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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OSJ6

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: **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 **03/24/2016** (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**
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 :
Connie Brady, HFE NE II 03/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/29/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
__X__ 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) **00**

VOLUNTARY
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

March 29, 2016

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

Dear Ms. Mutch:

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

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

Effective March 4, 2016 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 29, 2016

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

RE: Project Number S5507025

Dear Ms. Mutch:

On February 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 24, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 24, 2016 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 February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, effective March 4, 2016 and therefore remedies outlined in our letter to you dated February 12, 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, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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	3/24/2016 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 F0156	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	03/04/2016	LSC	03/04/2016	LSC	03/04/2016
ID Prefix F0329	Correction	ID Prefix F0428	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(c)	Completed	Reg. #	Completed
LSC	03/04/2016	LSC	03/04/2016	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)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	03/29/2016	28651	3/24/2016
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?
2/4/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245507	A. Building 01 - MAIN BUILDING 01 B. Wing	3/24/2016

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 Reg. # NFPA 101 LSC K0021	Correction Completed 02/16/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 02/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 03/29/2016	**SIGNATURE OF SURVEYOR** 35482	**DATE** 3/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OSJ6

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 **02/04/2016** (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**
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:

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 03/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/22/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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

Certified Mail # 7013 3020 0001 8869 0701

February 12, 2016

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

RE: Project Number S5507025

Dear Ms. Mutch:

On February 4, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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;

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 March 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 4, 2016 (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 August 4, 2016 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

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 _____	02/04/2016

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. 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 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	RECEIVED FEB 26 2016 Minnesota Dept of Health Mankato	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	approved kmk 3/2/16 F156 Hillcrest does provide both orally and in writing in a language that the resident understands Notice of Medicare Non-Coverage for Medicare and Medicaid Services (CMS) Form-10123; however, for further compliance the facilities admissions team educated on the notice guideline for issuing "Notification of Medicare non-coverage."	

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

Dean Mutch | Administrator | 2-26-16

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 _____	02/04/2016

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 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	Monthly audits for compliance will be Conducted and review at QA and A quarterly. Monitoring for compliance will be done by Administrator or designee. Run- Point Click Care report @ least monthly + prn or wkly @ ~~Medicare~~ Medicare mtg - Check d/c date & signature of resident to ensure timely. Medicare wkly mtg discuss the need for CMS notice - 2 days notice + forms completed, all completed now. RECEIVED FEB 2 6 2016 Minnesota Dept of Health Mankato	3-4-16

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a timely Medicare liability and appeal rights notice of Medicare non-coverage when skilled nursing services were terminated for 1 of 3 residents (R42) reviewed for liability notice and beneficiary appeal rights. Findings include: Review of R42's Notice of Medicare Non-Coverage for Medicare and Medicaid Services (CMS) Form-10123 indicated skilled nursing services ended on 10/13/15. R42 was notified of the discontinuation of skilled nursing services on 10/16/15. The facility had been aware of R42's Non-covered services since 10/12/15; however, R42 was not informed until 10/16/15, 3 days after the skilled nursing services were terminated.	F 156		

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F 156	Continued From page 3 When interviewed on 2/4/16, at 1:15 p.m., the director of nursing (DON) confirmed the Medicare denial notice had not been provided to R42 on 10/12/15, when skilled nursing services terminated. The DON was aware the notification should have been received at least 48 hours prior to skilled nursing services ending. The DON further verified she discovered the error on 10/16/16, and issued a Medicare denial notice to R42. The "Notification of Medicare Non-Coverage" policy, dated 12/13/12, last revision 11/14 indicated when a resident is deemed no longer coverable under medicare guidelines a letter will be issued at least two days prior to non-coverage.	F 156		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 follow the plan of care for monitoring bruising for 2 of 3 residents (R6 & R65) reviewed for non-pressure related skin conditions. Findings include: During observations on 2/3/16, at 12:28 p.m., R6 was noted to have a 50 cent size bruise on the right lower arm, inner right arm, left wrist and top	F 282	F282 Hillcrest does follow the plan of care for monitoring bruising of facility residents; however, to further comply Education for NA/R reporting skin alterations to include bruising be completed on or before 3-4-2016.	

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F 282	Continued From page 4 of left hand. The bruises were dark purplish in color. During interview with R6 at this time, revealed he had these bruises for several days but was unsure of how he obtained the bruises. R6 indicated he was receiving Coumadin (a blood thinner). Review of R6's current physicians orders included an order for Coumadin (a blood thinner). Review of R6's current plan of care identified a focus topic of having a potential risk for alterations in skin integrity related to the use of Coumadin, as well as the use of steroids, and a diagnosis of pemphigus (a autoimmune disease of the skin). Interventions include; monitor bruising of the skin, notify the physician of signs and symptoms of bleeding and encourage the resident to avoid bumping self. Interview with nursing assistant (NA)-A on 2/3/16, at 12:15 p.m., indicated she had not been aware of R6's bruises located on his right arm, left wrist and hand. NA-A further explained she assumed the areas of bruising located on R6 upper extremities were age spots. NA-A further confirmed the identified bruises had not been reported to the charge nurse. Interview with nurse manager (NM)-A on 2/3/16, at 12:29 p.m., indicated R6 has fragile skin due to his diagnosis of pemphigus and confirmed the identified bruising was evident on the residents arms, wrist and hands. NM-A further stated the bruising should have been reported and monitored by staff when identified. Interview with the director of nursing (DON) on 2/4/16, at 8:35 a.m., confirmed R6's bruising on	F 282	R6 skin/bath audit revised on 2/8/16 reflect current bruise status Education on the body audit tool @least weekly will be completed for all licensed staff on or before 3-4-2016. Policy and procedure reviewed and updated. Monitoring of body audit's to be completed monthly and quarterly reviewed for compliance at QA and A. DON + Nurse managers conducting body audits why for 1st 3 months completed. this applies to F309 also	3-4-16

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F 282	Continued From page 5 his arms, wrist and hands. The DON also verified the bruised areas should have been identified as bruises and reported to the charge nurse so they were monitored per the plan of care. Observations on 2/3/16 at 12:37 p.m., R65 was observed to have a 50 cent size bruise on the lower right arm, a 25 cent size bruise on the outer right hand as well as on the top of the left hand. The bruises were dark purplish in color. During interview with R65 at this time, indicated he gets bruises on his arms from scratching his skin and that he bruises easily. Review of R65's current physicians orders included an order for Aspirin. Review of R65's admission skin assessment dated 1/1/16, identified R65 as having bruises on his arms from a previous fall at home. The assessment did not include the specific location of the bruising nor the size or color. Review of R65's current plan of care identified a focus topic of having a potential risk for alterations in skin integrity related to impaired physical mobility. The care plan further indicated the resident has multiple bruises scattered on the body and weekly body audits are being implemented. Interview with nursing assistant (NA)-A on 2/3/16, at 12:40 p.m. indicated she identified R65's bruises on 2/1/16, during his bath but thought they were age spots. NA-A confirmed the identified bruises had not been reported to the charge nurse. Interview with the director of nursing (DON) on	F 282		

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F 282	Continued From page 6 2/4/16, at 8:35 a.m. confirmed R65's bruising located on his right arm and hands. The DON also verified the bruised areas should have been identified as bruises and reported to the charge nurse for monitoring per the plan of care.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and monitor bruising for 2 of 3 residents (R6, R65) reviewed for non-pressure related skin conditions. Findings include: On 2/3/16, at 12:28 p.m. R6 was observed to have a 50 cent size bruise on the right lower arm, inner right arm, left wrist and top of left hand. The bruises were dark purplish in color. When interviewed at this time, R6 indicated he had evidence of these bruises for several days but was unsure of how he obtained them. R6 also indicated he was receiving Coumadin (a blood thinner). Review of R6's current physicians orders included an order for Coumadin (a blood thinner).	F 309	F309 Hillcrest does provide residents with the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being; however, to further comply Educational in servicing for NA/R reporting skin alterations to include bruising will be provided on or before 3-4-16. Care plan audits for resident's that have bruising identified upon admission, quarterly,	

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F 309	Continued From page 7 Review of R6's current plan of care identified a focus topic of having a potential risk for alterations in skin integrity related to the use of Coumadin, as well as the use of steroids, and a diagnosis of pemphigus (a autoimmune disease of the skin). Interventions include: monitor bruising of the skin, notify the physician of signs and symptoms of bleeding and encourage the resident to avoid bumping self. Review of R6's weekly bath/shower skin audit forms dated 12/18/15, 12/25/15, 1/8/16, 1/15/16, 1/22/16 and 1/29/16 did not identify any bruising of the skin. Interview with nursing assistant (NA)-A on 2/3/16, at 12:15 p.m., indicated she had not been aware of the R6's bruises on his right arm, left wrist and hand. NA-A further explained she assumed the areas of bruising on R6 upper extremities were age spots. NA-A confirmed the identified bruises had not been reported to the charge nurse. Interview with nurse manager (NM)-A on 2/3/16, at 12:29 p.m. indicated R6 has fragile skin due to his diagnosis of pemphigus. She further confirmed the evidence of bruising located on R6's arms, wrist and hands. NM-A stated the bruising should have been reported and monitored by staff when identified. Interview with the director of nursing (DON) on 2/4/16, at 8:35 a.m. confirmed the bruising located on R6's arms, wrist and hands. The DON also verified these bruised areas should have been identified as bruises (not age spots) and reported to the charge nurse.	F 309	and annually. Findings to be reviewed and evaluated by QA and A quarterly. The Director of Nurses or Designee will monitor for compliance. see F282 additions	3-4-16

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F 309	Continued From page 8 When observed on 2/3/16, at 12:37 p.m. it was noted that R65 had a 50 cent size bruise on the lower right arm, a 25 cent size bruise on the outer right hand as well as on the top of the left hand. The bruises were dark purplish in color. When interviewed during this time, R65 indicated he gets bruises on his arms from scratching his skin and that he bruises easily. Review of R65's current physicians orders included an order for Aspirin. Review of R65's admission skin assessment dated 1/1/16, identified R65 as having bruises on his arms from a previous fall at home. The assessment did not include the specific location of the bruising nor the size/color. Review of R65's current plan of care identified a focus topic of having a potential risk for alterations in skin integrity related to impaired physical mobility. The care plan further indicated the resident has multiple bruises scattered on the body and weekly body audits are being implemented. Review of R65's weekly bath/shower skin audit forms dated 1/4/16, 1/11/16, 1/18/16, 1/25/16 and 2/1/16, did not identify any bruising of the skin. Interview with nursing assistant (NA)-A on 2/3/16, at 12:40 p.m. indicated she identified R65's bruises on 2/1/16, during his bath but thought they were age spots. NA-A confirmed the identified bruises had not been reported to the charge nurse. Interview with the director of nursing (DON) on 2/4/16, at 8:35 a.m. confirmed bruising was	F 309		

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F 309	Continued From page 9 located on R65's right arm and hands. The DON also verified these areas should have been identified as bruises and reported to the charge nurse. The facility was unable to obtain a policy for identifying and monitoring bruising.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 Hillcrest resident's drug regimen is free from unnecessary drugs. However, to further comply Policy and procedure reviewed for continued anti-Psychotic use to include gradual dose reduction or the justification by provider for continued use Education provided to Nurse Managers on policy	

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F 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician provided justification for the continued use of antipsychotic medications for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4 had diagnoses documented on the annual Minimum Data Set (MDS) dated 1/12/16, which included schizophrenia and bipolar disorder. Review of the most current physician orders indicate R4 receives: Olanzapine (Zyprexa) 15 mg daily and Aripiprazole (Abilify) 5 mg daily (antipsychotics) for schizophrenia and bipolar. Review of the "Consultation Report" dated 11/9/15, by the consultant pharmacist, indicated "review of periodic antipsychotic evaluation for clinical appropriateness of a gradual dose reduction (GDR) or justification for continuation of Abilify and Olanzapine". Written response noted by the physician assistant (PA) on 11/12/15, indicated "no change" to medication regimen. No documented justification was evident. Review of the physician progress notes dated 11/12/15 and 12/8/15, did not include a response to the GDR recommended by the pharmacist nor justification for continued use of the antipsychotic medications. When interviewed on 2/3/16, at 1:06 p.m., R4 indicated that he takes medicine for his schizophrenia and bipolar disorder but doesn't see anything different. R4 stated, "My kids think it helps me".	F 329	and procedure for continued anti- psychotic use. ongoing Monthly review of GRD will be completed and report given to QA and A quarterly. DON Policy and procedure will be given to providers for review. Monitoring for compliance will be completed by Director of Nurses or designee. R4 on 2/4/16 MD documented the rationale for not doing GDR for R4 Audits were completed for all residents on AP meds were recommended to review by primary MD / pharmacy.	3-4-16

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F 329	Continued From page 11 During an interview on 2/4/16, at 12:54 p.m., director of nursing (DON) verified there was no justification and/or GDR response addressed by the health care provider for R4 since 10/7/14. The "Gradual Dose Reduction (GDR)" policy, undated, specifies after the 1st year a GDR should be attempted annually, unless clinically contraindicated. It further specifies contraindication to mean the continued use is in accordance with relevant current standards or practice or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility AND physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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F 428	Continued From page 12 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a gradual dose reduction (GDR) and/or justification for continued use of antipsychotic medications was acted upon for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4 had diagnoses documented on the annual Minimum Data Set (MDS) dated 1/12/16, which included schizophrenia and bipolar disorder. Review of the most current physician orders indicate R4 receives: Olanzapine (Zyprexa) 15 mg daily and Aripiprazole (Abilify) 5 mg daily (antipsychotics) for schizophrenia and bipolar. Review of the "Consultation Report" dated 11/9/15, by the consultant pharmacist, indicated "review of periodic antipsychotic evaluation for clinical appropriateness of a gradual dose reduction (GDR) or justification for continuation of Abilify and Olanzapine". Written response noted by the physician assistant (PA) on 11/12/15, indicated "no change" to medication regimen. Review of the physician progress notes dated	F 428	F428 Hillcrest does provide drug regimen of each resident monthly by a licensed pharmacist. The Gradual Dose Reduction policy and procedure reviewed and education will be provided to provider on or before 3-4-2016. Quarterly Pharmacy report will continue to be given to QA and A quarterly. Monitoring for continued compliance will be done by Director of Nurses or designee. see F329 for additional	3-4-16

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 _____	02/04/2016

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 428	Continued From page 13 11/12/15 and 12/8/15, did not include any response to the GDR recommendation by the pharmacist nor justification for continued use. During an interview on 2/4/16, at 12:54 p.m., director of nursing (DON) verified there was no justification and/or gradual dose reduction (GDR) response addressed by the health care provider for R4 since 10/7/14. During a phone interview on 2/5/16, at 11:00 a.m. the consulting pharmacist confirmed he did not recommend further follow up of R4's psychoactive medications since the review dated 11/9/15. The "Gradual Dose Reduction (GDR)" policy, undated, specifies after the 1st year a GDR should be attempted annually, unless clinically contraindicated. It further specifies contraindication to mean the continued use is in accordance with relevant current standards or practice or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility AND physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.	F 428		

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

F5507025

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2016**

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 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 February 4, 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 2000 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	K 000	**APPROVED** Tom Linhoff ***By Tom Linhoff at 10:29 am, Mar 17, 2016***	

RECEIVED
FEB 25 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Doug Mutch	Administrator	2-25-16

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 By email to: 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 71 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 021		

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K 021	Continued From page 2 Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an	K 021	K21 Smoke barrier penetrations closed, put into place by Maintenance Director on or by 2-16-16. Monitoring for compliance will be done by Administrator, Maintenance Director, and /or designee.	2-16-16

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K 021	Continued From page 3 approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. FINDINGS INCLUDE: During Facility Inspection on February 4, 2016, between the hours of 10:00 AM and 12:30 PM, Penetrations were observed above the lay-in ceiling tiles at the Northeast Smoke Barrier wall. Note: All Smoke Barriers need to be checked to ensure compliance. This deficient practice was confirmed with the Facility Maintenance Director.	K 021	K25 The doorway will be kept closed at all times and not held open by a devise of any sort. All wedges or carts removed to prevent door from being held open to hallway. Audit through safety committee will be done periodically. Monitoring for compliance will be done by Administrator, Maintenance Director, and /or designee.	2-4-16
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	K 025		