performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct dai audits for 2 weeks as needed to me figree completion date: 3/18/2022 | liability in nents. for ent cal sidents by the e e e audit e the or accine or ure that vill not rse ne facility | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER | | ` ′ | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--|--|---------------------|---|--------|-------------------------------|--|
| | 245507 | B. WING | | | C / 18/2022 | |
| NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABIL | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | , 52 | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| vaccinated or the vaccinated. Pneumococcal vacc | e resident has already been | f 8 | 83 | | | |
| F 887 SS=D COVID-19 Immuniz CFR(s): 483.80(d)(3) §483.80(d) (3) COV LTC facility must de and procedures to e (i) When COVID-19 facility, each reside is offered the COVI immunization is me resident or staff me immunized; (ii) Before offering (members are provious regarding the beneficated associated with the COVID-19 vaccious) In situations who requires multiple do resident representate provided with current additional doses, in benefits or risks and associated with the requesting consent additional doses; (v) The resident or | All Covider of the co | F8 | 87 | | 3/18/22 | |

| AND DIAN OF CORRECTION IDENTIFICATION NUMBER | | JLTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|--|--------------------|---|---|-----------------|----------------------------|
| | | 245507 | B. WING | | | 02/1 | C 18/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, 0 714 SOUTHBEND A MANKATO, MN | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH COI | DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 887 | Final Rule - 6 [CMs requirements of 48 under IFC-5 [CMs and (vi) The resident's documentation that the following: (A) That the reside was provided educe benefits and potent COVID-19 vaccine (B) Each dose of Coto the resident; or (C) If the resident; or (C) If the resident of vaccine due to mecontraindications of (vii) The facility mate to staff COVID-19 includes at a minin (A) That staff were the benefits and possociated with CO (B) Staff were offer information on obtain (C) The COVID-19 related information Disease Control ar Healthcare Safety This REQUIREME by: Based on interview facility failed to ensure the control of the covider of the c | ge their decision; re not subject to the Interim S-3415-IFC], must comply with 3.80(d)(3)(v) that apply to staff 3414-IFC] medical record includes t indicates, at a minimum, nt or resident representative ation regarding the tial risks associated with ; and COVID-19 vaccine administered did not receive the COVID-19 dical r refusal; and intains documentation related vaccination that num, the following: provided education regarding otential risks DVID-19 vaccine; red the COVID-19 vaccine or aining COVID-19 vaccine; and vaccine status of staff and as indicated by the Centers for nd Prevention's National | F 8 | Plan of Corre Please accep facility's credi This Plan of Constitute any by the facility | ection□F887 of the following as the lible allegation of comp Correction does not y admission of guilt or and is submitted only the regulatory requirements. | liability in | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | SURVEY PLETED |
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| | | 245507 | B. WING | | | 00/ | · . |
| NAME OF F | DOVIDED OD CUDDUED | 243307 | B: *** | | TREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 18/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | | | |
| HILLCRE | ST CARE & REHABIL | LITATION CENTER | | | 14 SOUTHBEND AVENUE | | |
| | | | | M | IANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 887 | Continued From pa | ge 41 | , F8 | 87 | | | |
| | 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 | | | | How corrective action will be taken those affected by the alleged defici practice: ¿All residents have been reassessed. | ent | |
| | Consent Form," sig representative, and | ned by R41, her facility nursing staff on 7/2/21, | | | re-offered the Covid 19 vaccine if the have not received. It. How will the facility identify other re | ney sidents | |
| | Furthermore, R41's documentation R41 | VID-19 vaccination. medical record lacked and/or her representative | | | having the potential to be affected I same deficient practice? Any unvaccinated residents are at | | |
| | after admission, no | OVID-19 vaccine upon and/or rwere provided education nd/or benefits of the vaccine. | | | the deficient practice. The measures the facility will take of systems the facility will alter to ensure the systems the facility will alter to ensure the systems. | | |
| | R41's medical reco | rd lacked documentation that was administered or | | | the problem will be corrected and voccur: | vill not | |
| | contraindicated. | | | | The facility has re-educated nu managers on offering the Covid 19 vaccine to all new admissions | | |
| | | DS assessment dated | | | vaccine to all flew autilissions | | |
| | | R49 was admitted to the facility | | | Quality Assurance plans to monitor performance to make sure that corrections are achieved and are | facility | |
| | Consent Form," uns | esident Vaccine Administration signed and undated by R49, | | | permanent: DON or Designee will conduct dai | | |
| | not address COVID | and facility nursing staff; did 0-19 vaccination. Furthermore, | | | audits for 2 weeks as needed to me figr compliance. | onitor | |
| | and/or his represen COVID-19 vaccine | rd lacked documentation R49 tative were offered the upon and/or after admission, | | | Completion date: 3/18/2022 | | |
| | provided education | nis representative were related to the risk and/or sine. R49's medical record | | | | | |
| | | ion that COVID-19 vaccine | | | | | |
| | 2:28 p.m. the region indicated when res | on 2/17/22, at approximately nal nurse consultant (RNC) idents are admitted to facility, representative are provided | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245507 | B. WING | | 1 | C 18/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | 210001 | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| HILLCRE | EST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 887 | facility "Resident Variance and resident and pertussis (Tdap and COVID-19, provaccines, sign and declining of vaccinations conservaccinations and R49 and/or the offered COVID-19 in the offered COVID-19 in the offered covident in | accine Administration Consent ted it is her expectation that er goes through the consent and/or representative, offering the included tetanus, diphtheria, b), pneumococcal, influenza, vide education regarding date forms consenting to or ations, and then administer inted. On 2/17/22 at approximately cated being unaware if R41 ir representatives had been vaccine during admission and to this further. RNC indicated the erview, R41 and R49 had not been offered COVID-19 indicated nursing staff will and the encorrection of COVID-19 vaccine. It is assessment dated R51 admitted to the facility on assessment dated R51 admitted to the facility on accived first dose on 1/12/22. | F 88 | 37 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>,</i> | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
| | | 245507 | B. WING | | C 02/18/2022 |
| | PROVIDER OR SUPPLIER | | 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTHBEND AVENUE 1ANKATO, MN 56001 | 02/16/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLÉTION |
| F 887 | after admission nor representative were the risk and/or bendered and the risk and/or bendered and/or lack COVID-19 vaccine. When interviewed of 2:28 p.m. RNC indicated and/or his represense second dose of CO admission or thereafurther. RNC indicatinterview, R51 had been offered second vaccination. RNC in contact R51's represent and the representation of the representation. RNC in contact R51's represent and the representation of the re | OVID-19 vaccine upon and/or that he and/or his a provided education related to efits of the vaccine. R51's ed documentation of contraindications. On 2/17/22, at approximately cated being unaware if R51 tative had any follow-up for VID-19 vaccine during after and needed to check into ated later on 2/17/22, following not had any follow-up nor had dose of COVID-19 indicated nursing staff will sentative for of second dose for COVID-19 vaccination policy dated however only addressed staff. Initary/Comfortable Environ divironmental Conditions ovide a safe, functional, ortable environment for the public. In its not met as evidenced ion and interview, the facility for 103, 201, 216) were maintained in | F 887 | Plan of Correction ☐ Home like Environment Please accept the following as the facility's credible allegation of comp | 3/18/22 |
| | 11 residents (R21, I R13, R213, R59, R9 | sanitary conditions, impacting R264, R1, R55, R46, R57, 9, R4). In addition, the facility s used in resident resident | | This Plan of Correction does not constitute any admission of guilt or by the facility and is submitted only | liability |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 245507 | B. WING | | | | C 19/2022 |
| NAME OF I | DROVIDER OR SURRUER | 243307 | 5: ******* | | BEET ADDRESS OITY STATE ZID CODE | 02/ | 18/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | | SOUTHBEND AVENUE | | |
| | | | | MA | NKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 921 | Continued From pa | ge 44 | F 92 | 21 | | | |
| | (R3, R32) were kep manner; free of dus | and 417), impacting residents of in a clean and sanitary of and debris. | | l t | response to the regulatory requiren How corrective action will be taken those affected by the alleged defici practice: | for ent | |
| | Findings include: | | | | Housekeeping has deep cleane the effected rooms and done a faci | lity | |
| | | eening on 2/14/22, from 12:30 following observations were | | | audit and cleaned any dirty fans, ce tiles and repainted rusted vents. | eiling | |
| | made: | ollowing observations were | | | Maintenance has either replaced o | - | |
| | | ied by R21: The white toilet | | - 1 | cleaned all of the effected toilets. | | |
| | bowl was heavily st color. | ained with a dark gold, rusty | | | How will the facility identify other re having the potential to be affected be | | |
| | | ied by R1 and R264: An | | | same deficient practice? | by tile | |
| | | of gray dust and debris | | ` | All residents of the facility have the | 9 | |
| | | yer lint was observed in the | | | potential to be affected by the same | | |
| | | ne floor under the window; | | | alleged deficient practice. | | |
| | | ear the window were stained | | | The measures the facility will take o | | |
| | | splatter pattern; the white | | | systems the facility will alter to ensu | | |
| | | vily stained with a dark gold, return air vent in the | | - 1 | the problem will be corrected and w occur: | /III HOL | |
| | | ad gray fuzzy material on the | | ` | Housekeeping has established a । | new | |
| | slats. | g,, | | | checklist, and received training for | | |
| | Room 103, occup | ied by R55: The wall-mount | | | cleaning rooms to ensure all rooms | are | |
| | hand sanitizer dispe | | | | kept appropriately | | |
| | | ied by R46 and R57: The | | | 0 111 4 | | |
| | | ser in the bathroom was | | | Quality Assurance plans to monitor | facility | |
| | | air vent in the bathroom ceiling a significant amount of gray | | | performance to make sure that corrections are achieved and are | | |
| | fuzzy material on th | | | - 1 | permanent: | | |
| | | ied by R13: The return air vent | | ' | Administrator or Designee will con | duct | |
| | | ling was rusty and had a | | | daily audits of identified areas for 2 | | |
| | | of gray fuzzy material on the | | | as needed to monitor f¿r compliand | | |
| | slats. | | | | spot check as part of the QAPI pro | | |
| | | ied by R59 and R213: The | | | Completion date: 3/18/2022 | | |
| | | e bathroom ceiling had a | | | | | |
| | slats. | of gray fuzzy material on the | | | | | |
| | | ied by R9: The white toilet ained with a dark gold, rusty | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | IPLE CONSTRUCTION NG | СОМ | E SURVEY PLETED |
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| | | 245507 | B. WING | | | C 18/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 921 | was rusty and had a fuzzy material on the return air vent in a significant amount slats. There were fi inches by two inchedrain, causing an intedges. Room 201, occup amount of gray dust dryer lint was obsert the floor under the result of the wall behind the brown material; the retail to the wall behind the brown material that matter. During an interview from 1:51 p.m. to 2 stated when housed only mopped down didn't move furnitur bugs, mouse dropp from trees were obsinear the small wind was also a fine layer window sill. Mouse the closet floor. In a the bathroom ceilingray fuzzy material. | r vent in the bathroom ceiling a significant amount of gray be slats. In on the memory care unit, in the ceiling was rusty and had at of gray fuzzy material on the ve tiles, approximately two es, missing from around the regular surface with sharp lied by R4: An excessive than debris resembling thick eved in the return air vent on window. O wing: The wall-mounted he sink was empty; the returning was heavily soiled with gray rim around the hopper (a large isposal of clinical waste) and hopper was splattered with had the appearance of fecal and observation on 2/14/22, the eping cleaned his floor, they the middle of the room, they e or mop under the bed. Dead alow air conditioning unit. There are of dirt and dust on the droppings were observed on addition, the return air vent in ginad a significant amount of | F 92 | 21 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | ING | COMPL | |
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| | | 245507 | B. WING | | | C 02/18/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COI 714 SOUTHBEND AVENUE MANKATO, MN 56001 | DE | 02, 10,2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BI | |
| F 921 | 5 feet in front of a sidirectly toward him. approximately 4 - 5 from the fan toward were heavily soiled. During a telephone a.m., family member visited R4 on 2/13/2 away from the wall droppings and dirtuithe chair had not be under for awhile. Findisappointed in how floor just going dowith a mop and not under R4's bed. Find things that would lapicked it up. During an interview at 12:50 p.m., with nursing (ADON), to environmental conclin addition, in room sanitizer dispenser 111 the paper towel was still empty, both The ADON asked serill them. With per looked through draw of mice. Observed on the window sill a Observed a return a window with an exclust/debris in it. The | mall fan that was blowing Observed strands of dust inches in length blowing out IR3; the blades of the fan with gray fuzzy material. interview on 2/16/22, at 9:06 er (FM)-E stated when she 22, she moved the recliner to sit in it and noticed mouse under it; adding it was obvious een pulled out and mopped E-E stated she had been whousekeepers mopped the own the center of the room mopping under furniture or I-E stated R4 often dropped and under his bed and no one and observation on 2/16/22, the assistant director of gether observed the above terns by going to each room. 103, the wall mount hand was still empty, and in room dispenser in the bathroom in initially observed on 2/14/22. taff to notify housekeeping to mission from R4 in room 201, wers and closet for evidence mouse droppings in a drawer, air vent on the floor below the cessive/heavy amount of gray e ADON admitted the mouse | FS | 921 | | |
| | to residents and sta | essive dust posed a health risk off, and stated she would have oughly clean R4's room and | | | | |

| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | ING | | | E SURVEY PLETED |
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| | | 245507 | B. WING | | | | C 18/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, 2 714 SOUTHBEND AVENUE MANKATO, MN 56001 | IP CODE | 1 027 | 10/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD THE APPROPI | BE | (X5) COMPLETION DATE |
| F 921 | During an interview at 1:36 p.m., togeth environmental servi observed the above going to each room started a list on 2/1 needed to be replace (room 201) to look a droppings had been had been cleaned, below the window we dust and debris, an closet floor. During an interview following the tour of administrator stated rooms came as sor particularly the condicility had problem administrator stated acceptable, and addresidents a sanitary adding "we will take to buring an interview housekeeping superaware of return air we bathrooms and the resident rooms, but ever been cleaned trained housekeeper or tell him about the usually mentioned to the showed new househeep worked with an above the showed with a showed with an above the showed with an above the showed with a sho | and observation on 2/16/22, er with the administrator and ices director (ESD)-A, environmental concerns by ESD-A stated she had 4/22, of stained toilets that ced. Went into R4's room at areas where mouse in seen; the window sill which the return air vent on the floor which was heavily soiled with indicated the mouse droppings on the state of a surprise, dition of the toilets, adding the swith rusty water. The did what he observed was not mitted it was not providing and home-like environment, | FS | 921 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | | E SURVEY PLETED |
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| | | 245507 | B. WING | | | | C 1 8/2022 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, 714 SOUTHBEND AVENUE MANKATO, MN 56001 | ZIP CODE | , <u>, , , , , , , , , , , , , , , , , , </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | CTION SHOULD THE APPROPE | BE | (X5) COMPLETION DATE |
| F 921 | only mopped down stated he had recer about that, adding housekeepers did at them around to ma personal fans in roor room 417 occupied heavy amount of fur room 401, the fan von R3 from about 5 large fan on top of a not in operation. HS housekeepers to not cleaned and take the them cleaned, addiblow dust on reside floor vent in room 1 ceiling tile, bathroof HS-C stated the factor of the replacing the return air vents. During an interviewed discussed environn maintenance assist stated the facility who some things needed adding that the conference in the return air vents. The factor of the replacing the return air vents at the facility who maintenance assist stated | ident stated housekeepers the center of the room, HS-C ntly talked to a housekeeper ne wanted to trust that the a thorough job, but didn't follow ke sure. HS-C was shown oms 401 occupied by R3, and by R32, both which had a zzy gray material on them. In was small, and blowing directly feet away. In room 417, a a dorm size refrigerator was S-C stated he expected office when fans needed to be nem to maintenance to have ng it wasn't good for fans to ents. Together looked at the 01, as well as the stained in vent and rusty toilet bowl; cility was planning to replace if toilets, and he would take g the ceiling tiles and cleaning in on 2/18/22, at 1:46 p.m., nental findings with ESD-A, as old and acknowledged it oreplaced such as toilets, dition of some toilets was not what should be found in a C stated staffing been a challenge given they but admitted some of the going on for a long time (e.g., lid up in vents) and could not ecent shortage of staff. ESD-A | FS | 021 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ELE CONSTRUCTION | | E SURVEY PLETED |
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| | | 245507 | B. WING | | (00/ | |
| NAME OF F | PROVIDER OR SUPPLIER | 243307 | _ | | 02/ | 18/2022 |
| HILLCRE | ST CARE & REHABIL | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 921 | During an interview housekeeper (H)-A mop under beds or furniture. H-A stated housekeepers and a clipboard with reschecked off when did not include pronwere done each day towels. When askee everything, H-A adn remember and did lips a cliptopy titled. | on 2/18/22, at 2 p.m., stated no one had hold her to move and mop under d they were short the job was stressful. H-A had ident rooms listed that she one cleaning a room. The list npts to ensure specific tasks y, such as replacing paper d how she remembered to do nitted there was a lot to her best. | F 92 ⁻ | | | |
| | Residents' rooms, of housekeeping would floors and tabletops would remain alert (droppings) and rep Environmental Servoutlined step by steresident rooms. The mop the floors, e.g. under the bed. | dated August 2013, indicated d clean surfaces such as son a regular basis. Personnel for evidence of rodent activity port such findings to the vices Director. The policy p process for cleaning e policy did not specify how to move furniture and/or to mop | F 929 | 5 | | 3/18/22 |
| | program so that the rodents. This REQUIREMENT by: Based on observate review, the facility for pest control program building. This failure | ain an effective pest control facility is free of pests and on the facility is free of pests and on the facility is not met as evidenced ion, interview, and document alled to implement an effective on to eliminate mice in the eaffected R4, and had the left for the facility of the facil | | Plan of Correction □ Pest free environment Please accept the following as the facility's credible allegation of compl This Plan of Correction does not constitute any admission of guilt or I | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | | E CONSTRUCTION | | SURVEY PLETED |
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| | | 245507 | B. WING | | | 02/ |) 1 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | 210001 | · · | | TREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| | | | | | 14 SOUTHBEND AVENUE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | M | ANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 925 | Continued From pa | ge 50 | F 9 | 25 | by the facility and is submitted only | in | |
| | indings include: | | | | response to the regulatory requiremental How corrective action will be taken | nents. for | |
| | renal disease (rena | uded diabetes, end stage I failure) requiring dialysis (the | | | those affected by the alleged deficient practice: | | |
| | | g toxins from the body), and I precautions for recurrent | | | Guardian pest control reviewed entire facility for pest hazards with r | | |
| | clostridium difficile | . (a bacteria in the bowel which | | | interventions for effected rooms, bu | | |
| | causes diarrhea an | d tever). | | | additional findings. Per guardian's recommendations, the facility has | | |
| | | num Data Set (MDS) | | | resealed the windows in 201 and 13 | | |
| | | 1/26/22, indicated R4 was ad adequate hearing and | | | Pest repellants are also being utilize Guardian will continue to round at the | | |
| | vision, clear speech | n, was understood and able to | | | facility on a monthly basis, and upo | | |
| | | uired assistance from staff for out of bed and moving about in | | | facility need. How will the facility identify other re- | sidents | |
| | a wheelchair. R4 di | | | | having the potential to be affected to same deficient practice? | | |
| | | on 2/14/22, at 1:51 p.m., R4 | | | All residents of the facility have the | | |
| | | n 201, reported he had mice in em in the ceiling and I've seen | | | potential to be affected by the same alleged deficient practice. |) | |
| | them on the floor. H | leard them in the ceiling | | | The measures the facility will take of | | |
| | droppings on his flo | led that there had been mice for and in his dresser drawers. ace staff put live traps in his | | | systems the facility will alter to ensu | | |
| | | tht five mice over several | | | occur: Housekeeping staff will be educate | ed on | |
| | | vere observed in visible areas ted his wife had been there on | | | identifying and reporting signs of pethe facility. | ests in | |
| | | ed mice droppings out of his | | | the facility. | | |
| | | 4 stated his wife brought a NA) into the room to show her, | | | Quality Assurance plans to monitor performance to make sure that | facility | |
| | | scoured the entire room and | | | corrections are achieved and are | | |
| | put some kind of pe | eppermint repellent in the | | | permanent: | ا | |
| | | aintenance and housekeeping e in his room. R4 didn't know if | | | Administrator or Designee will con daily audits for 2 weeks as needed | | |
| | | rofessional exterminator. | | | monitor far compliance. Completion date: 3/18/2022 | | |
| | | p.m., observed dead bugs, nd "helicopter" leaves from | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|--|-------------------------------|----------------------------|
| | | 245507 | B. WING | | l | C |
| NAME OF F | PROVIDER OR SUPPLIER | 240001 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 18/2022 |
| IIII I CDE | CT CADE & DELIADU | ITATION CENTER | | 714 SOUTHBEND AVENUE | | |
| HILLORE | ST CARE & REHABIL | LITATION CENTER | | MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 925 | Continued From pa | ge 51 | F 92 | 5 | | |
| | Observed a small a lower left corner of tape placed around conditioner was loo | and deep window sill. ir-conditioning unit in the the large window. Silver duct the opening of the air se in some spots. on 2/16/22, at 8:16 a.m., | | | | |
| | housekeeper (H)-B of mice in the facilit "I've seen mouse di clothing chewed on occurred, H-B state housekeeping supe another housekeep H-B could not recal | admitted to seeing evidence y and in rooms 201 and 401. roppings in room 401 and in room 201." When this ed she told her boss, ervisor (HS)-C, then her and er deep-cleaned room 401. I when that was, but stated it | | | | |
| | no mice droppings R3 was asleep in a front of a small fan toward him. Noticed approximately 4 - 5 from the fan; the blasoiled with gray fuz. | ion on 2/16/22, at 8:21 a.m., were observed in room 401. broda chair about 5 feet in that was blowing directly d two strands of dust inches in length blowing out ades of the fan were heavily zy material. | | | | |
| | if either had seen er rooms, H-A stated "had not, but had be seen mice in their roseen droppings, "no rooms." When asker room (201) and son but couldn't recall whas the stated if she sa | JA)-A and (H)-A, when asked vidence of mice in resident not often." NA-A stated she en told some residents had some. H-A stated she had be everywhere, just one or two ed which rooms, stated R4's meone on the northwest wing, which room or which resident aw droppings, she informed it cleaned the room well. | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | LE CONSTRUCTION | | E SURVEY IPLETED |
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| | | 245507 | B. WING | | 1 | C 18/2022 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 021 | 10/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 925 | During a telephone p.m., family member aware of mice in Radobserved holes in cit was from mice. F 2/13/22, she cleaned and saw mouse dromice had eaten throstated she noticed a 2/13/22, when she the wall to sit in it. Frecliner had obvious cleaned under for a mice droppings and told a staff member cleaned the floor work a droppings, adding the repel mice. FM-Emice in R4's room, droppings, adding the R4's recliner at one Facility policy titled was reviewed and in maintain an on-goir ensure the building. A service report from the dated 1/24/22, was administrator and redocumented by the Performed inspectic common space, has activities. I expected kitchen, talk with foshe still has issues drawers. I expected. | interview on 2/16/22, at 9:06 or (FM)-E stated she was 4's room, adding she had one of his shirts and suspected M-E stated while visiting on ed a small chest of drawers oppings in it and also noticed ough a bag of Cheetos. FM-E at lot of mouse droppings on pulled R4's recliner away from furthermore, FM-E stated the sly not been pulled out and a while as there were many 4 dirt under it. FM-E stated she who then came in and ell. FM-E stated she cleaned rs of mice droppings and put ets in the drawers and closet E stated she had never seen but had seen plenty of there had been a trap behind time. Pest Control, dated May 2008, andicated the facility would no pest control program to would be kept free of rodents. | F 925 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · ′ | TIPLE CONSTRUCTION NG | COM | E SURVEY PLETED |
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| | | 245507 | B. WING | | | C 18/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 021 | 10/2022 |
| HILLCRE | EST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE MANKATO, MN 56001 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | (X5) COMPLETION DATE |
| F 925 | room), talk with the director (ESD)-A ab wall, but she said of that she would try to hole. I find that the point of entry for mi kitchen drawers. In here. No other active During an interview FSD-A stated they mice, but not anymore found in kitchen drastated they speculate the basement via a building to the ice in hole had been seall evidence of mice. Dobserve mouse dro surfaces, or floors. During an interview HS-C stated he had about mice in a which he puts a tube trapcan go in, but they commonth; the technical housekeeping and and informed them When asked if he k coming in, HS-C stated there was a maintenance would identified, staff clear room and he placed | environmental services eout sealing that hole in the an't move the ice machine and of find a way to seal up that whole [sic] pedometry [sic] the ce that are getting in to nentioned this last time I was rities found. on 2/16/22, at 10:50 a.m., used to have problems with ore. Mice droppings had been awers in the past. FSD-A ted mice were coming from pipe that comes into the nachine. FSD-A stated that ed and denied further ouring kitchen tour, did not ppings in drawers, on on 2/16/22, at 11:57 a.m., I not heard anything from staff le. If staff tell him about mice, in the residents room mice can't get out. HS-C stated trol came to the facility once a | F 92 | 25 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | PLE CONSTRUCTION 3 | COM | E SURVEY IPLETED |
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| | | 245507 | B. WING | | | C 18/2022 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 02/ | 10/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETION DATE |
| F 925 | of nursing (ADON), protective equipmer R4, looked through evidence of mice. The drawer dressers again were looked through found in the underwisheets that FM-E pto 2/13/22. Observed sill and the floor of air vent on the floor an excessive/heavy it. This was pointed stated she was awareports of mice had attention recently. The and mice droppings could pose a health and stated she wouthoroughly clean R4 ESD-A. On 2/16/22, at 1:36 and ESD-A, went in where mouse droppings on the floor below the soiled with dust and droppings on the cleadministrator and Emost of 2/13/22, cleadroppings and put of mice. During an interview | ge 54 O p.m., with assistant director donned PPE (personal nt) and with permission from drawers and closet for there were two, identical three ainst one wall; all 6 drawers h and mice droppings were wear drawer. Noticed the dryer faced in the drawers on mouse droppings on window the closet. Observed a return below the window which had amount of gray dust/debris in out to the ADON. The ADON are of mice in the facility, but not been brought to her the ADON acknowledged mice could spread germs and risk to residents and staff, all have housekeeping the room and follow up with the window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape, the return air vent he window which was heavily the duct tape. | F 925 | 5 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
|--------------------------|---|--|---------------------|---|-------|----------------------------|
| | | 245507 | B. WING | | 1 | C 18/2022 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 021 | 10/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 925 | of mice in R4's roor outside food, which The administrator's mice were getting in the pest exterminat tomorrow to address acknowledged mice acceptable, nor was environment, addin During a telephone p.m., ST-F stated he facility on 2/17/22. Smain problem with the wall behind the room adjacent to the told maintenance as about this in the pado; I don't know if it didn't look at it." Whoked in room 118 of mice, adding the down to the floor ar would cause the pip to MA-B he could use an office near the kerports of mice in the not go into R4's root During an observations observed the area I dining room adjace square, floor-mode positioned at an anapproximately 10 fekitchen. Behind the pipe-work, with muland into the wall. O | in, adding "he brings in a lot of is a food source for mice." tated he did not know how not R4's room and would have or come back today or is it. The administrator in a residents room was not is it a sanitary and home-like if "we will take care of it." Interview on 2/18/22, at 1:30 is was called to come to the ST-F stated he believed the mice was related to the hole in ice machine in the dining is ekitchen. ST-F stated he had is sistant (MA)-B and ESD-A ist. "I told MA-B what he could is completely sealed up I hile there, ST-F stated he where there had been reports re was a heat duct that went and not sealed up because it be to freeze. ST-F suggested itchen where there had been ne ceiling. ST-F stated he did | F 9: | 25 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | LE CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|---|---------------------|---|-------|----------------------------|
| | | 245507 | B. WING | | 1 | C 18/2022 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 | 1 021 | 16/2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 925 | Multiple penetration floor and wall. During an interview ESD-A, MA-B and I in the wall behind the room had been sea pipes after the ST-F 1/24/22, and there I in kitchen drawers. evidence of mice in the building by other on recommendation room 118, MA-B we purchased a floor vipipe, and the ventor around it. Regarding placed around the destance of mice in the building placed around the destance of the health of reshome-like environmentation in the building had an exterminato. Facility policy titled indicated the facility pest control program an on-going pest control program and on-going pest control program an on-going pest control program and on-going pest control | on 2/18/22, at 1:46 p.m., with HS-C, ESD-A stated the hole he ice machine in the dining held with steel wool around the had been at the facility on had been no more mice noted Not able to say if continued dicated mice were getting into means. ESD-A stated based has from ST-F on 2/17/22, for ent to a hardware store and ent; put steel wool over the over steel wool and caulked g R4's room, caulking was putside of window in his room. HS-C acknowledged mice enthe building; it wasn't good idents and it did not create a nent. ESD-A stated they took very seriously; that's why they | F 925 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|---------------------------------------|-----|-------------------------------|--|
| | | 0.45507 | | <u> </u> | С | | |
| | | 245507 | B. WING _ | | 02/ | 18/2022 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTER | | 714 SOUTHBEND AVENUE | | | |
| | | | | MANKATO, MN 56001 | | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | | BE | (X5) COMPLETION DATE | |
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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 <u>only a suggestion</u> 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.

Hillcrest Care & Rehabilitation Center March 8, 2022 Page 2

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

M. Pais

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/30/2022 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____

С

| | | 00031 | | B. WING | | I | C 18/2022 |
|--------------------------|--|---|---|---|--|------------------------------|--------------------------|
| | PROVIDER OR SUPPLIER | | 714 SOUT | DRESS, CITY, S THBEND AVE D, MN 56001 | | 1 521 | . 0, 2022 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| | Initial Comments *****ATTEN NH LICENSING In accordance with 144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of fithe Minnesota Depa Determination of whice corrected requires of the number and MN Ru When a rule contain comply with any of the lack of compliance. The result in the assessing that was violated ducorrected. You may request a that may result from orders provided that the Department with notice of assessme INITIAL COMMENT On 2/14/22, through was conducted at years. | NTION****** CORRECTION ORE Minnesota Statute, section order has been y. If, upon reinspectiency or deficiencies ected, a fine for each one assessed in accordines promulgated by artment of Health. The ther a violation has compliance with all rule provided at the alle number indicated has several items, fail the items will be consumed the items will be consumed in the initial inspectation of a fine even in a written request is non-compliance with a written request is non-compliance. | DER section issued ion, it is cited violation rdance rule of s been tag below. ure to sidered e upon rule will if the item ction was ssments th these made to ot of a ce. | 2 000 | | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/18/22

Electronically Signed

If continuation sheet 1 of 42

(X6) DATE

6899

TITLE

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|--------------------------|--|-------------------|--------------------------|
| | | 00024 | | | 00/4 | |
| | | 00031 | B. WING | | 02/1 | 8/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | ITATION CENTE | HBEND AVE D, MN 56001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | |
| | these orders and id be completed. | entify the date when they will | | | | |
| | SUBSTANTIATED: | laint was found to be H5507070C (MN80943) ng orders were issued. | | | | |
| | 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. | | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet https://www.health n/infobulletins/ib14_ orders are delineate Department of Hea you electronically. is necessary for State enter the word "corr text. You must then State licensure proc completion date, the | in state.mn.us/facilities/regulatio 1.html The State licensing ed on the attached Minnesota alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the | | | | |

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|--------------------------|---|--|
| | | 00031 | B. WING | | C 02/18/2022 |
| | PROVIDER OR SUPPLIER | ITATION CENTE | DRESS, CITY, STHBEND AVE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE |
| 2 000 | FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAI IS NO REQUIREMI CORRECTION FOI | RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF | 2 000 | | |
| 2 565 | Plan of Care; Use Subp. 3. Use. A co | 5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the | 2 565 | | 3/18/22 |
| | by: Based on observati review, the facility fa comprehensive care reviewed for smokin reviewed for transm Findings include: R26's admission re R26 was admitted 9 nicotine dependency neoplasm of mandi squamous cell care other parts of face. R26's quarterly Min assessment dated | ent is not met as evidenced on, interview, and document ailed to develop a e plan for 1 of 1 resident (R26) ng, 1 of 2 residents (R4) nission based precautions. cord printed 2/17/22, indicated 0/19, diagnoses included e, diabetes, malignant ble (jaw cancer), and inoma (cancer) of skin of imum Data Set (MDS) 1/26/22, indicated R26 had behavior symptoms, required | | Plan of Correction 656 Developmed Care Plans Please accept the following as the credible allegation of compliance. The Plan of Correction does not constitute admission of guilt or liability by the sand is submitted only in response to regulatory requirements. How corrective action will be taken those affected by the alleged deficit practice: R26 s care plan has been upon reflect that he is able to smoke independently who an assistive devis no longer on transmission based precautions and the care plan has a updated appropriately. How will the facility identify other respective in the care plan has a updated appropriately. | facility's his ute any facility the for ent ated to se. R4 |

Minnesota Department of Health

Minnesota Department of Health

| STATEMENT OF DEFICIE AND PLAN OF CORRECT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | LE CONSTRUCTION : | (X3) DATE S COMPL | |
|---|--|--|---------------------------------|---|---|--------------------------|
| | | | | | C | |
| | | 00031 | B. WING | | 02/18 | 8/2022 |
| NAME OF PROVIDER OF | RSUPPLIER | | Γ ADDRESS, CITY, | | | |
| HILLCREST CARE 8 | & REHABII | I ITATION CENTE | OUTHBEND AV ATO, MN 5600 | | | |
| PREFIX (EACH | DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| On 2/14/2 reviewed smoking i updated of the care president with dangers of independent was obseliated to smoke. On 2/14/2 wheelchate cigarette was obseliated to smoke ashes drown as he significant was obseliated to smoke the ashes burned hit able to flict outside to independent without an without ar | on physical mobility of mobility and in horse of mobility and in horse of mobility and in horse of mobility of mob | In assist for activities of daily device of a wheelchair. The plan dated 1/27/22, was not identify R26 smoked or arons. The care plan was then the cluded R26 currently smoke safely, educate on potential and cigarette smoking, and moking per evaluation. Ituation dated 10/8/21, and R26 was deemed independently door with his mouth. R26's black jacke ashes on the bottom of his st. R26 when asked, confirm the jacket while smoking. In p.m. R26's jacket had one the bottom of the jacket and hole was from a cigarette but he do to the facility. R26 stated on his jacket or clothing since facility. R26 stated sometimes clothing, but he had never burned his clothes and was less off his clothing. In a.m. the resident went dependently. R26 stated smoking independently dropping on his clothing. The ashes in the smoking | ny no ed, ent t ned d urn he es | having the potential to be affected same deficient practice? All residents of the facility have potential to be affected by the sat alleged deficient practice. The measures the facility will tak systems the facility will alter to end the problem will be corrected and occur: The facility has updated all so and transmission based precauting plans. The facility has re-educated managers on the care plan process. Quality Assurance plans to monity performance to make sure that the care achieved and are permanent. Administrator or Designee will contain a daily audits for 2 weeks as needed monitor for compliance. Completion date: 3/18/2022 | the me e or ensure that d will not ensure that d will not ensure the nurse ess. tor facility corrections in conduct | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 4 of 42

| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | SURVEY |
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| | OF CORRECTION | IDENTIFICATION NUMBER: | ` ′ | | | LETED |
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| | | 00031 | B. WING | | 1 | , 8/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS CITY S | STATE, ZIP CODE | | |
| | | 714 SOUT | HBEND AVE | | | |
| HILLCRE | EST CARE & REHABII | ITATION CENTE | D, MN 56001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 4 | 2 565 | | | |
| | his cigarette into the | e container | | | | |
| | (LPN)-C stated on the evaluated R26's sm safely get in and our safely, ashed cigare extinguished and place place. LPN-C shole jacket and state ago. LPN-C indicate concerns and did not interventions or reswith no concerns where R26's care plan was and confirmed the smoking prior to lass | p.m. licensed practice nurse the evening of 2/14/22, she noking and observed resident at of the building, light cigarette ette appropriately, laced cigarette in the stated R26 showed her the ted the hole happened a while ed she did not witness of implement any new trictions as R26 was evaluated hile he smoked. LPN stated is expected to identify smoking care plan had not included at night [2/14/22], and further r 2021, R26 restarted | | | | |
| | administrator stated R26 smoking evalu deemed to smoke i administrator stated plans to be thoroug plan was not comprincluded. On 2/15/22, at 3:48 wheelchair outside on resident. | d he expected resident care h, and confirmed R26's care rehensive without smoking p.m. R26 was seated in smoking no ashes observed | | | | |
| | stated she expected plans would identify | p.m. interview with DON d that smoking resident's care the resident smoked and ons included in the care plan. | | | | |
| | Facility policy titled dated 11/18, indicat | Resident Smoking Policy ted: | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 5 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | DATE SURVEY COMPLETED | |
|--|--|--|---|---|--------------------------------|--------------------------|
| | | 00031 | B. WING | | | C 18/2022 |
| | PROVIDER OR SUPPLIER | TATION CENTER 714 SOUT | DRESS, CITY, ST FHBEND AVEI D, MN 56001 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 565 | It is the intent of this procedure for safe evaluation of reside are capable of smo provide a designate residents who chool of a resident is identificated. b. All residents who the need of adaptive 4. Residents who cevaluated upon adrondition/cognition, safe smoking pract 6. Residents require assistance with smooth facility and resident on the individual result. The facility must and/or progress no interventions to ma | s policy to outline the resident smoking including ents to determine those who king independently, and to ed smoking area for those use to smoke. It is in i | 2 565 | | | |
| | diagnoses including digestive tract) due difficile (c-diff; a bad | | | | | |
| | assessment dated cognitively intact, h vision, clear speech understand. R4 req | mum Data Set (MDS) 1/26/22, indicated R4 was ad adequate hearing and n, was understood and able to uired assistance from staff for out of bed and moving about in | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 6 of 42

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------------|---|-------------------|--------------------------|
| | | | | | 0004 | |
| | | 00031 | D. WING | | 02/1 | 8/2022 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| HILLCRI | EST CARE & REHABI | I ITATION CENTE | THBEND AVE D, MN 56001 | | | |
| (V4) ID | SLIMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON. | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 6 | 2 565 | | | |
| | a wheelchair. R4 w bladder and freque During an interview at 2:09 p.m., contact on R4's door with ir gloves when entering three different bout have a [foul lang hands. They give morning, but that's his hands before melp him wash his had the state of the state o | as occasionally incontinent of ntly incontinent of bowel. and observation on 2/14/22, of precaution signs were noted astructions to wear gown and the room. R4 stated he had so of c-diff over the past year. "I uage] of a time washing my he a wet wash cloth in the all." R4 added, he didn't wash eals and staff didn't offer to hands. Seed on 2/17/22, failed to occus area. As a result, the | | | | |
| | care plan lacked in providing comprehe c-diff and measures of c-diff. During an interview licensed practical nresponsible for upd acknowledged after electronic medical nresponsible for upd acknowledged after electron | terventions/tasks related to ensive care for management of is to take to prevent the spread of on 2/17/22, at 12:55 p.m., urse (LPN)-A stated she was ating R4's care plan, and relooking through R4's record, that c-diff was not a care plan and hence there in related to the disease or to disprecautions (TBP's). LPN-A be expected for c-diff to be plan for a resident who had a land acknowledged the knowing measures to prevent to other residents. When the ermined what goes on a property is to stated she didn't know how | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | B) DATE SURVEY COMPLETED | | |
|--|---|--|--|--------------------------|--|--------------------------------|--------------------------|
| | | 00031 | | B. WING | | | C 18/2022 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCRI | EST CARE & REHABII | LITATION CENTE | | HBEND AVE D, MN 56001 | _ | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT | ULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 565 | regional nurse conswould expect c-diff plan in order to ensappropriate care retable in order to ensappropriate care retable in command of c-diff to ounaware R4's care ensured it would be a second of c-diff to ounaware R4's care ensured it would be a second of care will be resident. The care updated as the conresident changes. | sultant (RNC)-C stated to be a focus area on ure a resident received ated to c-diff, and to ed in order to prevent the residents. RNC-C plan did not include contact added. Clostridium Difficile, contact added. Clostridium Difficile, contact and measures would be occurrence of c-diffusion to other residents. Precautions for c-diffusion to other residents. For c-diffusion to other residents. For c-diffusion increase aways factors, frequent had and water, wearing glass or contaminated iterith bleach. Furthermost and interest and water was and water based hand sanitizer. The awere to be monitive to the contact and water to be monitive to the contact and th | a care ed ensure he C was -diff and dated d be were ff to The d people areness and oves ms, and ore, the s with I hygiene were tored for 1/6/22, hes and ourposes ent. The e to the and s of the | 2 565 | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 8 of 42

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED | | |
|--|--|---|---|---------------------------|--|------|--------------------------|
| | | | | 71. 501251110. | | | |
| | | 00031 | | B. WING | | 1 | 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | LITATION CENTE | | THBEND AVE D, MN 5600° | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | nursing staff on the implementation of control plans, and then auditirector of nursing of findings of the auditional performance in committee for record ongoing compliance. TIME PERIOD FOR (21) days. | sing or designee could development and comprehensive reside dit to ensure compliar or designee could repts to the Quality Assumprovement (QAPI) mmendations to ensure. | ent care nce. The nort rance ure | 2 565 | | | 0/40/00 |
| 2 900 | Subp. 3. Pressure comprehensive resion for nursing services development of an provides that: A. a resident who without pressure sores unle condition demonstrate authenticates, that is a resident who receives necessary promote healing, promote healing, promote healing, promote from developments. | sores. Based on the ident assessment, the must coordinate the ursing care plan which or enters the nursing hores does not developes the individual's clates, and a physician they were unavoidable ho has pressure sore of treatment and service event infection, and reloping. | e director ch nome p linical e; and es ces to prevent | 2 900 | | | 3/18/22 |
| | review, the facility fa | on, interview and doc ailed to comprehensivent interventions to p | vely | | Plan of Correction 686 Treatmer to prevent/Heal Pressure ulcers Please accept the following as the | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 9 of 42

| Minneso | <u>ita Department of He</u> | ealth | | | | |
|-------------------|-----------------------------|---|-------------------|---|--------------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SI | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | : | COMPLE | :IED |
| | | | | | C | |
| | | 00031 | B. WING | | 02/18 | 12022 |
| | | 00031 | | | 02/10 | 12022 |
| NAME OF F | PROVIDER OR SUPPLIER | STRE | ET ADDRESS, CITY, | STATE, ZIP CODE | | |
| | | 714 \$ | SOUTHBEND AV | ENUE | | |
| HILLCRE | ST CARE & REHABII | I ITATION CENTE | KATO, MN 5600 | | | |
| (V4) ID | QUIMMADV QTA | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION |)N | (VE) |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROI | | DATE |
| | | | | DEFICIENCY) | | |
| 2 900 | Continued From pa | oge 0 | 2 900 | | | |
| 2 300 | Continued i Tom pa | ige 9 | 2 300 | | | |
| | worsening and prev | vent additional pressure uld | ers | credible allegation of compliance. | This | |
| | | pping for 1 of 1 resident (R2 | | Plan of Correction does not consti | tute any | |
| | | geable PU's (Full-thickness | | admission of guilt or liability by the | | |
| | | s in which the extent of tiss | ue | and is submitted only in response | to the | |
| | <u> </u> | ulcer cannot be confirmed | | regulatory requirements. | | |
| | | ired by slough or eschar) a | | How corrective action will be taker | | |
| | • (1 | artial thickness skin loss of | | those affected by the alleged defic | ient | |
| | | e resulted in actual harm wh | | practice: | | |
| | | ers worsened and addition | al | ¿R28 has been reassessed for her | | |
| | PU's were acquired | d. | | alteration in skin care plan. R28 c | | |
| | | | | to refuse repositioning. Reviewed | | |
| | Findings include: | | | benefits of this choice with the res | | |
| | | | | How will the facility identify other re | | |
| | | to the facility on 7/31/18, w | ith | having the potential to be affected | by the | |
| | | ed on the diagnosis report | | same deficient practice? | | |
| | | 2, including; congestive hea | | All residents are at risk related to | the | |
| | | ronic condition in which the | | deficient practice. | | |
| | | np blood as well as it should | d), | The measures the facility will take | | |
| | | pread muscle pain and | | systems the facility will alter to ens | | |
| | | erthritis (when bone protect | | the problem will be corrected and | will not | |
| | |), spinal stenosis (narrowir | | occur: | | |
| | | istory of PU on coccyx and | | The facility has completed an | | |
| | buttocks, dehydration | on, diarrhea, and joint pair | ٦. | all resident s interventions with sl | | |
| | Observation and int | tomiou on 0/44/00 -t 4:00 | | breakdown to insure that they are | | |
| | | terview on 2/14/22, at 1:38 | | The facility has re-educated th | | |
| | | to the surveyor she had a | oir | nursing staff on the importance of | | |
| | | was sitting in her wheelch | ali | and repositioning residents Q2 ho | | |
| | | tated she had a PU on her | | The facility has initiated a wee | | |
| | | not healing and she was | | wounds meeting until 100 percent | | |
| | _ | lought she had the sore for ure. R28 indicated she she | | compliant with pressure ulcer previnterventions. Quality Assurance of | | |
| | | | ; uiù | interventions. Quality Assurance p monitor facility performance to ma | | |
| | not recall being rep | ositioned every 2 hours. | | that corrections are achieved and | | |
| | D28's quartarly min | nimum data set (MDS) | | permanent: | alt | |
| | | ายได้เกิดเลย รัยเ (เพียร์) 12/15/21, identified R28 as | | DON or Designee will conduct at | ıdite ae | |
| | | nterview for mental status | ' | noted above in the wound manage | | |
| | | | ad | | SILICILL | |
| | | initively intact). R28 require | | meeting. | | |
| | | ce with activities of daily livi | 119 | Completion date: 3/18/2022 | | |
| | | ed mobility. R28 required | | | | |
| | extensive assistance | be with tolleting and | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | | SURVEY PLETED |
|--|--|---------------------------|--|-----------------------------------|--------------------------|
| | | A. BUILDING: | | | |
| | 00031 | B. WING | | | C 1 8/2022 |
| NAME OF PROVIDER OR SUPPL | ER STREET AI | DDRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCREST CARE & REH | ARII ITATION CENTE | THBEND AVE O, MN 56001 | | | |
| PREFIX (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| at risk for PU's a Interventions; pland bed, turning care and nutrition indicated R28 dutilized a wheeled Review of the Bindicated R28's breakdown. The continues to have buttock as well a open area, that hydrophilic treat ordered. Encourno longer than repositioning. Rin bed/chair to put chair sitting to 2 asleep on the tofrom pressure a with cares and with care an | ne MDS identified R28 as being and identified one stage 2 PU. The sessure reducing device on chair and repositioning program, PU anal intervention. The MDS do not exhibit any behaviors. R28 chair for mobility. Traden scale dated 12/15/21, risk factor was mild for skin assessment indicated R28 are an open area on the right as a new area that is dry near the looks like it may open. Triad ment dressing applied as arage the resident to avoid sitting hour in the wheelchair without apositioning at least every 2 hours revent skin breakdown. Limit hours. Avoid the resident falling ilet. Wheelchair cushion on chair pplying, staff to monitor skin daily weekly with skin inspection. Treekly Pressure Wound buttock measures 0.3 centimeter by 0.3 cm. width. The center of the orange in color and surrounded Unstageable. uttock measures 0.1 cm length by the wound bed is dry with no | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 11 of 42

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | A. BUILDING. | | | , |
| | | 00031 | B. WING | | | 8/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCRI | EST CARE & REHABI | I HAHON CENTE | THBEND AVE D, MN 56001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 900 | Unstageable2/2/22-right buttool length by 0.5 cm will Pain with treatment PU on 12/29/22 and 0.6 cm width) right buttool cm length by 1.2 cm (necrotic/dead) tiss Unstageable. left buttool 0.5 cm width. 100% treatment. Unstage 1/2/22 with measu 1.0 cm in width) 2/9/22-right buttool length by 1.4 cm will Unstageable right buttool cm width. 100% sleft buttool c | k (distal) measures 0.5 cm idth. 100% granulation tissue. Unstageable (newly acquired d measured 0.5 cm length by ck (proximal) measures 1.7 m width. 100% slough slough ue. Pain with treatment. k measures 1.2 cm length by slough tissue. Pain with reatment in the idea of the idea o | 2 900 | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 12 of 42

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
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| | | 00031 | B. WING | | 02/1 | 8/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLORE | EST CARE & REHABI | TITATION CENTE 714 SOUT | HBEND AVE | NUE | | |
| | TOT OAKE G KENADI | MANKATO | D, MN 56001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | ge 12 | 2 900 | | | |
| 2 900 | Review of the curre 2/16/22, included a avoid sitting for long wheelchair without date 2/9/22). The pan order to reposition bed/chair to previous chair sitting to 2 homogeneous chair sit | ent physicians orders dated in order to encourage R28 to ger than 1 hour in the repositioning every shift (order hysicians orders also included on R28 at least every 2 hours ent pressure to bottom. Limit urs. plan dated 2/16/22, identified sk alteration in skin integrity evenous statis ulcer, skin and open area to right buttock (1). Interventions listed; do not expensive would assessments, d dry, encourage mobility, and report concerns to charge assessments by licensed staff in interventions as needed an indicated R28 has an in | 2 900 | | | |
| | interventions per pl Review of the nursi | nysicians order ng assistant (NA) care sheet | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------------|--|--------------------------------|---------------------|
| | | 00031 | B. WING | | l l | C 18/2022 |
| | | | | NTATE 710 0005 | 02/ | 10/2022 |
| NAME OF | PROVIDER OR SUPPLIER | | , | STATE, ZIP CODE | | |
| HILLCRI | EST CARE & REHABII | I HAHON CENTE | THBEND AVE O, MN 56001 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF C | ORRECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE LE APPROPRIATE | COMPLETE DATE |
| 2 900 | Continued From pa | ge 13 | 2 900 | | | |
| | and with all transfer repositioning every PRN. Offer R28 to refuses to sleep in bathroom stay with for safety (related to make sure the resid hours of 10:00 p.mThe NA care sheet physicians orders for Review of the NA h 1/1/22 to 2/15/22, (R28, did not include | t did not reflect the current | | | | |
| | from 8:00 a.m. to 1 from 1:00 p.m. to 3 not offered reposition | ations on 2/15/22 and 2/16/22, 0:30 a.m. (2 1/2 hrs) and :30 p.m. (2 1/2 hrs). R28 was oning or off-loading. During observed to walk by the | | | | |
| | treatment was done R28's wound dress saline. There was a drainage on the dre have 2 PU's on the left buttock. When R28 flinched and cowere measured by Measurements: Right buttock-(prox width by 0.1 cm der recent measurements Right buttock (dista | imal) 1.1 cm length by 1.7 cm oth (increase in size from mos | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 14 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|---|---|--------------------------------|--------------------------|
| | | 00031 | | B. WING | | l l | C 18/2022 |
| NAME OF PROVID | | LITATION CENTE | 714 SOUT | DRESS, CITY, S THBEND AVE D, MN 56001 | | | |
| | EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM. | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| mosi Left cm of mosi left cm of mosi The redd exuce PU's durir as si matt cush with would would nurs weel Confia.m. off-le sloud obse adm ansy staff without Revi 1/5/2 evaluation button small whice frust havin with | buttock- 1.2 cm lepth (increase t recent measu skin around all ened. Triad hy late) wound dre R28 stated s ag the day and he can. R28 ha ress on her be ion on her cha RN-D, stated s had care for R28 had sare for R28 had improve e practitioner p s. inued observa to 12:15 p.m. haded. R28 ren ched in her whe eved to go in a inistering medi evering call lite a also walked by out offering to r ew of a physica 2, indicated f uation and trea bocks. The note Il area starting h is new from I ration that wou ng pain with wo treatments. The | arge 14 arements on 2/9/22) In length by 1.2 cm were din length and depturements on 2/9/22. It is pressure ulcers were drophilic (absorbs were ssing was applied to she tries to off-load, stay off of her bottomed a pressure reducted and a pressure reducted and a pressure reducted and a pressure reducted and was unsure if the two or not, but did incorovides wound care to see the control of the room and the control of the room and the control of the room and putting clothing and putting c | as slightly bund of all 3 lay down on as much on duction his time provide he dicate the every 2 m 9:00 oned or and f were must tray, away. The mes to a dated and care guicers to a new auttocks, sees R28 is mpliant d | 2 900 | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 15 of 42

Minnesota Department of Health

| | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
|--------------------------|--|---|------------------------------|--|-----------------------------------|--------------------------|
| | | | A. BUILDING | : | | _ |
| | | 00031 | B. WING | | | C 1 8/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREE | ADDRESS, CITY, | STATE, ZIP CODE | | |
| HILLCR | EST CARE & REHABI | I ITATION CENTE | OUTHBEND AVI ATO, MN 5600 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 900 | 0.3 cm by 0.1 cm. size with a scant ar slough and unstage measures 1.0 cm but Unstageable The pencourage R28 to a hour in the wheelch to encourage incremultivitamin. Occup wheelchair position Review of a physici 2/9/22, indicated revaluation and treat buttocks. The note there has been no her bottom and cor sitting. The progres continues to have a buttock wounds, but do not stay on. The right proximal 1.0 cm by 1.4 cm bincreased in size, reslough and unstage tender. Right distal buttock by 0.6 cm by 0.1 cm size. There is no occur unstageable and so the left buttocks ul 0.9 cm by 0.1 cm. No odor or drainagunstageable. Surrountageable. Surrountageable. Surrountageable. Surrountageable. Surrountageable. Surrountageable. Surrountageable seat is recommended. | The wound has increased in mount of drainage. 100% eable The left buttocks by 0.6 cm. No drainage. Progress note indicated to avoid sitting for longer than thair without repositioning and assed protein at meals and pational therapy (OT) for sing and overlay to bed. James visit progress note date R28 was seen for wound can then the wounds at the standard reposition over head that the resident indicates they buttocks ulceration measures and odor or drainage. 100% eable. Surrounding skin is tender. It wound has increased dor and scant drainage. Urrounding skin is tender. It wound has increased dor and scant drainage. Urrounding skin is tender. It wound has increased in size e. 100% slough and bunding skin is tender deeded (PRN) until healed. It is receiving peri care. Pado mended and encourage ting for more than an hour | de to on er s | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 16 of 42

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | o. I | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--|---------------------|---|-------------------|--------------------------|
| | | 00031 | В. \ | WING | | 02/1 | 8/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | STF | REET ADDRES | SS, CITY, S | TATE, ZIP CODE | | |
| HILLCRE | EST CARE & REHABII | ITATION CENTE | 4 SOUTHBI NKATO, M | | NUE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | ge 16 | 2 | 900 | | | |
| | indicated R28's PU not seem to get bet be turned and report confirmed she was repositioning or off-hour. RN-D further assistance with repwill often attempt to Interview on 2/16/2: R28 will at times rewhen offered. NA-D repositioned or off-stated he was not a or repositioned eve | 2, at 11:30 a.m. NA-D sta fuse to off-load or lay do 0 indicated R28 should be 0 oaded every 2 hours. NA ware of R28 being off-lo ry 1 hour. NA-D further f get busy, it is difficult to | ould ut or ry 1 ag, but ated wn e A-D aded | | | | |
| | medication assistar follows the NA's car off-loading R28. TM care directed staff hours PRN. TMA-A independently trans requires assistance (NM)-D indicated R been updated to reforders for reposition thought the NA's we | 22, at 1:30 p.m. trained at (TMA)-A indicated she are sheet for repositioning MA-A confirmed the NA ploto reposition R28 every 2 further indicated R28 wisfer self, but verified R28 at 3:30 p.m. nurse ma 28's care plan should has flect the current physicial and NM-D indicated sheer repositioning R28 where the the current physicial and the course of the current physicial and the cu | nager ve ille | | | | |
| | the staff were just v NM-D also confirme were not always co | risualizing R28's whereal and weekly skin assessme and the by the licensed noised the and the NP was monitoring | oouts. ents ursing | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 17 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ' | E CONSTRUCTION | | SURVEY PLETED |
|---|---|--|---------------------------------------|---|------------------------------|------------------|
| | | | A. BUILDING | · | 1 , | c |
| | | 00031 | B. WING | | I | 18/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| HILLCR | EST CARE & REHABI | I HAHON CENTE | JTHBEND AVI TO, MN 5600 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | COMPLETE DATE |
| 2 900 | Continued From pa | ige 17 | 2 900 | | | |
| | Interview on 2/16/2 nurse consultant (N (DON) confirmed R been updated to re orders of reposition to encourage sitting NC-A stated the fatrained on how to minterventions per in Review of the facility Wound Management upon a significant of as a development of impairment, the foll tissue tolerance ob the completed, to dimplement intervention and to promote heat update the NA care education with the Document refusals SUGGESTED MET Director of Nursing review, and/or revisensure care and seworsening or devel The Director of Nur educate all approprincedures. The Director of nongoing compliance monitoring to the fat Committee. | 2, at 3:00 p.m. the facility IC)-A and director of nursing R28's plan of care should have flect the current physicians sing (at least every 2 hours and for no more than an 1 hour) cility nursing staff had been nanage PU's and implement dividualized care plan by policy Skin Assessment and the dated 7/2018, included change in a residents skin such a pressure related skin owing actions will be taken;; a servation and evaluation will be termine skin tolerance and tions to prevent breakdown aling, update the plan of care, a sheets and complete resident including risk/benefits in the medical record. THOD OF CORRECTION: The or designee could develop, see policies and procedures to prevent of pressure ulcers. The same provided to prevent of pressure ulcers are provided to prevent of pressure ulcers. The procedure of the policies and procedures to provide the policies and procedures to provide the policies and procedure to prevent of pressure ulcers. The policies and procedure to prevent of pressure ulcers are provided to prevent of pressure ulcers. The policies and procedures to provide the policies and procedure to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are provided to prevent of pressure ulcers. The policies are prevent of pressure ulcers are provided to prevent of pressure ulcers. The policies are prevent of pressure ulcers are prevent of pre | d d d d d d d d d d d d d d d d d d d | | | |

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|--------------------------|---|--|---------------------|---|--|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | LETED |
| | | 00031 | B. WING | | 02/1 | 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | ITATION CENTE | HBEND AVE | | | |
| | | MANKATO | D, MN 56001 | | | 0.45 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY) | D BE | (X5) COMPLETE DATE |
| 21375 | Continued From pa | ge 18 | 21375 | | | |
| 21375 | MN Rule 4658.0800 Program |) Subp. 1 Infection Control; | 21375 | | | 3/18/22 |
| | home must establis | on control program. A nursing sh and maintain an infection signed to provide a safe and nt. | | | | |
| | by: Based on observati review the facility fa transmission-based closure of room doo R50) symptomatic a COVID-19. The faci implementation of p or mitigate the risk potential to affect al within the facility. Findings include: During entrance cor p.m., the administra R14, R50, R38) cor were on droplet/cor residents resided or R14's medical diag sheet, printed on 2/ Lewy body (brain di thinking, movement was diagnosed with remained asymptor period, off precaution | I precautions by ensuring ors for 2 of 3 residents (R14, and known to be positive with cility's failure to ensure proper precautions to prevent of COVID-19 outbreak had the II other 63 residents and staff of the failure to have COVID-19 and stact precautions, all three in 500 unit of facility. Inosis listed on admission face 18/22, identified dementia with sease causing problems in the positive COVID-19 on 2/7/22, natic throughout isolation on on 2/18/22. | | Plan of Correction F880 Please accept the following as the credible allegation of compliance. Plan of Correction does not constitute admission of guilt or liability by the and is submitted only in response regulatory requirements. How corrective action will be takenthose affected by the alleged deficipractice: ¿No residents are currently on transmission based precautions. How will the facility identify other rehaving the potential to be affected same deficient practice? All residents have the potential to affected by the deficient practice. The measures the facility will alter to ensithe problem will be corrected and occur: The facility has re-educated not and dietary staff on Donning/Doffir and having the door closed for Corresidents. Quality Assurance plans to monito performance to make ourse that are | This tute any facility to the for ient esidents by the or sure that will not ursing ng PPE vid + | |
| | R50's medical diag | nosis listed on admission face | | performance to make sure that co | | |

| AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER D0031 STREET ADDRESS, CITY, STATE, ZIP CODE THILLCREST CARE & REHABILITATION CENTEI (X4) ID PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) 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 33/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. EXTREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 PREFIX TAG PROPIDE TAG PROPIDE TAG PROPIDE TAG PROPIDE TAG PRO | Minnesc | Minnesota Department of Health | | | | | | |
|--|-----------|---|---|-------------------------|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER THILLCREST CARE & REHABILITATION CENTE! STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | |
| AMME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTEI SUMMARY STATEMENT OF DEFICIENCIES MANKATO, MN 56001 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 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 2/9/22-21/41/22. 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 | | | 00031 | B. WING | | _ | | |
| AND CONTROL CARE & REHABILITATION CENTE THE SOUTHBEND AVENUE MANKATO, MN 56001 | NAME OF I | | CTDEET AD | | CTATE ZID CODE | | | |
| CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION CHORNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DEFICIENCY 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 CX5) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CAPPROPRIATE DEFICIENCY) DATE CAPPROPRIATE DEFICIENCY DATE CAPPROPRIATE DATE CAPPROPRIATE DEFICIENCY DATE CAPPROPRIATE DATE C | NAME OF I | PROVIDER OR SUPPLIER | | | | | | |
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| droplet/contact precautions signs posted outside. Multiple observations of room doors being open a. Re-education of stall as noted above. Root cause analysis See attachment 1. IP/DON shall complete the following. " Grouping of residents, or cohorting, | | sheet, printed on 2/from acute care hos care plan, dated 12 history of kidney fai dialysis 3x/week, conchronic condition in blood effectively), a lungs). R50 was di COVID-19 on 2/7/2 cough, nausea vom Isolation precaution Ionger experiencing. During initial observation for R41 and R50 will precautions was obduration of time roounknown, staff not coming out of room. R14 2/14/22 at 6:41 p.m. 2/15/22 at 7:19 a.m. 2/16/22 at 7:40 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. | 18/22, identified admission spital. Further review of R50's /29/21, revealed R50 had a lure and receives outpatient ongestive heart failure (CHF- a which the heart cannot pump nd pneumonia (infection of the agnosed with positive 2; became symptomatic with hiting on 2/9/22-2/14/22. Is removed 2/18/22, as R50 no g symptoms. Vation on 2/14/22 at 2:27 p.m. idents with confirmed 14 and R50's room doors had cautions signs posted outside. In sof room doors being open hile on droplet/contact served during survey. The lam doors were open was observed to be in and/or s at the following times; | | DON or Designee will conduct audits for 2 weeks as needed to make the first compliance. Directed Plan of Correction 1. Address how corrective action accomplished for those residents be affected by the deficient practice. a. The facility currently does not any residents on transmission bas precautions. Therefore no addition residents are currently being affect the deficient practice. 2. Address how the facility will id other resident having the potential affected by the same practice. a. Re-education of staff as noted Root cause analysis. See attachmal IP/DON shall complete the following. Grouping of residents, or conditions with an infectious disease (positive residents) from residents not affected. Plans to cohort should carefully established in advance a should be centered on implementatin infection control practices. | n will be found to be have ed nal ted by entify to be labove. nent 1. ng. orting, separate se who are id be nd ation of it as the ease, rent ays to f illness is (e.g., ered | | |
| 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. 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. | | 2/15/22 at 2:51 p.m 2/16/22 at 7:40 a.m 2/16/22 at 8:42 a.m | | | care location for residents with dis including those with or without cur symptoms of illness. Anticipate wa | ease, rent ays to | | |
| Multiple observations of room doors being open " Grouping of residents, or cohorting, | | for R41 and R50 wl precautions was ob duration of time roo | nile on droplet/contact served during survey. The im doors were open was | | should be done when possible to see residents with an infectious diseast (positive residents) from residents | separate se who are | | |
| ividitiple observations of room doors being open Grouping of residents, or conording, | | for R41 and R50 wl precautions was ob duration of time roo | nile on droplet/contact served during survey. The im doors were open was | | should be done when possible to see residents with an infectious diseast (positive residents) from residents | separate se who are | | |
| | | 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 | | | other resident having the potential affected by the same practice. a. Re-education of staff as noted | to be above. | | |
| | | longer experiencing symptoms. During initial observation on 2/14/22 at 2:27 p.m. two of the three residents with confirmed | | | residents are currently being affect the deficient practice. 2. Address how the facility will id other resident having the potential | ted by entify | | |
| the deficient practice. 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 the deficient practice. 2. Address how the facility will identify other resident having the potential to be affected by the same practice. | | COVID-19 on 2/7/2 cough, nausea vom Isolation precaution | 2; became symptomatic with iting on 2/9/22-2/14/22. is removed 2/18/22, as R50 no | | a. The facility currently does not any residents on transmission bas precautions. Therefore no additio | have ed nal | | |
| 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 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. | | chronic condition in blood effectively), a | which the heart cannot pump nd pneumonia (infection of the | | Address how corrective action accomplished for those residents | found to | | |
| 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 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. | | care plan, dated 12 history of kidney fai | /29/21, revealed R50 had a lure and receives outpatient | | audits for 2 weeks as needed to m f;r compliance. | | | |
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| T14 SOUTHBEND AVENUE MANKATO, MN 56001 | | | 00031 | B. WING | | _ | | |
| NAME OF PROVIDER OR SUPPLIER THILLCREST CARE & REHABILITATION CENTEI (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) 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 SUMMARY STATEMANTON CENTE THE SOUTHBEND AVENUE MANKATO, WN 56001 PREFIX TAG PR | | | | | | COMPL | ETED | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | STATEMEN | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPI A. BUILDING | (X3) DATE SURVEY COMPLETED | | |
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| 21375 | 02/16/22 at 7:20 a.r 02/16/22 at 8:42 a.r 02/16/22 at 8:42 a.r During interview on registered nurse (R residents with COV open. RN-C indicatorsed. During interview on indicated residents isolation, should ha RN-B indicated difficlosed as he was a to open door frequent RN-B indicated she re-education to staf rooms closed at all | m. 2/16/22, at 7:20 a.m. 2/16/22, at 7:20 a.m. 2/10-19 and room doors being ted doors should be kept 2/16/22, at 7:37 a.m. RN-B with COVID-19 and on ve rooms doors closed. 2/16/25 at 7:37 a.m. en and on ve rooms doors closed. 2/16/26 at 7:37 a.m. en and on ve rooms doors closed. 2/16/27 at 7:37 a.m. en and on ve rooms doors closed. 2/16/28 at 7:37 a.m. en and on ve rooms doors closed. 2/16/29 at 7:37 a.m. en and on ve roo | 21375 | must leave their room, ensure the is wearing a mask. "Provide dedicated equipment areas, as able. All noted above are currently part facility s policies and procedures will be re-educated on Covid 19 policy/procedure. The facility will provide education residents regarding Transmission precautions. Completion date: 3/18/2022 | for of the . Staff |
| | Control Program, d facets of infection prossible infections existing infections, complications or disand ensuring that the techniques and proappropriate isolation necessary. Policy of specific related to Corevention. SUGGESTED MET The facility administreview and revise prelation to the facility related to Covid-19 designee could prostaff on infection controls. | Infection Prevention and ated 8/17, indicated: Important prevention include; identifying or potential complications of instituting measures to avoid assemination, educating staffiney adhere to proper cedures, implementing in precautions when did not indicate anything COVID-19 infection control and arthrough the colicies and procedures in the administrator or vide education to all facility ontrol. The administrator or weekly/monthly audits for | | Date Resident Covid Vaccing Current Action Notes Initial | e |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 21 of 42

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
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| | could report finding Assurance and Per (QAPI) committee f ensure ongoing cor | irector of nursing or designees of the audits to the Quality formance Improvement or recommendations to appliance. R CORRECTION: Twenty-on | | | | |
| 21530 | . , , |) A.B.C Drug Regimen Revie | v 21530 | | | 3/18/22 |
| | reviewed at least m currently licensed be This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is incavailable through the system. It is not sue B. The pharma irregularities to the eart and the attending period must be acted upor physician visit, or so pharmacist. For pur upon means the act are port and the signification of nursing services C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely after fer the matter to the survey of the survey | en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992 corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next poner, if indicated by the proses of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. In ing physician does not concurs the prosession of the ingential of | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE S | |
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| HILLCRE | EST CARE & REHABII | ITATION CENTE | HBEND AVE), MN 5600' | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21530 | the attending physic justification for the ophysician does not must be referred for assessment and as by part 4658.0070. The medical director must refer the mattrassessment and assessment dated to ensure the following series of | edical director determines that cian does not have adequate order and if the attending change the order, the matter review to the quality surance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality surance committee. The tian the ast evidenced and document review, the ure consulting pharmacist were acted upon, addressed, the medical record for 1 of 5 iewed for unnecessary The tian the tian the tian the tian the tian that the tian t | 21530 | Plan of Correction 755 Pharmacy Please accept the following as the credible allegation of compliance. Plan of Correction does not constitue admission of guilt or liability by the and is submitted only in response regulatory requirements. How corrective action will be taken those affected by the alleged deficipractice: ¿The facility has reviewed the pharmactice: | e facility's This itute any e facility to the n for cient armacy nacy with esidents by the ne ne or sure that will not urse | |
| | | ug ADR's [adverse drug tol daily use of psychotropic | | managers on reviewing pharmacy recommendations with the provide | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 23 of 42

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE S | |
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| | | 714 SOU | THBEND AVI | | | |
| HILLURI | EST CARE & REHABII | MANKAT | O, MN 5600 | 1 | | |
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| 21530 | Continued From pa | ge 23 | 21530 | | | |
| 21330 | medication related with daily Cymbalta depression) use, in administer medicati ADR's, report suspondical doctor/phy reviewed by MD/PA mood and behavior document mood state occurrence. R17's Medication R indicated an order fanxiety and sertraling depressive disorder R17's Consultant P | to diagnosis of depression (medication used for terventions included ion as ordered monitoring for ected ADR's to MD/PA visician assistant], medications and pharmacist, be alert to all changes, and monitor and ate/behaviors upon Leview Report printed 2/18/22, for buspirone 10 mg tablet for the 100 mg related to major re. harmacist's Medication | 21330 | facility policy Quality Assurance plans to monito performance to make sure that co are achieved and are permanent: DON or Designee will conduct do audits for 2 weeks as needed to reform to compliance. Completion date: 3/18/2022 | orrections aily | |
| | identified R17's me reviewed by the cor indicated R17 contibuspirone, ensure the PCC [point click can monitoring. The conformacist's Medicand 2/15/22, indicated from 12/2 continued on sertrating indicated to ensure PCC [point click can monitoring. R17's medical reconevidence nursing recommendation 2/15/22, for behavior On 2/18/22, at 10:4 telephone with the formatical review of the process of | dication regimen had been asulting pharmacist (CP), and nued on sertraline and the following was completed: re] orders for behavior presponding Consultant cation Review dated 1/11/22, ted recommendations were 1, and the CP indicated R17 line and buspirone, and again the following was completed: re] orders for behavior ard was reviewed and lacked eviewed and/or acted upon the ons dated 12/14/21, 1/11/22, or or monitoring. 9 a.m. an interview via CP indicated a monthly view was completed of all | | | | |

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | LETED |
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| | EST CARE & REHABII | 714 SOUT | HBEND AVE | | | |
| THELOIL | I | MANKATO | D, MN 56001 | | | |
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| 21530 | residents residing a recommendations of the director of nursi. The CP indicated the expected to be add outlined on the repostated the following of the recommendation and recommendation and recommendation for been implemented, behavior monitoring further stated monti recommendations of the CP stated November pharmacy recommendations of the CP stated November pharmacy recommendations of the CP with resident recommendations at the CP with resident recommendations of the recommendations of the recommendations. The was aware of the rate last month and expected 100%, of upon. | at the facility. The CP indicated were sent monthly via email to ng (DON) and administrator. The recommendations were ressed within the timeframe out or within a month. The CP month he reviewed the status attions and verified completion, ons were reissued if not a confirmed R17's last or behavior monitoring had not and indicated daily target gwas expected. The CP hely the residents pending were discussed with the DON. The ember through December, and the DON indicated are the CP pharmacy and the DON indicated uted the CP pharmacy nursing the ceived a monthly email from atts pharmacy and the DON indicated uted the CP pharmacy nursing the nurse managers. The cility received R17's CP on 12/14/21, 1/11/22, and the DON indicated she managers to have addressed CP monthly. The DON further indicated the recommendations acted | 21530 | | | |
| | | 0 a.m. the administrator e managers received the CP | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 25 of 42

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3) DATE : COMPL | | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21530 | pharmacist's recomaddressed. Facility policy titled dated 12/19, indicar 1. Behavioral symp The GDR may be a contraindicated if the Resident's taworsened after the within the facility AN Physician has rationale for why arreduction at that time resident's function behavior. A policy and proced pharmacy recommon SUGGESTED MET director of nursing or revise policies are pharmacy reviews. to the staff. The que could develop a system of the TIME PERIOD OF | and verified the consultant amendations had not been Gradual Dose Reductions, ted: toms related to dementia: considered clinically are: arget symptoms returned or most recent attempt at a GDR ND documented the clinical any additional attempted dose are would be likely to impair the are increase distressed Gradual Dose Reductions, ted: toms related to generate the clinical any additional attempted dose are would be likely to impair the are or increase distressed Gradual Dose Reductions, ted: toms related to generate the control of the con | 21530 | | | |
| 21600 | (21) Days. MN Rule 4658.1335 Emergency Supply | 5 Subp. 2 Stock Medications; | 21600 | | | 3/18/22 |
| | nursing home may medication supply v | ncy medication supply. A have an emergency which must be approved by a. The contents, maintenance, | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 26 of 42

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE S | |
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| | | | 71. BOILDING. | | С | |
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| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCRE | EST CARE & REHABII | LITATION CENTE | THBEND AVE D, MN 5600' | | | |
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| 21600 | Continued From pa | ge 26 | 21600 | | | |
| | and use of the eme must comply with p | ergency medication supply art 6800.6700. | | | | |
| | This MN Requirement by: | ent is not met as evidenced | | | | |
| | Based on observati review, the facility for routine reconciliation | ion, interview and document ailed to ensure a system for on of controlled substances 1 emergency kit (E-Kit) to ss/diversion. | | Plan of Correction 755 Pharmacy Please accept the following as the credible allegation of compliance. Plan of Correction does not consti- admission of guilt or liability by the and is submitted only in response regulatory requirements. | facility's This itute any facility to the | |
| | 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. | | | How corrective action will be taken those affected by the alleged defining practice: ¿The facility has initiated a count each shift for E-Kit Ativan. How will the facility identify other in having the potential to be affected 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 systems the facility will alter to ensist the problem will be corrected and occur: | between esidents by the he ne or sure that | |
| | confirmed staff wer the E-Kit controlled she did not underst E-Kit needed to be staff had access to | O on 5/12/21, at 11:00 a.m. e not periodically reconciling substances. NM-D indicated and why reconciling of the done, because only licensed the medication room. | | The facility has re-educated n and TMAs on the new Emergency process. Quality Assurance plans to monito performance to make sure that co are achieved and are permanent: DON or Designee will conduct da | r Kit or facility orrections | |
| | | e not reconciling the E-Kit | | audits for 2 weeks as needed to n f¿r compliance. | | |
| | | 2, at 12:00 p.m. with the | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 27 of 42

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | SURVEY LETED |
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| | | | 7. BOILDING. | | С | |
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| HILLCRE | ST CARE & REHABII | I ITATION CENTE | HBEND AVE D, MN 56001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21600 | Continued From pa | ge 27 | 21600 | | | |
| | | n the policy for reconciliation of d be aware of the process. | | | | |
| | Process (undated) that all controlled so every shift, includin E-Kit (contains vials must remain under numbered tag on it. count is correct musign the controlled of | ty Controlled Drug Count indicates it is the expectation ubstances must be counted g the cubix and refrigerator s of lorazepam) The E-Kit double lock plus have a . A visual check to ensure st take place each shift, and drug count log acknowledging bunted with cubex, refrigerator | | | | |
| | administrator, cons could review and re to include processe substances stored | THOD OF CORRECTION: The ultant pharmacist or designee evise policies and procedures as for monitoring controlled in the E-Kit. The administrator, cist or designee could perform nal audits to ensure | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 21665 | MN Rule 4658.1400 | O Physical Environment | 21665 | | | 3/18/22 |
| | functional, comforta environment, allowi | ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible. | | | | |
| | by: Based on observati | ent is not met as evidenced ion and interview, the facility f 71 rooms (rooms 101, 103, | | Plan of Correction Home like Environment | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| HILLCREST C | ARE & REHABII | ITATION CENTE | THBEND AVE D, MN 5600 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21665 Con | Continued From page 28 | | | | | |
| 111, good 11 r R13 failed room (R3 mar Find Dur p.m madRd bow coldRd excerese return three with toiled rust bath slattRd hanRd pap emp was fuzzRd in the sign slats | 112, 113, 115, d repair and in sesidents (R21, R213, R59, Rd to ensure fands (R32) were keptered for a sesident screen and sesident screen and sesident screen and sesident screen are vent on the ceiling tiles now a gold-colored at bowl was heavily streen and the sesident screen and the sesiden | 201, 216) were maintained in sanitary conditions, impacting R264, R1, R55, R46, R57, 9, R4). In addition, the facility is used in resident resident and 417), impacting residents of in a clean and sanitary is and debris. The white toilet ained with a dark gold, rusty ied by R1 and R264: An of gray dust and debris yer lint was observed in the ied floor under the window; the window were stained splatter pattern; the white willy stained with a dark gold, return air vent in the ied by R55: The wall-mount enser was empty. Ied by R46 and R57: The ser in the bathroom was air vent in the bathroom ceiling a significant amount of gray | 21665 | Please accept the following as the credible allegation of compliance. Plan of Correction does not constitute and is submitted only in response regulatory requirements. How corrective action will be taken those affected by the alleged deficipractice: Housekeeping has deep clear the effected rooms. Maintenance either replaced or cleaned all of the effected toilets. How will the facility identify other rhaving the potential to be affected 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 systems the facility will alter to ensure the problem will be corrected and occur: Housekeeping has established a checklist for cleaning rooms to entrooms are kept appropriately Quality Assurance plans to monitor performance to make sure that coare achieved and are permanent: Administrator or Designee will coalily audits for 2 weeks as needed monitor for completion date: 3/18/2022 | This itute any e facility to the end all of has he esidents by the end or sure that will not end all or facility o | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 29 of 42

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE | SURVEY |
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| 21665 | slatsRoom 115, occupilibowl was heavily st color. The return air was rusty and had a fuzzy material on the return air vent in a significant amount slats. There were fi inches by two inched drain, causing an intedgesRoom 201, occupility amount of gray dusty dryer lint was obsert the floor under the vertility room on 200 soap dispenser at the floor under the vertility room on 200 soap dispenser at the floor under the vertility room on 200 soap dispenser at the floor under the vertility room on 200 soap dispenser at the floor under the vertility room on 200 soap dispenser at the floor under the wall behind the brown material; the result of the wall behind the brown material that matter. During an interview from 1:51 p.m. to 2 stated when housed only mopped down didn't move furniture bugs, mouse dropp from trees were obstant of the small wind was also a fine layer. | of gray fuzzy material on the led by R9: The white toilet ained with a dark gold, rusty revent in the bathroom ceiling a significant amount of gray e slats. In on the memory care unit, in the ceiling was rusty and had to f gray fuzzy material on the ve tiles, approximately two es, missing from around the regular surface with sharp lied by R4: An excessive t and debris resembling thick yed in the return air vent on | 21665 | DEFICIENCY) | | |
| | | nddition, the return air vent in g had a significant amount of on the slats. | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 30 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
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| HILLCRI | EST CARE & REHABII | ITATION CENTE | THBEND AVE | _ | | | |
| | | MANKAT | O, MN 56001 | | | | |
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| 21665 | Continued From pa | ge 30 | 21665 | | | | |
| | R3 in room 401 was 5 feet in front of a s directly toward him. approximately 4 - 5 from the fan toward were heavily soiled | ion on 2/16/22, at 8:21 a.m., s asleep in a broda chair about mall fan that was blowing Observed strands of dust inches in length blowing out IR3; the blades of the fan 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. | | | | | | |
| | at 12:50 p.m., with a nursing (ADON), to environmental condition, in room sanitizer dispenser 111 the paper towel was still empty, both The ADON asked s refill them. With per looked through draw of mice. Observed on the window sill a Observed a return a window with an exclust/debris in it. The | and observation on 2/16/22, the assistant director of gether observed the above terns by going to each room. 103, the wall mount hand was still empty, and in room dispenser in the bathroom h initially observed on 2/14/22. taff to notify housekeeping to mission from R4 in room 201, wers and closet for evidence mouse droppings in a drawer, and the floor of the closet. Fair vent on the floor below the dessive/heavy amount of gray the ADON admitted the mouse tessive dust posed a health risk | | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 31 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING | A. Bollbirto. | | c |
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| NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | |
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| 21665 | to residents and state housekeeping thore follow up with main During an interview at 1:36 p.m., togethen environmental servobserved the above going to each room started a list on 2/1 needed to be repla (room 201) to look droppings had been cleaned, below the window of dust and debris, and closet floor. During an interview following the tour of administrator state rooms came as sof particularly the confacility had problem administrator state acceptable, and addresidents a sanitary adding "we will take During an interview housekeeping super aware of return air bathrooms and the resident rooms, but ever been cleaned trained housekeeping that it is build the usually mentioned. | aff, and stated she would have oughly clean R4's room and stenance and housekeeping. If and observation on 2/16/22 ther with the administrator and rices director (ESD)-A, we environmental concerns by the ESD-A stated she had 4/22, of stained toilets that ced. Went into R4's room at areas where mouse in seen; the window sill which the return air vent on the flowhich was heavily soiled with the mouse droppings on the difference of the condition of the resider mewhat of a surprise, dition of the toilets, adding the with rusty water. The difference was not limitted it was not providing y and home-like environment. | t e e e e e e e e e e e e e e e e e e e | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 32 of 42

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| ши і сві | EST CARE & REHABI | 714 SOUT | THBEND AVE | NUE | | |
| HILLORI | EST CARE & REHABII | MANKAT | O, MN 56001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| 21665 | Continued From page 32 | | 21665 | | | |
| | times before starting informed that a responsive properties only mopped down stated he had received about that, adding the housekeepers did at them around to material personal fans in room or com 417 occupied heavy amount of fur room 401, the fand on R3 from about 5 large fan on top of anot in operation. His housekeepers to not cleaned and take the them cleaned, additional blow dust on reside floor vent in room 1 ceiling tile, bathroom HS-C stated the fact some of the stained care of the replacing the return air vents. During an interview discussed environme maintenance assist stated the facility which was some things needed adding that the confidence of the staffed, findings had been and were short staffed, findings had been addust and debris builting that the confidence of the staffed, findings had been and debris builtings had bee | g on their own. When ident stated housekeepers the center of the room, HS-C atly talked to a housekeeper ne wanted to trust that the a thorough job, but didn't follow ke sure. HS-C was shown oms 401 occupied by R3, and by R32, both which had a zzy gray material on them. In was small, and blowing directly feet away. In room 417, a dorm size refrigerator was S-C stated he expected office when fans needed to be nem to maintenance to have ng it wasn't good for fans to ents. Together looked at the 01, as well as the stained m vent and rusty toilet bowl; cility was planning to replace deficites, and he would take g the ceiling tiles and cleaning of toilets, and HS-C. ESD-A as old and acknowledged d to replaced such as toilets, dition of some toilets was not what should be found in a C stated staffing been a challenge given they but admitted some of the going on for a long time (e.g., ld up in vents) and could not ecent shortage of staff. ESD-A | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | X3) DATE SURVEY COMPLETED | | |
|--|--|---|---|---------------------------|---|--------------------------------|--------------------------|
| | | | | A. BUILDING. | A. BOILDING. | | |
| | | 00031 | | B. WING | | | 8/2022 |
| NAME OF PROVID | ER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCREST CA | ARE & REHABII | LITATION CENTE | | THBEND AVE D, MN 56001 | | | |
| | EACH DEFICIENCY | TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| Durir hous mop furnit hous a clip chec did n were towe every reme Facil Resid hous floors would (drop Envir outlir resid mop unde SUG admi main impo funct admi main perio safe, is ma | ekeeper (H)-A under beds or ure. H-A stated ekeepers and oboard with resided off when dot include promotion done each dals. When asked thing, H-A adrember and did lity policy titled dents' rooms, dekeeping would and tabletops do remain alert opings) and reponmental Serviced step by steem trooms. The floors, e.g. or the bed. GESTED MET nistrator or destenance and hor including and hoministrator or destenance and hor including and the clean, functional and to the clean and the c | on 2/18/22, at 2 pstated no one had move and mop used they were short the job was stressident rooms listed lone cleaning a round to ensure spay, such as replacid how she remembitted there was a | d hold her to nder sful. H-A had a that she som. The list ecific tasks ng paper abered to do a lot to infecting 3, indicated such as is. Personnel dent activity to the expolicy aning specify how to and/or to mop ECTION: The cate on the san, the trainate with the to conduct ensure a environment | 21665 | | | |

6899

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | (X3) DATE COMP | |
|---|---|---|--------------------------|---|--------------------------------|--------------------------|
| | | | A. BUILDING. | | С | |
| | | 00031 | B. WING | | 1 | , 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | ITATION CENTE | THBEND AVE D, MN 5600 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21730 | Continued From pa | ge 34 | 21730 | | | |
| 21730 | MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance | | 21730 | | | 3/18/22 |
| | condition on the site conducive to the ha insects, rodents, or eliminated immedia control program mupersonnel. This MN Requirement | nd rodent control. Any e or in the nursing home urborage or breeding of other vermin must be tely. A continuous pest ust be maintained by qualified ent is not met as evidenced | | | | |
| | 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. | | | Plan of Correction Home like Environment Please accept the following as the credible allegation of compliance. Plan of Correction does not constitute admission of guilt or liability by the and is submitted only in response | This tute any facility | |
| | renal disease (rena process of removin transmission based | uded diabetes, end stage I failure) requiring dialysis (the g toxins from the body), and I precautions for recurrent (a bacteria in the bowel which d fever). | | regulatory requirements. How corrective action will be taker those affected by the alleged defic practice: Housekeeping has deep clean the effected rooms. Maintenance either replaced or cleaned all of the effected toilets. How will the facility identify other re- | ient ned all of has e | |
| | assessment dated cognitively intact, havision, clear speech understand. R4 req transferring in and a wheelchair. R4 di | | | having the potential to be affected 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 systems the facility will alter to ensure the problem will be corrected and the same deficient practice. | by the ne or sure that | |
| | who resided in roon | on 2/14/22, at 1:51 p.m., R4 n 201, reported he had mice in em in the ceiling and I've seen | | occur: Housekeeping has established a checklist for cleaning rooms to ens | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 35 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | LE CONSTRUCTION :: | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|-------------------------|---|--|--------------------------|
| | | 00031 | B. WING | | 02/1 |) 8/2022 |
| | PROVIDER OR SUPPLIER | ITATION CENTE 714 SOU | DDRESS, CITY, THBEND AV | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| 21730 | them on the floor. In yesterday." R4 add droppings on his floor. It was tated maintenar room and had cauge months. No traps wo of the room. R4 stated maintenar room and had cauge months. No traps wo of the room. R4 stated resser drawers. R nursing assistant (Nothen housekeeping put some kind of perroom. R4 stated maintenance was a few mouse droppings at trees on R4's wide. Observed a small allower left corner of tape placed around conditioner was lood. During an interview housekeeper (H)-B of mice in the facility "I've seen mouse declothing chewed on occurred, H-B states housekeeping superanother housekeeper H-B could not recall was a few months at During an observation mice droppings. R3 was asleep in a front of a small fan | Heard them in the ceiling led that there had been mice for and in his dresser drawers are staff put live traps in his left five mice over several arere observed in visible areas ted his wife had been there one and defended his wife brought a law into the room to show her, scoured the entire room and experiment repellent in the laintenance and housekeeping in his room. R4 didn't know if the rofessional exterminator. p.m., observed dead bugs, and "helicopter" leaves from and deep window sill. hir-conditioning unit in the large window. Silver duct the opening of the air see in some spots. I on 2/16/22, at 8:16 a.m., admitted to seeing evidence y and in rooms 201 and 401. Troppings in room 401 and in room 201." When this ed she told her boss, ervisor (HS)-C, then her and er deep-cleaned room 401. I when that was, but stated it | 1 | rooms are kept appropriately Quality Assurance plans to make sure that are achieved and are perman. Administrator or Designee with daily audits for 2 weeks as new monitor for compliance. Completion date: 3/18/2022 | at corrections ent: vill conduct | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 36 of 42

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|-------------------------------|--------------------------|
| | | | | C | |
| | 00031 | B. WING | | 02/1 | 8/2022 |
| NAME OF PROVIDER OR SUPPL | ER STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HILLCREST CARE & REHA | BILITATION CENTE | THBEND AVE | | | |
| OLUMAN DIV | | O, MN 56001 | | | |
| PREFIX (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY) | D BE | (X5) COMPLETE DATE |
| 21730 Continued From | page 36 | 21730 | | | |
| | - 5 inches in length blowing out blades of the fan were heavily uzzy material. | | | | |
| nursing assistar if either had see rooms, H-A state had not, but had seen mice in the seen droppings, rooms." When a room (201) and but couldn't reca H-A stated if she her boss HS-C, During a telephor p.m., family meraware of mice ir observed holes it was from mice 2/13/22, she cle and saw mouse mice had eaten stated she notic 2/13/22, when seen the wall to sit in recliner had obvected the floom R4's dresser drafabric softeners to repel mice. Finice in R4's room | ew on 2/16/22, at 8:26 a.m., with t (NA)-A and (H)-A, when asked a evidence of mice in resident and "not often." NA-A stated she been told some residents had in rooms. H-A stated she had "not everywhere, just one or two sked which rooms, stated R4's someone on the northwest wing, II which room or which resident. saw droppings, she informed and cleaned the room well. The interview on 2/16/22, at 9:06 and cleaned the room well. The interview on 2/16/22, at 9:06 and cleaned the room well. The stated while visiting on aned a small chest of drawers droppings in it and also noticed through a bag of Cheetos. FM-E and a lot of mouse droppings on the pulled R4's recliner away from the truthermore, FM-E stated the ously not been pulled out and on a while as there were many and dirt under it. FM-E stated she over who then came in and the well. FM-E stated she cleaned wers of mice droppings and put the pulled she had never seen and, but had seen plenty of g there had been a trap behind | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------------|--|--------------------------------|--------------------------|
| | | 00031 | B. WING | | I | C 18/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | TATE, ZIP CODE | | |
| HILLCRE | EST CARE & REHABII | ITATION CENTE | THBEND AVE O, MN 56001 | _ | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21730 | Facility policy titled was reviewed and i maintain an on-goir ensure the building. A service report frod dated 1/24/22, was administrator and redocumented by the Performed inspectic common space, ha activities. I expected kitchen, talk with foshe still has issues drawers. I expected hole in wall behind room), talk with the director (ESD)-A abwall, but she said cathat she would try to hole. I find that the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers, of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers. I make the point of entry for mikitchen drawers | Pest Control, dated May 2008, ndicated the facility would a pest control program to would be kept free of rodents. In Guardian Pest Solutions received from the eviewed. The following was service technician (ST)-F: ons of door entrances, llways and there were no d [sic] dining room area and od service director (FSD)-A, with mice in her (kitchen) d [sic] area again here is a big ice machine (in resident dining environmental services yout sealing that hole in the an't move the ice machine and of find a way to seal up that whole [sic] pedometry [sic] the doe that are getting in to mentioned this last time I was wities found. If on 2/16/22, at 10:50 a.m., used to have problems with ore. Mice droppings had been awers in the past. FSD-A stated mice were coming from pipe that comes into the machine. FSD-A stated that ed and denied further ouring kitchen tour, did not appings in drawers, on | | | | |
| | HS-C stated he had | on 2/16/22, at 11:57 a.m., d not heard anything from staff le. If staff tell him about mice, | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 38 of 42

Minnesota Department of Health

| WIIIIII | na Department of He | ailli | | | | |
|--------------------------|--|--|---------------------------|---|-----------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
| 7110 1 12/11 | OF CONTRECTION | BENTI TOXTTON NOWBER. | A. BUILDING: | | | |
| | | 00031 | B. WING | | 00/4 | |
| | | 00031 | | | 02/1 | 8/2022 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| HILLCRE | ST CARE & REHABII | ITATION CENTE | THBEND AVE D, MN 56001 | | | |
| (VA) ID | CLIMMADV CTA | | - | | | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21730 | Continued From pa | ge 38 | 21730 | | | |
| 21730 | he puts a tube trap can go in, but they of Guardian Pest Commonth; the technicia housekeeping and and informed them When asked if he know coming in, HS-C sta "numerous places, stated there was a maintenance would identified, staff clear room and he placed placed packets of prepel mice. On 2/16/22, at 12:5 of nursing (ADON), protective equipment R4, looked through evidence of mice. The drawer dressers again were looked through found in the underwisheets that FM-E placed sill and the floor of air vent on the floor an excessive/heavy it. This was pointed stated she was awareports of mice had attention recently. The and mice droppings could pose a health in the control of the | in the residents room mice can't get out. HS-C stated trol came to the facility once a | 21730 | | | |
| | ESD-A. | t's room and follow up with p.m., with the administrator | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 39 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---|---|--------------------------------|--------------------------|
| | | | A. BOILDING. | A. BOILDING. | | |
| | | 00031 | B. WING | | l l | C 18/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, S | STATE, ZIP CODE | | |
| IIII I CDI | TOT CADE & DELIABI | 714 SO | UTHBEND AVE | ENUE | | |
| HILLCRI | EST CARE & REHABII | MANKA | TO, MN 5600 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21730 | Continued From pa | ge 39 | 21730 | | | |
| | and ESD-A, went in where mouse dropp window sill which has conditioner with los on the floor below the soiled with dust and droppings on the cladministrator and Emost of 2/13/22, cladroppings and put of mice. During an interview administrator acknowled food, which The administrator since were getting in the pest exterminat tomorrow to address acknowledged mice acceptable, nor was | ato R4's room to look at areasonings had been seen; the ad since been cleaned, the are duct tape, the return air vershe window which was heavily didebris, and the mice oset floor. R4 informed the ESD-A that FM-E had spent eaning drawers of mice dryer sheets in them to repel on 2/16/22, at 1:49 p.m., the owledged he had been aware m, adding "he brings in a lot of its a food source for mice." It is a food source for mice. The tated he did not know how onto R4's room and would have or come back today or its it. The administrator is it a sanitary and home-like | r et | | | |
| | During a telephone p.m., ST-F stated h facility on 2/17/22. Smain problem with the wall behind the room adjacent to the told maintenance as about this in the pado; I don't know if it didn't look at it." Whoked in room 118 of mice, adding the down to the floor ar would cause the pip to MA-B he could u | g "we will take care of it." interview on 2/18/22, at 1:30 le was called to come to the ST-F stated he believed the mice was related to the hole ice machine in the dining e kitchen. ST-F stated he hassistant (MA)-B and ESD-A st. "I told MA-B what he could is completely sealed up I hile there, ST-F stated he where there had been report re was a heat duct that went and not sealed up because it be to freeze. ST-F suggested se wire mesh. ST-F checked itchen where there had been | d s | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 40 of 42

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | | | | |
|---|--|---|---|--|-------------------------------|--------------------------|--|--|--|--|--|
| | | 00004 | | | 00/4 | | | | | | |
| | | 00031 | <u>I</u> | | 02/1 | 8/2022 | | | | | |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | | | | | | |
| HILLCREST CARE & REHABILITATION CENTE 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 | (EACH CORRECTIVE ACTION SHOULD BE COMPLI | | (X5) COMPLETE DATE | | | | | |
| 21730 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | 21730 | DETIGIENCT) | | | | | | | |
| | | Pest Control, dated May 2008, would maintain an effective | | | | | | | | | |

Minnesota Department of Health

STATE FORM 8UD511 If continuation sheet 41 of 42

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | | | | |
|--|--|----------------------------|---|-------------|-------------------------------|--|--|--|--|--|
| | | A. BUILDING: | | | _ | | | | | |
| | 00031 | B. WING | | I | C 1 8/2022 | | | | | |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | | | | | |
| HILLCREST CARE & REHABILITATION CENTE MANKATO, MN 56001 | | | | | | | | | | |
| PREFIX (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE | | | | | |
| an on-going pest of the building was ke Additionally, mainted necessary, assisted services. Facility policy titled Residents' rooms, of personnel would resordent activity (drop findings to the Envious SUGGESTED MET The administrator of preventative pest/rodeveloped and impleducate staff on the routine environment adequate pest/rode report these finding performance improfurther recommend compliance. | m; that the facility maintained ontrol program to ensure that opt free of insects and rodents. Enance, when appropriate and doin providing pest control. Cleaning and Disinfecting dated August 2013, indicated main alert for evidence of opings) and report such ronmental Services Director. THOD OF CORRECTION: or designee could ensure a ordent control program was elemented. The facility could esse policies and perform that rounds/audits to ensure ent control. The facility could gest to the quality assurance evement (QAPI) committee for lations to ensure ongoing. R CORRECTION: Twenty-one | 21730 | | | | | | | | |

6899

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F5507032

(X2) MULTIPLE CONSTRUCTION

Printed: 03/03/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 245507 B. WING 02/16/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTE 714 SOUTHBEND AVENUE MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 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. 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.