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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OKN2

Facility ID: 00031

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245507**

2. STATE VENDOR OR MEDICAID NO. (L2) **134463000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HILLCREST CARE & REHABILITATION CENTER**
(L4) **714 SOUTHBEND AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **01/9/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 1/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/27/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **01/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245507

February 22, 2017

Ms. Heather Slama, Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

Dear Ms. Slama:

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 January 6, 2017 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

Ms. Heather Slama, Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: Project Number S5507026

Dear Ms. Slama:

On December 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 9, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 9, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 17, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 6, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 9, 2016, effective January 6, 2017 and therefore remedies outlined in our letter to you dated December 19, 2016, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245507 Y1	A. Building B. Wing Y2	1/9/2017 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0221	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.10(e)(1), 483.12(a)(2)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed
LSC	01/06/2017	LSC	01/06/2017	LSC	01/06/2017
ID Prefix F0356	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(g)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/06/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 03048	DATE 1/9/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/9/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245507 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/17/2017 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	01/06/2017	LSC K0321	01/06/2017	LSC K0353	01/06/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0712	01/06/2017	LSC K0781	01/06/2017	LSC K0918	01/06/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 35482	DATE 1/17/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/8/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OKN2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00031

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245507**

2. STATE VENDOR OR MEDICAID NO. (L2) **134463000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HILLCREST CARE & REHABILITATION CENTER**
(L4) **714 SOUTHBEND AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **12/09/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/19/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **01/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 19, 2016

Ms. Dori Mutch, Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: Project Number S5507026

Dear Ms. Mutch:

On December 9, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 18, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 18, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 June 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	12/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §482.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must-	F 221		1/6/17

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

Electronically Signed | 12/21/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245507	A. BUILDING _____ B. WING _____	12/09/2016

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

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F 221	Continued From page 1 (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess the appropriate use of a wheelchair tray table for 1 of 1 resident (R13) reviewed for physical restraints. Findings include: On 12/05/16, at 11:45 a.m. during the initial tour R13 was observed seated in room in a Broda wheelchair (w/c) with a tray table velcroed to the chair. The tray table attached to the arms of the w/c and extended approximately 16 inches in front of the resident limiting access to her body below the waist. The tray table top had no items placed on it and there were no staff present in the room with the resident. On 12/06/16, at 2:21 p.m. R13 was observed seated in a recliner in room with feet raised and blanket over body; resident had eyes closed and appeared to be sleeping. R13's Broda w/c was observed in the room with attachable tray table leaning against the wall next to the w/c. On 12/07/16, at 8:08 a.m. R13 was observed in the south dining room seated in a Broda chair with a tray table attached to the chair that crossed	F 221	The lap tray for affected resident was removed and discontinued. Facility has no other physical restraints in use. A restraint assessment will be completed, an order will be obtained, a consent form will be signed, and interventions will be care planned for all residents before applying a physical restraint. Nursing staff will be educated on the facility restraint policy. Audits will be conducted, if applicable, and reported to QA committee.	

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F 221	Continued From page 2	F 221		

the lower half of her body. R13 was seated up to the dining room table while the w/c tray table remained attached to the w/c. The w/c tray table was low enough to fit under the dining room table. Resident was eating breakfast independently. Staff were not observed to be in the dining room at this time.

On 12/07/16, at 9:30 a.m. R13 was observed sitting in the south chapel. R13 was seated in a Broda chair with a tray table attached to the w/c that crossed the lower half of the residents body. Two staff were observed present in the chapel area at that time.

When interviewed on 12/07/16, at 10:37 a.m. nursing assistant (NA)-E informed surveyor that R13 was currently at the "stick club" activity in the north dayroom. NA-E indicated the staff encouraged her to stay busy with activities or the resident would wander up and down the hall and in and out of other residents' rooms. NA-E further included R13's wheelchair tray table remained attached to the w/c most of the time when the resident was in the w/c. NA-E confirmed R13 was unable to remove the w/c tray table on her own. NA-E further confirmed R13 had a history of attempting to self transfer from the w/c and also out of bed, adding that the resident was in a low bed with a fall mat.

On 12/07/16, at 10:39 a.m. R13 was observed in the north dayroom participating in the "stick club" activity program. R13 was seated in a Broda w/c with a tray table attached to the w/c that crossed the lower half of her body. The activity director was observed to direct the residents to do different movements with the sticks to the music. R13 was limited with performing the directed

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F 221	Continued From page 3 movements due to the tray table in front of her. On 12/07/16, at 10:57 a.m. R13 returned to the south lounge area following the exercise activity. The surveyor asked R13 if she could remove the tray table from her w/c. R13 stated "I think so" and attempted to removed the tray table from the w/c. R13 was unable to remove the tray and proceeded to propel herself up to the nurses station. R13 asked a NA at the desk if the tray table could be removed from her w/c. The NA informed R13 that the tray table could not be removed. The NA then propelled R13 back to the sitting area on the south wing. R13 was observed to sit calmly in her w/c next to another resident. At 11:06 a.m. the resident then propelled self out of the sitting area and down the hallway to the dining room. On 12/07/16, at 11:16 a.m. R13 was observed seated in a Broda w/c in south dining room with tray table attached to the w/c. The tray table fit underneath the dining room table enabling the resident to sit up to the table to eat. R13 was seated with one other resident at that time, eating meal independently, with no attempts to leave the table. Staff were present in the dining room only when bringing food to residents or transporting residents into the dining room. At 11:23 a.m. trained medication aide (TMA)-A was observed to sit at R13's table and assist the other resident seated with R13. TMA-A remained at R13's table until approximately 11:45 a.m. R13 was observed to sit and eat her meal calmly throughout the observation with no attempts to leave the table. Review of R13's significant change Minimum Data Set (MDS) assessment dated 8/30/16, indicated R13 had severe cognitive impairment,	F 221		

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F 221	Continued From page 4	F 221		

delusions, hospice care, extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The assessment further identified the resident as having behavioral symptoms towards others of rejection of care and wandering with significant risk of getting to a potentially dangerous place. The MDS revealed R13's behaviors had worsened since the prior assessment.

Review of R13's care plan dated 9/8/16, identified the resident as having impaired physical mobility with risk for falls. The care plan included falls that occurred on 3/25/16, 4/19/16, 6/17/16, 6/29/16, 8/29/16, 9/10/16, 9/17/16, 9/21/16, 10/2/16, 10/6/16, 10/8/16 and 10/10/16. Interventions included: encourage resident to allow room door to remain open during HS (hour of sleep) for closer monitoring of her positioning & attempts for self transfers. When resident returns to her room following meals or activity, encourage transfers to her recliner or bed to reduce risk of self transfer/falls. Call light will be kept within reach and answered promptly; encourage resident to use and to not self transfer for safety purposes. The care plan did not include the use of a w/c tray table attached to R13's Broda chair. Review of R13's hospice care plan dated 11/3/16, did not include the use of a w/c lap tray.

Review of R13's incident reports from 8/29/16 - 10/29/16 revealed the following: Fall from w/c on 9/5, 9/10, 9/16, and 9/17/16; fall from recliner on 9/21 and 9/24/16 and fall from bed on 8/29, 9/17, 9/24, 10/3, 10/6, 10/7, 10/10, 10/28, and 10/29/16. No injuries were noted.

Review of R13's most current signed physician orders dated 11/3/16, did not include an order for

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F 221	Continued From page 5 the w/c tray table. On 12/07/16, at 1:36 p.m. R13 was observed in room in recliner with feet elevated and afghan covering the resident. R13's eyes were closed and appeared to be sleeping. NA-E and NA-F were observed across the hall within sight of R13's room at a charting station and were interviewed at this time. NA-F indicated the recliner was R13's favorite chair and was content in the chair when tired. NA-F further included earlier in the day R13 was more alert and would then attempt to transfer self when placed in the recliner. NA-E and NA-F confirmed when R13 was up in the w/c the tray table stayed attached to the chair most of the time other than when toileting every 2 hours. NA-E was unsure how long R13 had utilized the tray table, but that it was attached to the Broda w/c by hospice less than 6 months ago. When interviewed on 12/07/16, at 2:47 p.m. registered nurse case manager (RN)-C confirmed a physical restraint assessment had not been completed for the use of R13's w/c tray table. RN-C further included R13's tray table had not been identified as a restraint because she was unable to to transfer from the w/c and could propel herself while in the w/c with the tray table on. RN-C confirmed R13 had a history of falls that resulted mostly from transferring from the bed. RN-C indicated hospice had implemented the Broda w/c sometime in October 2016, and had also supplied the tray table at that time. RN-C included tray table on R13's w/c was convenient for staff to utilize during activities as R13 would become too anxious to remain at a table during an activity. RN-C confirmed R13 would not be able to remove the w/c tray table on her own and	F 221		

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F 221	Continued From page 6 included R13 was unable to stand on her own d/t weakness in her legs/knees. RN-C also confirmed R13 would not need the w/c tray table for positioning as the Broda chair was a good fit for her. RN-C confirmed the tray table was not assessed as a restraint and there was not a physician order for use. RN-C further confirmed the tray table had not been care planned. Review of the policy titled Restraints dated 9/11, included; Any form of restraint will not be the first intervention when meeting the needs of the resident and will be used as minimally as possible. Physical and chemical restraints will be used only to treat specific medical symptoms or in an emergency situation to protect residents or others from eminent danger...Physical Restraints - Are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body, that the resident cannot remove easily and restricts freedom of movement or normal access to ones body.	F 221		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement a protective	F 282	Protective boot was applied per order and care plan was updated.	1/6/17

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F 282	Continued From page 7 device in accordance with the written plan of care for 1 of 3 residents (R31)reviewed for non-pressure related skin conditions. Findings include: Review of R31's diagnosis report included diagnoses of paraplegia (paralysis of the lower half of the body) and diabetes mellitus. Bluestone, nursing home order from nurse practitioner dated 11/29/16, noted R31 had a left great toe ulceration being multifactorial diabetic and arterial. On 12/6/16, at 11:03 a.m. observation of R31's left foot revealed a dark purple bruise to the left great toe and a 1.0 centimeter (CM) scab on top of the 3rd toe. Review of R31's most current care plan dated 11/18/16, identified the resident as having alteration in skin integrity that included a red area on top of the left great toe. R31 is at risk for skin breakdown due to impaired mobility secondary to paraplegia. Interventions listed; daily treatment to left great toe per physician assistant (PA) orders, left boot on when up and off when in bed and to monitor skin during cares. Review of R31's treatment administration record for November and December 2016, included; each shift staff were to: (1.) Protect toes on left foot from injury resident should wear a boot with some protection that extents (sic) past the toes so we limit potential insult to toes every shift and (2.) Paint with betadine daily left great toe leave out of shoe using non skid sock until resolved also 3rd toe at bedtime for skin ulcer.	F 282	All residents care plans were reviewed to ensure appropriate interventions are in place. Nursing staff will be educated on the importance of following residents plan of care. Audits of implementation of care plan interventions will be conducted by DON or designee weekly x 4, monthly x 3 and results will be reported to QA committee for analysis and further recommendations.	

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F 282	Continued From page 8 Review of R31's physician orders dated 11/29/16, included; -Continue to cleanse toes on left foot daily and paint both left great toe and left 3rd toe with betadine daily. Goal is to keep ulcerations/blisters dry and intact. -Protect toes on left foot from injury, resident should wear a boot with some protection that extends past the toes to limit potential insult to the toes. On 12/6/16 at 2:17 p.m. R31 was observed to be up in a powered wheelchair (w/c) wearing a grippy sock and boot on his left foot. The toes and top third of his left foot did not have a toe protective guard on and fully exposed. During interview on 12/6/16, at 2:24 p.m. nursing assistant (NA)-D indicated R31 wears a boot to the left foot to protect his foot and toes. NA-D further included R31 will bump his feet on objects when up in his powered w/c. R 31 does not have sensation in his toes due to his paraplegia. On 12/7/16, at 10:26 a.m. R31 was observed in his room sitting in his powered w/c with slippers on both feet. During interview at this time, R31 stated he did not know why staff had not put his boot on his left foot. R31 further included he needs to wear the protective boot to the left foot because he bumps into things when in his w/c. On 12/7/16, at 1:20 p.m. and 2:29 p.m. R31 was observed sitting in a recliner chair in his room with slippers on both feet. No boot or protection was noted to the left foot. On 12/8/16, at 7:59 a.m. R31 was observed in his powered w/c with slippers on both feet. Observation at 3:12 p.m. R31 was observed in the hall in a powered w/c with both feet/toes	F 282		

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F 282	Continued From page 9 exposed and unprotected. During interview on 12/8/16, at 9:20 a.m. NA-B indicated she was not aware of R31's protective boot to the left foot/toes. At 9:21 a.m. NA-C indicated she was not aware of when R31's protective boot needed to be on, but did confirm she knew the resident had a protective device for the left foot/toes. Review of the undated Resident Care Sheet utilized by NA's for R31, had no information related to the use of the protective boot to the left foot/toes. During interview on 12/8/16, at 11:37 a.m. NA-C stated "nobody really knew if it was suppose to be on or off" (indicating the protective boot). During interview on 12/8/16, at 12:32 p.m. registered nurse (RN)-B verified R31 was to wear a protective boot to his left foot. RN-B indicated R31 had a non pressure sore to his left great toe and required the left foot boot for protection. RN-B verified no information had been included on the Resident Care Sheet, utilized by the NA's for R31's care. RN-B confirmed the residents wound to his left great toe had not been measured nor described in the record and that the care plan had not always been implemented by the staff. During observation on 12/8/16, at 3:12 p.m. R31 was in his powered w/c without the boot protector to his left foot/toes. At 3:13 p.m. interview with the OT verified R31's protective toe guard was missing and the residents toes were not protected.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		1/6/17

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F 309	Continued From page 10 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement a protective device for 1 of 1 resident (R31) who had an ulcerated toe. Findings include: Review of R31's diagnosis report included diagnoses of paraplegia (paralysis of the lower half of the body) and diabetes mellitus. Bluestone, nursing home order from nurse practitioner dated 11/29/16, noted R31 had a left	F 309	Protective boot was applied per order and care plan was updated. All residents care plans were reviewed to ensure appropriate interventions are in place. Nursing staff will be educated on the importance of following residents□ plan of care. Audits of implementation of care plan interventions will be conducted by DON or designee weekly x 4, monthly x 3 and results will be reported to QA committee	

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F 309	Continued From page 11 great toe ulceration being multifactorial diabetic and arterial. On 12/6/16, at 11:03 a.m. observation of R31's left foot revealed a dark purple bruise to the left great toe and a 1.0 centimeter (CM) scab on top of the 3rd toe. Review of R31's quarterly Minimum Data Set (MDS) assessment dated 10/13/16, identified R31 as being cognitively intact, requires extensive assistance with dressing and personal hygiene and has impairment of the lower extremities. The MDS further identified R31 as being independent with locomotion on and off the unit, utilized a wheel chair and did not have any skin ulcers present. Review of R31's Care Area Assessment (CAA) dated 4/15/16, indicated R31 was at risk for skin breakdown related to diagnosis of paraplegia. Review of R31's most current care plan dated 11/18/16, identified the resident as having alteration in skin integrity that included a red area on top of the left great toe. R31 is at risk for skin breakdown due to impaired mobility secondary to paraplegia. Interventions listed; daily treatment to left great toe per physician assistant (PA) orders, left boot on when up and off when in bed and to monitor skin during cares. Review of R31's treatment administration record for November and December 2016, included; each shift staff were to: (1.) Protect toes on left foot from injury resident should wear a boot with some protection that extents (sic) past the toes so we limit potential insult to toes every shift. (2.) Paint with betadine daily left great toe leave out of	F 309	for analysis and further recommendations.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 shoe using non skid sock until resolved also 3rd toe at bedtime for skin ulcer. Review of the bath/shower skin audit dated 11/28/16, indicated R31 had a wound to the left great toe, and had developed a slough (dead tissue) center and increased purple color to toe. It further indicated R31 had a scab to left 3rd toe and superficial open area to the medial left 5th toe. No wound measurements were found in the medical record. Review of R31's physician orders dated 11/29/16, included; -Continue to cleanse toes on left foot daily and paint both left great toe and left 3rd toe with betadine daily. Goal is to keep ulcerations/blisters dry and intact. -Protect toes on left foot from injury, resident should wear a boot with some protection that extends past the toes to limit potential insult to the toes. On 12/6/16 at 2:17 p.m. R31 was observed to be up in a powered wheelchair (w/c) wearing a grippy sock and boot on his left foot. The toes and top third of his left foot did not have a toe protective guard on and fully exposed. During interview on 12/6/16, at 2:24 p.m. nursing assistant (NA)-D indicated R31 wears a boot to the left foot to protect his foot and toes. NA-D further included R31 will bump his feet on objects when up in his powered w/c. R 31 does not have sensation in his toes due to his paraplegia. On 12/7/16, at 10:26 a.m. R31 was observed in his room sitting in his powered w/c with slippers on both feet. During interview at this time, R31 stated he did not know why staff had not put his	F 309		

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	245507	A. BUILDING _____ B. WING _____	12/09/2016

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HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

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F 309	Continued From page 13	F 309		

boot on his left foot. R31 further included he needs to wear the protective boot to the left foot because he bumps into things when in his w/c. On 12/7/16, at 1:20 p.m. and 2:29 p.m. R31 was observed sitting in a recliner chair in his room with slippers on both feet. No boot or protection was noted to the left foot.

On 12/8/16, at 7:59 a.m. R31 was observed in his powered w/c with slippers on both feet. Observation at 3:12 p.m. R31 was observed in the hall in a powered w/c with both feet/toes exposed and unprotected.

During interview on 12/8/16, at 9:20 a.m. NA-B indicated she was not aware of R31's protective boot to the left foot/toes. At 9:21 a.m. NA-C indicated she was not aware of when R31's protective boot needed to be on, but did confirm she knew the resident had a protective device for the left foot/toes. Review of the undated Resident Care Sheet utilized by NA's for R31, had no information related to the use of the protective boot to the left foot/toes.

During interview on 12/8/16, at 11:37 a.m. NA-C stated "nobody really knew if it was suppose to be on or off" (indicating the protective boot).

During interview on 12/8/16, at 12:04 p.m. occupational therapist (OT) indicated R31 was to wear the left protective boot to protect his foot/toes and that OT provided the staff with a protective boot/toe guard on 11/30/16.

During interview on 12/8/16, at 12:32 p.m. registered nurse (RN)-B verified R31 was to wear a protective boot to his left foot. RN-B indicated R31 had a non pressure sore to his left great toe

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F 309	Continued From page 14 and required the left foot boot for protection. RN-B verified no information had been included on the Resident Care Sheet, utilized by the NA's for R31's care. RN-B confirmed the residents wound to his left great toe. During observation on 12/8/16, at 3:12 p.m. R31 was in his powered w/c without the boot protector to his left foot/toes. At 3:13 p.m. interview with the OT verified R31's protective toe guard was missing and the resident's toes were not protected.	F 309		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	F 356		1/6/17

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F 356	Continued From page 15 (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently include current census information and the number of licensed and unlicensed staff worked on the daily nursing hour posting. This had the potential to effect all visitors to the facility in addition to the residents residing in the facility. Findings include: During the initial tour of the facility on 12/5/16, at 11:45 a.m. observation of the facility nursing hour posting was dated 12/1/16. In addition, the nursing hour posting did not include the number	F 356	The daily staffing report was modified to accurately reflect the total number and actual hours worked by licensed and unlicensed staff providing direct resident care. The HR/Scheduler will post the daily staffing hours and keep updated each day during the week. The weekend receptionist will post the daily staffing hours on the weekend. The South Charge Nurse will be responsible for ensuring that census and staffing hours are up to date each shift.	

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F 356	Continued From page 16 of licensed and unlicensed nursing staff for each shift nor did it include the end times of each shift. The posting also did not include the actual shifts worked. Throughout the survey observations on 12/6/16, 12/7/16 and 12/8/16, the nursing hour posting did not include the total numbers of licensed and unlicensed staff nor did it include the off starts (5:00 a.m., 10:00 a.m., 2:30 p.m. and 5:00 p.m.) as well as the end times of each shift according to the nursing schedule and actual hours worked. During an interview on 12/5/16, at 11:45 a.m. the human resource director (HR) indicated the nursing hours posted is not updated when there is a change in hours nor is the nursing staff posting updated on the weekends. The HR director further confirmed the posting did not include the current census nor the number of licensed and unlicensed staff working.	F 356	The staff responsible for the posting and updating of the daily staffing hours were educated on the posting requirements. The administrator or designee will conduct audits 3 times per week x 2 weeks, weekly x 4, then monthly x 3 to ensure presence and accuracy of the daily staffing posting and report results to QA committee for analysis and further recommendation.	

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	245507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 8, 2016. At the time of this survey, Hillcrest Health Care Center was found not to be in substantial 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This one-story with partial basement facility was constructed in 1957, with one building addition constructed in 1963. Both buildings were determined to be of Type II(000) construction. The facility is fully fire sprinkler protected throughout. The facility has a 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 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293 SS=F	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in	K 293		1/6/17

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K 293	Continued From page 2 accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that exit and directional signs are displayed in accordance with 7.10 .This deficient practice could affect 57 of the 57 residents. Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) FINDINGS INSCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, observation revealed the the following exits to the exterior were observed without the proper exit signage: a.) Therapy Room door to the exterior. b.) South Dining Room door to the exterior. c.) North Dining Room door to the exterior. This deficient practice was verified by the Facility Maintenance Director.	K 293	Master Electric will be here December 30th to add interior exit signs to therapy room door, South dining room door and North dining room door.	
K 321 SS=F	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing	K 321		1/6/17

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K 321	Continued From page 3 system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain hazardous areas are protected by a fire barrier having 1-hour fire resistance rating. The deficient practice could affect 57 out of 57 residents. Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from	K 321	Storage room door (314) was fixed and now operational.	

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K 321	Continued From page 4 other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, observation revealed the self closing door device on the Storage Room (314) door was not operational. This deficient practice was verified by the Facility Maintenance Director.	K 321		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		1/6/17

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K 353	Continued From page 5 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the ceiling in the Northest Corridor in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 22 out of 57 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353	Kolbinger Construction LLC will be at the facility the week of December 26th to assess ceiling tiles on the North unit. Will set-up plan for replacement of ceiling tiles during this visit.	

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K 353	Continued From page 6 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, observation revealed that numerous drop in ceiling tiles were warped, sagging and cracked causing gaps and holes between the ceiling tiles and the ceiling grid tracks in the Northeast Corridor. These gaps and holes will adversely effect the operation of nearby fire sprinkler heads and smoke detectors by allowing the passage of heat and smoke through the ceiling. This deficient practice was verified by the Facility Maintenance Director.	K 353		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice	K 712	Education provided on fire alarm policy and need for a fire drill during the night shift during each quarter. A fire drill has been completed on the night shift within	1/6/17

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K 712	Continued From page 7 could affect 57 of 57 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, documentation review revealed that a night shift fire drill was not conducted during the 2nd quarter (Apr-Jun), 2016. This deficient practice was verified by the Facility Maintenance Director.	K 712	this quarter.	
K 781 SS=E	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written and current Space Heater Policy.This deficient practice could	K 781	Fire Code form was created addressing the rule of no space heaters allowed at Hillcrest Rehabilitation Center.	1/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 781	Continued From page 8 affect 57 of 57 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, documentation reviewed revealed that the Facility does not have a written Space Heater Policy that is specific to Hillcrest Care Center. This deficient practice was verified by the Facility Maintenance Director.	K 781	Form will be distributed to residents in their admission packets. Staff will receive the form during new employee orientation. All residents currently in the facility will receive the form that addresses no space heaters. All current employees will be educated on the no space heaters rule.	
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		1/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2016**

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

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K 918	Continued From page 9 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 57 of 57 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918	Monthly Emergency Generator Log updated to include transfer-time. All future Monthly Emergency Generator Load Test will have documentation on how long it takes the emergency generator to assume power and the amount of time the generator is cooling down after the load test.	

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	245507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 10 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test. The transfer time of how long it takes the emergency generator to assume power is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918		

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
December 19, 2016

Ms. Dori Mutch, Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5507026

Dear Ms. Mutch:

The above facility was surveyed on December 5, 2016 through December 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	12/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 5, 6, 7, 8, and 9, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to	2 505		1/6/17

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2 505	Continued From page 3 treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess the appropriate use of a wheelchair tray table for 1 of 1 resident (R13) reviewed for physical restraints. Findings include: On 12/05/16, at 11:45 a.m. during the initial tour R13 was observed seated in room in a Broda wheelchair (w/c) with a tray table velcroed to the chair. The tray table attached to the arms of the w/c and extended approximately 16 inches in front of the resident limiting access to her body below the waist. The tray table top had no items placed on it and there were no staff present in the room with the resident. On 12/06/16, at 2:21 p.m. R13 was observed seated in a recliner in room with feet raised and blanket over body; resident had eyes closed and appeared to be sleeping. R13's Broda w/c was observed in the room with attachable tray table leaning against the wall next to the w/c.	2 505	Corrected	

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2 505	Continued From page 4 On 12/07/16, at 8:08 a.m. R13 was observed in the south dining room seated in a Broda chair with a tray table attached to the chair that crossed the lower half of her body. R13 was seated up to the dining room table while the w/c tray table remained attached to the w/c. The w/c tray table was low enough to fit under the dining room table. Resident was eating breakfast independently. Staff were not observed to be in the dining room at this time. On 12/07/16, at 9:30 a.m. R13 was observed sitting in the south chapel. R13 was seated in a Broda chair with a tray table attached to the w/c that crossed the lower half of the residents body. Two staff were observed present in the chapel area at that time. When interviewed on 12/07/16, at 10:37 a.m. nursing assistant (NA)-E informed surveyor that R13 was currently at the "stick club" activity in the north dayroom. NA-E indicated the staff encouraged her to stay busy with activities or the resident would wander up and down the hall and in and out of other residents' rooms. NA-E further included R13's wheelchair tray table remained attached to the w/c most of the time when the resident was in the w/c. NA-E confirmed R13 was unable to remove the w/c tray table on her own. NA-E further confirmed R13 had a history of attempting to self transfer from the w/c and also out of bed, adding that the resident was in a low bed with a fall mat. On 12/07/16, at 10:39 a.m. R13 was observed in the north dayroom participating in the "stick club" activity program. R13 was seated in a Broda w/c with a tray table attached to the w/c that crossed the lower half of her body. The activity director was observed to direct the residents to do	2 505		

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2 505	Continued From page 5	2 505		

different movements with the sticks to the music. R13 was limited with performing the directed movements due to the tray table in front of her.

On 12/07/16, at 10:57 a.m. R13 returned to the south lounge area following the exercise activity. The surveyor asked R13 if she could remove the tray table from her w/c. R13 stated "I think so" and attempted to removed the tray table from the w/c. R13 was unable to remove the tray and proceeded to propel herself up to the nurses station. R13 asked a NA at the desk if the tray table could be removed from her w/c. The NA informed R13 that the tray table could not be removed. The NA then propelled R13 back to the sitting area on the south wing. R13 was observed to sit calmly in her w/c next to another resident. At 11:06 a.m. the resident then propelled self out of the sitting area and down the hallway to the dining room.

On 12/07/16, at 11:16 a.m. R13 was observed seated in a Broda w/c in south dining room with tray table attached to the w/c. The tray table fit underneath the dining room table enabling the resident to sit up to the table to eat. R13 was seated with one other resident at that time, eating meal independently, with no attempts to leave the table. Staff were present in the dining room only when bringing food to residents or transporting residents into the dining room. At 11:23 a.m. trained medication aide (TMA)-A was observed to sit at R13's table and assist the other resident seated with R13. TMA-A remained at R13's table until approximately 11:45 a.m. R13 was observed to sit and eat her meal calmly throughout the observation with no attempts to leave the table.

Review of R13's significant change Minimum Data Set (MDS) assessment dated 8/30/16,

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2 505	Continued From page 6	2 505		

indicated R13 had severe cognitive impairment, delusions, hospice care, extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The assessment further identified the resident as having behavioral symptoms towards others of rejection of care and wandering with significant risk of getting to a potentially dangerous place. The MDS revealed R13's behaviors had worsened since the prior assessment.

Review of R13's care plan dated 9/8/16, identified the resident as having impaired physical mobility with risk for falls. The care plan included falls that occurred on 3/25/16, 4/19/16, 6/17/16, 6/29/16, 8/29/16, 9/10/16, 9/17/16, 9/21/16, 10/2/16, 10/6/16, 10/8/16 and 10/10/16. Interventions included: encourage resident to allow room door to remain open during HS (hour of sleep) for closer monitoring of her positioning & attempts for self transfers. When resident returns to her room following meals or activity, encourage transfers to her recliner or bed to reduce risk of self transfer/falls. Call light will be kept within reach and answered promptly; encourage resident to use and to not self transfer for safety purposes. The care plan did not include the use of a w/c tray table attached to R13's Broda chair.

Review of R13's hospice care plan dated 11/3/16, did not include the use of a w/c lap tray.

Review of R13's incident reports from 8/29/16 - 10/29/16 revealed the following: Fall from w/c on 9/5, 9/10, 9/16, and 9/17/16; fall from recliner on 9/21 and 9/24/16 and fall from bed on 8/29, 9/17, 9/24, 10/3, 10/6, 10/7, 10/10, 10/28, and 10/29/16. No injuries were noted.

Review of R13's most current signed physician

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HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

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2 505	Continued From page 7 orders dated 11/3/16, did not include an order for the w/c tray table. On 12/07/16, at 1:36 p.m. R13 was observed in room in recliner with feet elevated and afghan covering the resident. R13's eyes were closed and appeared to be sleeping. NA-E and NA-F were observed across the hall within sight of R13's room at a charting station and were interviewed at this time. NA-F indicated the recliner was R13's favorite chair and was content in the chair when tired. NA-F further included earlier in the day R13 was more alert and would then attempt to transfer self when placed in the recliner. NA-E and NA-F confirmed when R13 was up in the w/c the tray table stayed attached to the chair most of the time other than when toileting every 2 hours. NA-E was unsure how long R13 had utilized the tray table, but that it was attached to the Broda w/c by hospice less than 6 months ago. When interviewed on 12/07/16, at 2:47 p.m. registered nurse case manager (RN)-C confirmed a physical restraint assessment had not been completed for the use of R13's w/c tray table. RN-C further included R13's tray table had not been identified as a restraint because she was unable to to transfer from the w/c and could propel herself while in the w/c with the tray table on. RN-C confirmed R13 had a history of falls that resulted mostly from transferring from the bed. RN-C indicated hospice had implemented the Broda w/c sometime in October 2016, and had also supplied the tray table at that time. RN-C included tray table on R13's w/c was convenient for staff to utilize during activities as R13 would become too anxious to remain at a table during an activity. RN-C confirmed R13 would not be able to remove the w/c tray table on her own and	2 505		

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	00031	A. BUILDING: _____ B. WING _____	12/09/2016

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2 505	Continued From page 8 included R13 was unable to stand on her own d/t weakness in her legs/knees. RN-C also confirmed R13 would not need the w/c tray table for positioning as the Broda chair was a good fit for her. RN-C confirmed the tray table was not assessed as a restraint and there was not a physician order for use. RN-C further confirmed the tray table had not been care planned. Review of the policy titled Restraints dated 9/11, included; Any form of restraint will not be the first intervention when meeting the needs of the resident and will be used as minimally as possible. Physical and chemical restraints will be used only to treat specific medical symptoms or in an emergency situation to protect residents or others from eminent danger...Physical Restraints - Are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body, that the resident cannot remove easily and restricts freedom of movement or normal access to ones body. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about what constitutes a restraint. The DON or designee, could randomly audit resident records to ensure devices that potentially restrain a resident have been assessed to ensure safe and least restrictive restraint use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		1/6/17

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2 565	Continued From page 9 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement a protective device in accordance with the written plan of care for 1 of 3 residents (R31)reviewed for non-pressure related skin conditions. Findings include: Review of R31's diagnosis report included diagnoses of paraplegia (paralysis of the lower half of the body) and diabetes mellitus. Bluestone, nursing home order from nurse practitioner dated 11/29/16, noted R31 had a left great toe ulceration being multifactorial diabetic and arterial. On 12/6/16, at 11:03 a.m. observation of R31's left foot revealed a dark purple bruise to the left great toe and a 1.0 centimeter (CM) scab on top of the 3rd toe. Review of R31's most current care plan dated 11/18/16, identified the resident as having alteration in skin integrity that included a red area on top of the left great toe. R31 is at risk for skin breakdown due to impaired mobility secondary to paraplegia. Interventions listed; daily treatment to left great toe per physician assistant (PA) orders, left boot on when up and off when in bed and to monitor skin during cares.	2 565	Corrected	

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2 565	Continued From page 10 Review of R31's treatment administration record for November and December 2016, included; each shift staff were to: (1.) Protect toes on left foot from injury resident should wear a boot with some protection that extents (sic) past the toes so we limit potential insult to toes every shift and (2.) Paint with betadine daily left great toe leave out of shoe using non skid sock until resolved also 3rd toe at bedtime for skin ulcer. Review of R31's physician orders dated 11/29/16, included; -Continue to cleanse toes on left foot daily and paint both left great toe and left 3rd toe with betadine daily. Goal is to keep ulcerations/blisters dry and intact. -Protect toes on left foot from injury, resident should wear a boot with some protection that extends past the toes to limit potential insult to the toes. On 12/6/16 at 2:17 p.m. R31 was observed to be up in a powered wheelchair (w/c) wearing a grippy sock and boot on his left foot. The toes and top third of his left foot did not have a toe protective guard on and fully exposed. During interview on 12/6/16, at 2:24 p.m. nursing assistant (NA)-D indicated R31 wears a boot to the left foot to protect his foot and toes. NA-D further included R31 will bump his feet on objects when up in his powered w/c. R 31 does not have sensation in his toes due to his paraplegia. On 12/7/16, at 10:26 a.m. R31 was observed in his room sitting in his powered w/c with slippers on both feet. During interview at this time, R31 stated he did not know why staff had not put his boot on his left foot. R31 further included he needs to wear the protective boot to the left foot because he bumps into things when in his w/c.	2 565		

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2 565	Continued From page 11 On 12/7/16, at 1:20 p.m. and 2:29 p.m. R31 was observed sitting in a recliner chair in his room with slippers on both feet. No boot or protection was noted to the left foot. On 12/8/16, at 7:59 a.m. R31 was observed in his powered w/c with slippers on both feet. Observation at 3:12 p.m. R31 was observed in the hall in a powered w/c with both feet/toes exposed and unprotected. During interview on 12/8/16, at 9:20 a.m. NA-B indicated she was not aware of R31's protective boot to the left foot/toes. At 9:21 a.m. NA-C indicated she was not aware of when R31's protective boot needed to be on, but did confirm she knew the resident had a protective device for the left foot/toes. Review of the undated Resident Care Sheet utilized by NA's for R31, had no information related to the use of the protective boot to the left foot/toes. During interview on 12/8/16, at 11:37 a.m. NA-C stated "nobody really knew if it was suppose to be on or off" (indicating the protective boot). During interview on 12/8/16, at 12:32 p.m. registered nurse (RN)-B verified R31 was to wear a protective boot to his left foot. RN-B indicated R31 had a non pressure sore to his left great toe and required the left foot boot for protection. RN-B verified no information had been included on the Resident Care Sheet, utilized by the NA's for R31's care. RN-B confirmed the residents wound to his left great toe had not been measured nor described in the record and that the care plan had not always been implemented by the staff. During observation on 12/8/16, at 3:12 p.m. R31	2 565		

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2 565	Continued From page 12 was in his powered w/c without the boot protector to his left foot/toes. At 3:13 p.m. interview with the OT verified R31's protective toe guard was missing and the residents toes were not protected. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of following the plan of care. The DON or designee, could randomly audit to be sure the plans of care is being followed to provide proper nursing care for the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement a protective	2 830	Corrected	1/6/17

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2 830	Continued From page 13 device for 1 of 1 resident (R31) who had an ulcerated toe. Findings include: Review of R31's diagnosis report included diagnoses of paraplegia (paralysis of the lower half of the body) and diabetes mellitus. Bluestone, nursing home order from nurse practitioner dated 11/29/16, noted R31 had a left great toe ulceration being multifactorial diabetic and arterial. On 12/6/16, at 11:03 a.m. observation of R31's left foot revealed a dark purple bruise to the left great toe and a 1.0 centimeter (CM) scab on top of the 3rd toe. Review of R31's quarterly Minimum Data Set (MDS) assessment dated 10/13/16, identified R31 as being cognitively intact, requires extensive assistance with dressing and personal hygiene and has impairment of the lower extremities. The MDS further identified R31 as being independent with locomotion on and off the unit, utilized a wheel chair and did not have any skin ulcers present. Review of R31's Care Area Assessment (CAA) dated 4/15/16, indicated R31 was at risk for skin breakdown related to diagnosis of paraplegia. Review of R31's most current care plan dated 11/18/16, identified the resident as having alteration in skin integrity that included a red area on top of the left great toe. R31 is at risk for skin breakdown due to impaired mobility secondary to paraplegia. Interventions listed; daily treatment to left great toe per physician assistant (PA) orders, left boot on when up and off when in bed and to	2 830		

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2 830	Continued From page 14 monitor skin during cares. Review of R31's treatment administration record for November and December 2016, included; each shift staff were to: (1.) Protect toes on left foot from injury resident should wear a boot with some protection that extents (sic) past the toes so we limit potential insult to toes every shift. (2.) Paint with betadine daily left great toe leave out of shoe using non skid sock until resolved also 3rd toe at bedtime for skin ulcer. Review of the bath/shower skin audit dated 11/28/16, indicated R31 had a wound to the left great toe, and had developed a slough (dead tissue) center and increased purple color to toe. It further indicated R31 had a scab to left 3rd toe and superficial open area to the medial left 5th toe. No wound measurements were found in the medical record. Review of R31's physician orders dated 11/29/16, included; -Continue to cleanse toes on left foot daily and paint both left great toe and left 3rd toe with betadine daily. Goal is to keep ulcerations/blisters dry and intact. -Protect toes on left foot from injury, resident should wear a boot with some protection that extends past the toes to limit potential insult to the toes. On 12/6/16 at 2:17 p.m. R31 was observed to be up in a powered wheelchair (w/c) wearing a grippy sock and boot on his left foot. The toes and top third of his left foot did not have a toe protective guard on and fully exposed. During interview on 12/6/16, at 2:24 p.m. nursing assistant (NA)-D indicated R31 wears a boot to the left foot to protect his foot and toes. NA-D	2 830		

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2 830	Continued From page 15 further included R31 will bump his feet on objects when up in his powered w/c. R 31 does not have sensation in his toes due to his paraplegia. On 12/7/16, at 10:26 a.m. R31 was observed in his room sitting in his powered w/c with slippers on both feet. During interview at this time, R31 stated he did not know why staff had not put his boot on his left foot. R31 further included he needs to wear the protective boot to the left foot because he bumps into things when in his w/c. On 12/7/16, at 1:20 p.m. and 2:29 p.m. R31 was observed sitting in a recliner chair in his room with slippers on both feet. No boot or protection was noted to the left foot. On 12/8/16, at 7:59 a.m. R31 was observed in his powered w/c with slippers on both feet. Observation at 3:12 p.m. R31 was observed in the hall in a powered w/c with both feet/toes exposed and unprotected. During interview on 12/8/16, at 9:20 a.m. NA-B indicated she was not aware of R31's protective boot to the left foot/toes. At 9:21 a.m. NA-C indicated she was not aware of when R31's protective boot needed to be on, but did confirm she knew the resident had a protective device for the left foot/toes. Review of the undated Resident Care Sheet utilized by NA's for R31, had no information related to the use of the protective boot to the left foot/toes. During interview on 12/8/16, at 11:37 a.m. NA-C stated "nobody really knew if it was suppose to be on or off" (indicating the protective boot). During interview on 12/8/16, at 12:04 p.m. occupational therapist (OT) indicated R31 was to wear the left protective boot to protect his	2 830		

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2 830	Continued From page 16 foot/toes and that OT provided the staff with a protective boot/toe guard on 11/30/16. During interview on 12/8/16, at 12:32 p.m. registered nurse (RN)-B verified R31 was to wear a protective boot to his left foot. RN-B indicated R31 had a non pressure sore to his left great toe and required the left foot boot for protection. RN-B verified no information had been included on the Resident Care Sheet, utilized by the NA's for R31's care. RN-B confirmed the residents wound to his left great toe. During observation on 12/8/16, at 3:12 p.m. R31 was in his powered w/c without the boot protector to his left foot/toes. At 3:13 p.m. interview with the OT verified R31's protective toe guard was missing and the resident's toes were not protected. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of following the plan of care. The DON or designee, could randomly audit to be sure the plans of care are being followed to provide proper nursing care for the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		1/6/17

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21426	Continued From page 17 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Citation Text for Tag 1426, Regulation D0OQ Hamersma, Vicky Based on interview and document review, the facility failed to ensure newly hired employees received timely baseline tuberculosis screening and tuberculin skin testing (TST) prior to starting work for 3 of 5 employees (E-2, E-4, E-5). This has the potential to effect all 56 residents in the facility, staff, and visitors. Findings Include: E-2 started on 10/17/16. E-2's baseline tuberculosis (TB) screening tool was completed on 10/17/16 with the first TST administered on 10/17/16. E-2 received second TST on 11/29/16, which is 22 days past the required 7 to 21-day timeframe.	21426	Corrected	

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21426	Continued From page 18 E-4 started at the facility on 11/28/16. E-4's baseline TB screening tool was completed on 12/7/16 with the first TST administered on 12/7/16. E-5 started at the facility on 10/17/16. E-5 ' s baseline TB screening tool was completed on 10/17/16 with first TST administered on 10/17/16. E-2 received second TST on 12/5/16, which is 28 days past the required 7 to 21-day timeframe. On 12/7/16. the assistant director of nursing (ADON) stated, "that E-4 had not received TST. and had received it today. " During interview on 12/7/16, at 1:30 pm with the ADON it was stated the normal procedure is that during the first day of classroom orientation new employees fill out the TB screening and a nurse administers the first step TST; then within 48 to 72 hours they are instructed to report to the nurse's station to have the TST read by the nurse. When questioned about the lack of timeliness of the TST administered to E4, the ADON stated she usually does the first day of orientation paperwork and makes sure the fist step TST is administered but was unaware who hired E4 as it must have been when she was absent, as she did not notice the lack of timeliness until she produced the paperwork. Facility policy, TB Exposure Control Plan dated 11/2010, reads " All paid and unpaid healthcare workers will receive baseline TB screening. The screening will include a written assessment of TB risk factors, any current TB symptoms, and a 2-step TST. Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis	21426		

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21426	Continued From page 19 infection control regulation in your facility, dated July 2013. Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e. month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. Page 23, Screening Residents, General principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of following the TB guidelines. The DON or designee, could audit to be sure the tuberculin skin test is given within the TB guidelines. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		