DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 29, 2025

Administrator
Hilltop Healthcare Rehabilitation And Skilled Nurs
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: May 2, 2025

Dear Administrator:

On May 23, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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May 9, 2025

Administrator
Hilltop Healthcare Rehabilitation And Skilled Nurs
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: May 2, 2025

Dear Administrator:

On May 2, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 2, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 2, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/28/25 to 5/2/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/28/25 to 5/2/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with NO deficiencies cited: H53663427C MN000111923 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

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

Electronically Signed | 05/13/2025

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §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). §483.12 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(2) 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 record review and interview, the facility failed to ensure psychotropic medication orders	F 605	• Corrective Action • Resident 29 duloxetine and prisitiq	5/20/25

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F 605	Continued From page 2 had an indication for use for 1 of 5 residents (R29) reviewed for unnecessary medications. Findings include: R29's quarterly Minimum Data Set (MDS) dated 4/8/25, indicated R29 was cognitively intact and identified diagnoses of secondary polycythemia (increased amount of red cells due to another medical condition), depression, anxiety, polyneuropathy (disease affecting peripheral nerves throughout the body), hypertension, acquired absence of foot, sleep apnea, and amputation of lower left leg. R29's provider orders reviewed on 4/30/25, included the following medication orders: -duloxetine oral capsule delayed release sprinkle 60 milligrams (mg), give one capsule by mouth one time a day for 'no indication listed' -pristiq oral tablet extended release 24 hour 25mg- give 25mg by mouth one time a day for 'no indication listed' During interview on 5/1/25 at 8:51 a.m., registered nurse (RN)-D reviewed medication orders for R29 and confirmed no indication listed for duloxetine and pristiq medications. RN-D stated expectation for every medication order to have an indication or diagnosis listed. During interview on 5/2/25 at 1:05 p.m., director of nursing (DON) stated expectation for every medication order to have an indication for use listed. Medication Administration policy last reviewed 4/1/24, explained facility's policy to administer all medications and treatments in a safe and	F 605	medications remain appropriate and updated with appropriate indication for use. • Identifying other residents • Residents currently residing in the facility receiving medications have the potential to be affected. • Current residents' medication list was reviewed to ensure all medication orders have an appropriate diagnosis or indication for use and included on physician orders. • Systemic Changes • IDT will be educated on F605 prior to start of next shift. • Nurses will be educated on F605 prior to start of next shift. o These in-services were either in-person, in a classroom setting or 1:1 either in person or by telephone. • Pharmacy consultant will audit medication orders during monthly reviews to ensure all medication orders have an appropriate diagnosis or indication for use and included on physician orders. • Monitoring • DON/designee shall audit new medication orders to ensure all medication orders have an appropriate diagnosis or indication for use and included on physician orders daily x 7 days then 10 medication orders weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved.	

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F 605	Continued From page 3 effective manner. Included in the procedure for administering medications was 'able to state indication.'	F 605	• Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 5 residents (R26, R30, R29) reviewed for MDS completion. Findings include: R26: R26's admit MDS dated 4/7/25, indicated R26 was cognitively intact with the diagnosis of COPD. MDS Section O., was coded incorrectly and indicated R26 was not receiving hospice. R26's Census documentation showed R26 was admitted on 3/31/25, with hospice services. R26's care plan with the admission date of 3/31/25, included care planning for hospice services. During an interview on 5/1/25 at 3:06 PM both registered nurse (RN-A) and the director of nursing (DON) were present and confirmed R26's admission MDS should have been coded to show that R26 was receiving hospice services.	F 641	• Corrective Action • Resident 26 MDS was updated to reflect hospice services. • Resident 30 MDS was updated to reflect no colostomy use. • Resident 29 MDS was updated to reflect the use of mobility device including a wheelchair. • Identifying other residents • Residents currently residing in the facility have the potential to be affected. • Systemic Changes • Staff responsible for MDS items educated regarding F641. • Staff responsible for MDS items educated on Accuracy of Assessments Policy. • IDT educated regarding F641. • IDT educated on Accuracy of Assessments Policy. • Monitoring • DON/Designee shall audit MDS assessments prior to submission to	5/20/25

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F 641	Continued From page 4 The facility policy Accuracy of Assessments dated 3/15/24, indicated the policy was created to ensure each resident received an accurate assessment reflective of the resident status at the time of assessment and staff were to follow the RAI manual. R30: R30's quarterly MDS dated 4/11/25, identified intact cognition and diagnoses of kidney failure and malignant neoplasm of the prostate. Section H, which covers bowel and bladder, identified R30 had a colostomy. During an interview on 5/2/25 at 10:21 a.m., RN-F confirmed R30 didn't have a colostomy. During an interview on 5/2/25 at 2:55 p.m., the MDS nurse stated section H of R30's MDS was marked in error. The MDS nurse stated accurate MDS' were important because it reflects how they should plan and care for him. R29: R29's quarterly MDS dated 4/8/25, indicated R29 was cognitively intact and with a functional limitation in movement on one side of the lower body. The MDS further indicated R29 did not use any mobility devices. R29's facesheet reviewed on 5/2/25, indicated diagnoses of secondary polycythemia (increased amount of red cells due to another medical condition), depression, anxiety, polyneuropathy (disease affecting peripheral nerves throughout the body), hypertension, acquired absence of foot, sleep apnea, and amputation of lower left	F 641	ensure residents received an accurate assessment reflective of the resident status at the time of assessment daily x 7 days then weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 641	Continued From page 5 leg. During observation on 4/30/25 at 10:20 a.m., R29 observed in bed with a wheelchair and prosthetic leg in resident's room. R29 confirmed using mobility devices when out of bed. During interview on 5/1/25 at 11:02 a.m., MDS coordinator explained MDS reports were done on a schedule dictated by regulations. MDS coordinator stated reports were based on documentation from nursing staff, and providers involved in the resident's care. MDS coordinator further explained parts of the MDS were done in-person with the resident. MDS coordinator reviewed R29's quarterly MDS from 4/8/25, and confirmed MDS indicated R29 did not use mobility devices. MDS coordinator stated the MDS was incorrect and R29 does use mobility devices including a wheelchair and prosthetic limb. During interview on 5/2/25 at 1:05 p.m., director of nursing (DON) stated expectation that MDS reports should accurately reflect the resident's status. DON confirmed R29's MDS from 4/8/25 was not accurate concerning mobility devices.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		5/20/25

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F 645	Continued From page 6 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645		

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F 645	Continued From page 7 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) reassessment after 30 days was conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided for 1 of 1 residents (R22) reviewed for PASARR. Findings include: R22's significant change Minimum Data Set (MDS) dated 4/10/25, identified R22 had severely impaired cognition and required substantial assistance with most activities of daily living (ADLs). R22's admission record, reviewed 5/2/24, identified diagnoses including dementia with	F 645	• Corrective Action • Resident 22 PASARR reassessment was completed. • All other Level II Preadmission Screening were audited and completed. • Identifying other residents • Residents currently residing in the facility with Level II Preadmission Screening for Persons with Mental Illness Determination for Nursing Facility Admission have the potential to be affected. • Systemic Changes • IDT Educated on F645 to ensure Level II Pre-Admission Screening and Resident Review (PASARR) reassessment after 30 days was	

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 645	Continued From page 8 agitation, delusional disorder, bipolar disorder, morbid obesity, essential tremor (neurological disorder characterized by uncontrolled shaking movements), bilateral hearing loss, depression, and schizophrenia. R22's pre-admission screening (PAS) dated 2/4/23, indicated R22 required a Level II assessment for mental illness to be done before admission to a nursing home. PAS further indicated R22 was in assisted living with an admission to the nursing home on 2/3/23 with an anticipated length of stay listed, "Less than 30 Days." R22 was also noted to have a diagnosis of schizophrenia. R22's Level II Preadmission Screening for Persons with Mental Illness Determination for Nursing Facility Admission completed on 2/7/23, indicated "admission is approved for post-hospital rehabilitative services for 30 days. This person may have a mental illness and may need specialized services, by [but] meets the requirements for post hospital rehabilitation. Further assessment and service plan changes must be documented upon at change in the resident's condition or when the nursing facility (NF) stay is anticipated to exceed 30 days. The NF is responsible for alerting LMHA to such changes." During interview on 5/1/25 at 11:19 a.m., admissions clerk (AC) stated PAS and PASARR were done before a resident's admission, and coordinated with Senior LinkAge Line (responsible for PAS in Minnesota). AC reported being unaware of R22's Level II assessment being limited to a 30 day admission and needed a reassessment after that point.	F 645	conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided • Persons responsible for Admissions educated on F645to ensure Level II Pre-Admission Screening and Resident Review (PASARR) reassessment after 30 days was conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided i. These in-services were either in-person, in a classroom setting or 1:1 either in person or by telephone. Any staff missing in-services will not work until they receive training. Any staff who fail to comply with the points of the in-services will be further educated and/or progressive discipline will begin as indicated. • Monitoring • DON/Designee shall audit Level II Pre-Admission Screening and Resident Review (PASARR) weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 645	Continued From page 9 During interview on 5/1/25 at 11:25 a.m., social services director (SSD) stated being unaware of R22's Level II assessment being limited to a 30 day admission. SSD reviewed R22's Level II assessment and confirmed it was limited to a 30 day admission. SSD stated Senior LinkAge Line should have been contacted when R22 stayed in the nursing home past 30 days. During interview on 5/2/25 at 1:06 p.m., director of nursing (DON) stated being unaware of R22's Level II assessment being limited to a 30 day admission. DON stated expectation for all PAS and PASARR assessments to be completed with required timeframes.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		5/20/25

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F 656	Continued From page 10 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop individualized and comprehensive care plans for for 2 of 2 residents (R30, R101) reviewed for pain and wound management. Findings include: R30: R30's quarterly Minimum Data Set (MDS) dated 4/11/25, identified intact cognition and diagnoses	F 656	• Corrective Action • Resident 30 care plan was updated to clearly identify actual pain and includes details related to pain rating/assessment; and goal rating for pain tolerance and how pain affected sleep, ADLs, activities, mood and behavior. • Resident 101 skin care plan was updated to clearly identify actual venous stasis and risk for pressure ulcers. The care plan was also updated to include instructions for positioning related to	

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F 656	Continued From page 11 of malignant neoplasm of prostate, chronic pain syndrome, and anxiety. Section J of the MDS, which looks at health conditions impacting the resident's functional status and quality of life, identified R30 had pain, scheduled and as-needed pain medications, and had pain that frequently affected sleep, therapy, and day-to-day activities. R30's provider orders dated 4/30/25, identified an order for morphine sulfate every two hours as needed for pain, and morphine sulfate (MS) extended release 15 mg tablet two times per day for pain. Orders for non-pharmacologic interventions were not found. R30's care plan dated 4/24/25, identified R30 had a diagnosis which can or may affect pain status. R30's care plan didn't clearly identify actual pain and lacked individualized details for R30's pain, how to assess or rate pain, a goal rating for pain tolerance, how the pain impacted sleep, ADLs, activities of leisure, mood, or behavior. During an interview on 4/28/25 at 7:24 p.m., R30 stated they didn't do a good job with pain medication, but he had signed up for hospice now. During an interview on 5/2/25 at 2:15 p.m., registered nurse (RN)-F stated the non-pharmacologic interventions in place were to try to get R30 to reposition, but he won't always do that and to encourage rest and assist to rest as able. RN-F stated R30 was a smoker and it was sometimes hard to get him to rest because he wanted to be outside. RN-F indicated she would be updating R30's care plan to be more specific about his pain, symptoms and	F 656	posture, turning and repositioning plan and coordination with wound care provider. • On 5/9/2025 the Comprehensive Person-Centered Care Planning Policy and Procedure was reviewed and remains appropriate. • Identifying other residents • Residents currently residing in the facility have the potential to be affected. • Systemic Changes • IDT educated on Care Plan Policy • IDT educated on F656 to ensure individualized and comprehensive care plans are developed and implemented to meet residents' needs. i. These in-services were either in-person, in a classroom setting or 1:1 either in person or by telephone. Any staff missing in-services will not work until they receive training. Any staff who fail to comply with the points of the in-services will be further educated and/or progressive discipline will begin as indicated. • Monitoring • Unit Managers/MDS Coordinator shall audit 20 resident care plans weekly to ensure comprehensive care plans are developed and implemented, weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 656	Continued From page 12 interventions. R101: R101's admission Minimum Data Set dated 2/17/25, identified intact cognition and diagnoses of bilateral lower extremity cellulitis, pain in the thoracic spine, and chronic pulmonary edema. R101's MDS identified two venous stasis ulcers, a risk for pressure ulcers but no actual pressure ulcer, and limited range of motion in both lower extremities. R101's care plan dated 2/11/25, identified a problem statement for skin integrity, but didn't clearly identify actual venous stasis and pressure ulcers. Interventions for R101 included meds/labs/treatments as ordered, incontinent care with incontinent brief changes, observe skin with AM and PM cares and report to team leader, weekly skin checks, pressure reduction cushion in wheelchair and bed, Circaid Velcro (compression wrap) to both lower extremities. The care plan lacked instruction for positioning in consideration of R101's posture, lacked a turning and repositioning program, and didn't include coordination with the outside wound care provider. R101's provider orders identified the following: -2/12/25 Elevate legs off and on throughout the day, try to keep pressure off spine as much as possible - recommend to closely monitor this area for breakdown and protect with padded foam like dressing - keep pressure off as able every shift. -2/19/25 Foam border to mid spine for protection, change every three days and as needed. -4/18/25 Wound care to mid spine: acetic wash,	F 656		

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F 656	Continued From page 13 apply a thin layer Mupirocin (antibiotic ointment) to wound bed only, cover with Allevyn (brand name foam dressing) gentle border or equivalent, change every other day. -4/18/25 Turn and reposition every two hours - She is to stay off her back R30's Weekly Wound Round Documentation dated 4/8/25, identified an abrasion to lower back which had been slow to heal, so weekly measurements would be started. The document indicated there was a positioning plan, but didn't indicate what the plan was. During an interview on 5/2/25 at 2:28 p.m., RN-F stated turning and repositioning were important, but especially for R101 because her back is shaped differently. During an interview on 5/2/25 at 3:31 p.m., the director of nursing (DON) stated care planning was important so they can meet the needs of the residents. A policy, Comprehensive Person-Centered Care Planning Policy and Procedure dated 3/14/25, identified the facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		5/20/25

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F 657	Continued From page 14 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that quarterly care conferences were completed for 1 of 1 resident (R17) reviewed for care conferences. Findings include: R17's quarterly Minimum Data Set (MDS) dated 11/11/24, identified diagnoses of chronic obstructive pulmonary disease (COPD), depression, and pressure ulcers.	F 657	• Corrective Action • Resident 17 care conference completed 5/1/2025, to review resident's care plan with family/resident and encourage involvement and input. • Audit and completion of all other residents to ensure care conferences are completed as required. • Identifying other residents • Residents currently residing in the facility and due for scheduled care	

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F 657	Continued From page 15 During interview on 4/28/25 at 12:50 p.m., R17 stated that he had only had one care conference since he admitted that he could remember. Care plan documentation notes, undated, identified that R17 had care conferences on 8/23/24 and 11/21/24. No further care conferences were documented. During interview on 5/1/25 at 8:22 a.m., social services director (SSD) stated that the last care conference for R17 would have been on 11/21/24. I believe the last couple of times we had scheduled care conferences, R17 was in the hospital. We typically schedule care conferences every three months and it looks like R17 is due for one. Care conferences are important to address any concerns, whether it be nursing, social services, or other concerns. Missing care conferences could cause resident concerns to be missed. During interview on 5/1/25 at 11:39 a.m., the director of nursing (DON) stated care conferences should occur quarterly and following a change in condition. Care conference are important in developing an individualized plan of care and allowing the patient to have involvement in their plan of care. Care Plan - Reviews/Conferences policy last reviewed 3/6/24, identified that the community will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and resident representative and/or family discussion/input.	F 657	conferences have the potential to be affected. • Systemic Changes • IDT team educated on Care plan Reviews/Care Conferences Policy. • Monitoring • DON Designee shall audit 10 residents' care conference schedules to ensure that care conferences were completed 5 X per week twice weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 684	Continued From page 16	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure weights were completed as ordered and failed to provide assessment and documentation before a visit to the emergency department for 1 of 2 residents (R3) reviewed for quality of care. Findings include: R3's quarterly Minimum Data Set (MDS) dated 1/27/25, identified intact cognition and diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), morbid obesity, obstructive sleep apnea, hypertension (HTN), and chronic kidney disease (CKD) stage 3. R3's care plan dated 2/4/25, identified R3 had a risk for, or actual, heart and circulation concerns related to diagnoses of hypertension and heart failure. Interventions included medications, treatments and labs per provider order and to monitor and document signs and symptoms of adverse side effects related to diagnosis and medication use.	F 684	• Corrective Action • Resident 3 weights are completed as ordered by physician and any refusals are documented on the EMR. Document and updated provider on any refusals. • DON, Dietician, Unit managers completed an audit of weights/refusals and updated care plan, orders, physician as needed. • Weight Policy reviewed and remains current. • Identifying other residents • Residents currently residing in the facility with orders for weight monitoring have the potential to be affected. • Systemic Changes • CNA/LPN/RNs educated on daily weights prior to the start of their next shift. • IDT educated on daily weights. • Monitoring • DON/Dietician/Unit Managers shall audit 5 residents' weights to ensure	5/20/25

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F 684	Continued From page 17 R3's provider orders identified: -4/2/24 an order for weights twice weekly. -5/6/24 an order for a 2000 milliliter (mL) fluid restriction daily. -7/16/24 an order for furosemide (a diuretic, or water pill) 120 milligrams (mg) on Mondays, Wednesdays, Fridays, and 80 mg on Tuesdays, Thursdays, Saturdays and Sundays. -4/25/25 an order for metolazone (a diuretic, or water pill) 2.5 mg, and Spironolactone (a diuretic, or water pill) 25 mg daily for CHF. -4/26/25 an order for daily weights. R3's EMR identified the following weight records for April 2025: -4/7 216.6 -4/21 223.7 -4/26 220 Review of R3's electronic medical record (EMR) for April 2025 didn't identify progress notes with R3's refusal of having weight taken, didn't identify an assessment or progress note for R3's symptoms prior to going to the emergency room the afternoon of 4/29/25. During an observation on 4/28/25 at 5:15 p.m., R3 was observed sleeping on her bed with her bare legs visible. Both of R3's lower extremities had tight, shiny skin and were reddish-purple in color from about mid-calf down. There were compression socks laying on the bed inside out. During an interview on 4/29/25 at 2:39 p.m., R3 stated her legs were "hurting so bad" and this happened sometimes, the nurse took her vitals, and she was going to the emergency room. At	F 684	physician orders are followed and refusals are documented and relayed to provider daily X 1 week, then weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 684	Continued From page 18 2:42 p.m., an ambulance arrived and took R3 via stretcher. During an interview on 4/29/25 at 3:02 p.m., nursing assistant (NA)-A stated the resident weights were done by the NAs, but the nurse will tell them who needs to be done, then they get it and report back to the nurse. During an interview on 4/30/25 at 7:19 a.m., R3 was back in the facility and stated the ER treated her for pain in her legs. R3 was wearing compression socks. During an interview on 5/2/25 at 1:57 p.m., registered nurse (RN)-F stated she would expect some kind of assessment and documentation when a resident is sent to the ER. RN-F would also expect daily weights to be taken as ordered and for refusals to be documented for R3. RN-F added R3 was known to refuse weights, and they would encourage her by educating her because she had heart problems, edema and leg pain so it would be important for her to have her weight taken. During an interview on 5/2/25 at 3:31 p.m., the director of nursing (DON) stated her expectation would be for daily weights to be done as ordered. The DON would also expect documentation in the medical record when a resident went to the ER.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		5/20/25

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F 698	Continued From page 19 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 ensure that vitals were performed pre and post dialysis for 1 of 1 resident (R19) reviewed for dialysis care. R19's admission Minimum Data Set (MDS) dated 3/20/25, identified diagnoses of chronic kidney disease, atrial fibrillation, coronary artery disease, diabetes mellitus, and hypertension. Resident was cognitively intact. R19's care plan, undated, identified that R19 received dialysis and interventions included to check access site every shift to ensure dressing is clean, dry and intact, resident exhibits no signs/symptoms of infection, patency of access site palpating pulse of extremity, and checking for warmth and color of extremity. Meds/labs/treatments as ordered/accepted. The care plan did not address assessment of vitals pre or post dialysis. R19's April 2025, Weights and Vitals charting failed to show vitals assessments pre and post dialysis. During interview on 4/28/25 at 6:36 p.m., R19 stated that the facility does not check her vitals or do any type of assessment after dialysis. On 4/30/25 at 12:10 p.m., trained medication aid (TMA)-A was in room with R19 upon her return from dailysis. TMA-A had not taken resident vitals. TMA-A stated that she belived that there is not any type of assessment for R19 when she	F 698	• Corrective Action • Resident 19 Dialysis care plan was updated to include vitals pre and post dialysis. • Dialysis Policy updated. • No other residents currently receiving dialysis in facility. • Identifying other residents • Residents currently residing in the facility receiving dialysis have the potential to be affected. • Systemic Changes • LPN/RN educated on Dialysis Policy prior to the start of their next shift. • TMA educated on Dialysis Policy prior to the start of their next shift. • IDT educated on Dialysis Policy. • Monitoring • DON/Designee shall audit all dialysis residents' pre and post dialysis daily X 5 days, then weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 698	Continued From page 20 returns from dialysis. During interview on 4/30/25 at 12:21 p.m., registered nurse (RN)-D stated that the staff assesses the dialysis site for redness, infection, and/or swelling upon return from dialysis and receives a post run report from the dialysis facility. Vitals are completed at the dialysis facility. During interview on 5/1/25 at 11:44 a.m., the director of nursing (DON) stated that there should be pre and post dialysis vitals taken for dialysis residents. It is important to ensure there are no complications from dialysis and ensure that R19 is returning in a better state than what she left us in. During interview on 5/1/25 at 12:01 p.m., RN-D looked at R19's vitals assessments and stated that he did not see post dialysis visit vital signs, only documentation of signs and symptoms. Facility policy, Dialysis, last reviewed 6/7/24, failed to address vitals assessments pre and post dialysis.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726		5/20/25

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F 726	Continued From page 21 accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to ensure competent administration of insulin occurred for 1 of 1 resident (R60) who was reviewed for insulin administration. Findings include: R60's quarterly Minimum Data Set (MDS) dated 3/6/25, indicated R60 was cognitively intact with the diagnosis of diabetes. R60's undated Care Plan indicated R60 had diabetes type II and instructed staff to administer medication and treatments as ordered. R60's Medication Review Report on or After	F 726	• Corrective Action • Resident 60 insulin orders remain appropriate. • RN-C was provided with 1:1 counseling and completed a Medication pass competency including insulin administration and infection control practices on 4/29/2025 and 5/2/2025. • Insulin Administration from a Pen Policy was reviewed and remains appropriate. • Hand Hygiene policy was reviewed and remains appropriate. • Medication Storage policy was reviewed and remains appropriate. • Identifying other residents	

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F 726	Continued From page 22 5/5/25, Orders included the following orders: Lantus Solostar inject subcutaneous 72 units at bedtime. Humalog Lispro insulin inject per sliding scale at bedtime. Blood sugars before meals and at bedtime R60's Medication Administration Record for April 2025, included the following insulin administrations: 4/25/25 Humalog scheduled time 2000 administered time at 2126 by registered nurse (RN-C), dose 1 unit. 4/25/25 Lantus scheduled time 2000 administered time at 2127 by RN-C, dose 72 units. R60's Weights and Vitals Summary 4/1/25 to 4/30/25 did not show R60 had experienced a low blood sugar the evening of 4/25/25, into the morning of 4/26/25. A progress note entered on 4/29/25, showed that R60 had reported concerns regarding an insulin administration that had occurred on 4/25/25. Note indicated an investigation had been started. The facility provided video clip dated 4/25/25, of a medication administration performed by RN-C on the evening of 4/25/25, was reviewed. The clip started with RN-C wearing gloves and handing R60 a snack at the left side of the nurse's station desk. RN-C moved to the right side of the desk, then went back to the left side, grabbed a computer mouse, returned to the right side of the desk and stood at the computer on the nurse station desk edge. With the same gloves on, RN-C opened the medication cart, removed a baggie with insulin pen(s) from medication cart,	F 726	• Residents currently residing in the facility receiving insulin have the potential to be affected. • Systemic Changes • All Nursing staff educated on Hand Hygiene Policy. • TMA's and Nurses educated on Medication Storage Policy. • Nurses educated on Insulin Administration from a Pen Policy. • IDT educated on Hand Hygiene Policy. • IDT Educated on Medication Storage Policy. • IDT was educated on Insulin Administration Policy. • Monitoring • DON/Designee to audit 5 nurses during insulin administration to ensure facility policies are followed daily x 5 days, then weekly X 3 weeks, then monthly x 3 months or until sustained compliance is achieved. • DON/Designee to audit 5 staff during Hand Hygiene to ensure facility policies are followed daily x 5 days, then weekly X 3 weeks, then monthly x 3 months or until sustained compliance is achieved. • DON/Designee to audit 5 medication passes to ensure facility policies are followed daily x 5 days, then weekly X 3 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 726	Continued From page 23 did not close the medication drawer, returned to end of nurse station, (same gloves on) removed the insulin pens from the baggie, and set them on the counter. (Same gloves on) RN-C went back to medication cart, opened the top right medication drawer and proceeded to enter both drawers with gloved hands. RN-C left both drawers open and moved out of the camera frame towards the nurse manager's office. RN-C returned in the frame wearing gloves with supplies in hand, stopped at the medication cart, partially closed the right drawer and then went back to R60 at the nurse station desk. RN-C removed what appeared to be a syringe from a wrapper and then drew insulin out of what appeared to be an insulin pen via the syringe. RN-C kept the syringe in hand, set down the pen and then grabbed a different pen and appeared to draw insulin from the 2nd pen. (Wear the same gloves) RN-C then set the pen down and administered the contents of the syringe to R60. With the same gloves on RN-C went between the medication cart and the administration area a few times and then returned to R60 at the desk with another baggie containing an insulin pen. RN-C set the pen down, can be seen putting hand in pocket and doing other actions at the desk. (With same gloves on) RN-C entered the open top left medication drawer, returned to R60 and then got a second dose of insulin ready to administer to R60. RN-C proceeded to administer a second injection of insulin to R60 (wearing the same gloves). RN-C returned items to the medication cart and touched several surface area while still wearing the same gloves. At the end of the video clip R60 wheeled away from the desk and RN-C can be seen at a computer, wearing the same gloves.	F 726		

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F 726	Continued From page 24 During an interview on 4/28/25 at 7:16 p.m., R60 stated they were worried they had received the wrong dose of Lantus insulin over the weekend because the nurse seemed unsure of what they were doing. The nurse had drawn their insulin into a syringe from insulin pens, and R60 suspected nurse had gotten the math wrong and given them too much insulin because they had experienced a low blood sugar that night. During a follow-up interview on 4/30/25 at 1:17 p.m., R60 stated the insulin administration they were concerned with had occurred on Friday 5/25/25. R60 reported the nurse had taken a BD syringe and drawn two doses of insulin out of insulin pens, and given it to them instead of administering the insulin with the pen. R60 stated they didn't think it was okay for the nurse to draw insulin from a pen, and they were concerned the nurse had done the math wrong and given them too much insulin because of the low blood sugar they had in the middle of the night. R60 was not able to pull up the low blood sugar value on their dexacom unit (which continuously monitored blood sugar). R60 indicated they had reported the events to the nurse manager yesterday (4/29/25). During an interview on 4/30/25 at 3:54 p.m., RN-C stated they could not recall all the details from the 5/25/25 evening shift, however they did remember they had given R60 two injections of Lantus insulin to equal the ordered bedtime dose of 72 units. They had explained to R60 the two doses would not be equal amounts, but the total dose would equal 72 units, so they were not sure why R60 thought they had received too much Lantus insulin. RN-C felt they had administered the correct amount because they had also had a second staff check the total dose prior to	F 726		

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F 726	Continued From page 25 administration. RN-C confirmed they had administered R60's insulin via a syringe after they had drawn the insulin out of R60's old and new insulin pens. During an interview on 4/30/25 at 4:43 p.m., the director of nursing (DON) stated they had talked with RN-C, and RN-C had confirmed they had drawn insulin out of insulin pens with a syringe and administered it to R60 via the syringe. During an interview on 5/1/25 at 8:03 a.m., RN-G stated they had been working the night shift on 5/25/25, into 5/26/25, and they had not been called to address a low blood sugar for R60. During an interview with the DON on 5/2/25 at 10:47 a.m., the video footage from 5/25/25, of R60's bedtime insulin administration was reviewed. The DON confirmed RN-C and R60's were the subjects being viewed in the video. The DON confirmed RN-C had opened the medication cart, removed insulin, and then had left the cart open, unlocked, and unattended during the course of the video. In addition, RN-C had also left insulin pens unattended at the desk. The DON stated the medication cart should not be left unlocked once medication is removed, and the cart and or medications should never be left unattended. The DON confirmed it appeared RN-C had not sanitized their hands or changed gloves at any point during the video and they had touched multiple surfaces, entered the medication cart and administered medications wearing the same gloves. The DON stated they expected infection prevention measures to be followed which included hand sanitization after touching dirty surfaces and sanitization and glove changes before and after insulin administrations.	F 726		

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F 726	Continued From page 26 The DON confirmed RN-C had drawn insulin from insulin pens and indicated this was not an acceptable medication administration practice. The DON stated they were in the process of addressing identified concerns with RN-C along with the additional concern that it was likely R60 had not received their bedtime Humalog insulin dose on 5/2/25. During an interview on 5/2/25 at 1:38 p.m., the consulting pharmacist stated it was not an acceptable practice to draw insulin from an insulin pen and indicated they believed manufacturers recommend against this practice either. Insulin pens are specifically designed to administer insulin directly to a person. Pens are also designed to hold insulin for priming, so a pen may show it is empty but there may still be insulin left in the pen that was intended for priming. The excess insulin is intended to be disposed of when the pen is empty, it should not be removed from the pen with a syringe. There really is not an acceptable reason to pull insulin from an insulin pen. During a follow up interview on 5/2/25 at 2:45 p.m., RN-C stated they had given R60 their Lantus insulin at the desk so they could verify with another nurse what dose to give R60. RN-C remembered giving R60 two injections of Lantus at the nursing station desk that night and stated they should not have drawn insulin from the insulin pens into syringes, they should have administered the insulin directly from the pen. RN-C's personnel file included a completed Skills Check Off form dated 9/27/18. The insulin administration check off included insulin administration by insulin pen. The competency	F 726		

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F 726	Continued From page 27 did not include drawing insulin from an insulin pen for administration. Hand sanitization before and after medication administration was included in administration steps. An additional interview document dated 4/30/25, indicated RN-C had confirmed they had drawn insulin out of an insulin pen for administration to R60. RN-C had also acknowledged infection prevention concerns that had occurred during R60's insulin administration. The facility policy Insulin Administration from Pen dated 6/7/24 included hand sanitization before and after administration of insulin. The policy did not include drawing insulin from an insulin pen for administration via a syringe. The facility policy Hand Washing dated 6/8/22, indicated the facility would follow CDC recommendations for handwashing the policy identified the following hand sanitization events: before and after glove use, after touching contaminated surfaces, before/after touching residents. The facility policy Medication - Storage dated 3/12/24, indicated all medications were to be stored in accordance with manufacturers recommendations and according to state and federal laws. All drugs and Biologics should be stored in locked compartments, and controlled substances should be stored with two locks.	F 726		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		5/20/25

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F 757	Continued From page 28 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an indication for use was connected to ordered medications for 2 of 5 residents (R88, R407) reviewed for unnecessary medications. Findings include: R88: R88's quarterly Minimum Data Set (MDS) dated 4/4/25, identified R88 was severely cognitively impaired, required partial to substantial assistance with activities of daily living (ADLs), and had diagnoses of cerebrovascular disease (condition that affects blood vessels supplying blood to the brain), dementia, hypertension, depression, hyperlipidemia, and a history of transient ischemic attack (temporary stroke).	F 757	• Corrective Action • Resident 88 medication list was reviewed with provider and updated indications/diagnosis for use as appropriate. • Resident 407 medication list was reviewed with provider and updated indications/diagnosis for use as appropriate. • Audit and correction of all residents completed to identify any other indications/diagnosis concerned. • Unnecessary Drugs Policy and Procedure reviewed and updated. • Identifying other residents • Residents currently residing in the facility receiving medications ordered by physician have the potential to be	

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F 757	Continued From page 29 R88's provider orders reviewed on 4/30/25, included the following orders: -aspirin oral capsule 81 milligrams (mg), give one tablet by mouth one time a day for "salicylate" -atorvastatin calcium oral tablet 80mg, give on tablet by mouth one time a day for "antihyperlipidemic" -clopidogrel bisulfate oral tablet 75mg, give one tablet by mouth one time a day for "platelet aggregation inhibitors" -losartan potassium oral tablet 100mg, give one tablet by mouth one time a day for "ARBs" -pantoprazole sodium oral tablet 40mg, give one tablet by mouth one time a day for "PPIs" During interview on 5/1/25 at 10:05 a.m., registered nurse (RN)-B reviewed ordered medications in R88's chart. RN-B confirmed R88's listed medications did not have a proper indication or diagnosis for use. RN-B stated expectation of all medication orders to have an indication for use or diagnosis attached. During interview on 5/2/25 at 1:05 p.m., director of nursing (DON) stated expectation for all medication orders to have an indication for use or diagnosis attached. R407: R407's admission MDS dated 4/14/25, identified diagnoses of bipolar disorder, post-traumatic stress disorder (PTSD), and chronic pancreatitis. R407 was cognitively intact. R407's provider orders reviewed on 4/29/25, included the following order:	F 757	affected. • Systemic Changes • Staff responsible for entering orders educated on F757 • IDT educated on F757 • Pharmacy consultant continues to review during monthly visits. • Monitoring • DON/Designee shall audit 10 new medication orders to ensure appropriate diagnosis/indication for use is included daily X 5 days, weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 757	Continued From page 30 -valacyclovir HCl Oral Tablet 1 gram (GM), give 1000 mg by mouth in the evening for x During interview on 5/1/25 at 11:41 a.m., the DON stated it was important and the expectation would be that there is a diagnosis for the use of R407's valyclovir. Medication Administration policy last reviewed 4/1/24, explained facility's policy to administer all medications and treatments in a safe and effective manner. Included in the procedure for administering medications was 'able to state indication.'	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/20/25

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F 761	Continued From page 31 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based observation, interview, and document review the facility failed to ensure medications were not left unsecured in resident accessible areas. In addition, the facility failed to ensure medications and biologics were properly stored in locked medication carts. Findings include: During an observation on 4/30/25 at 3:12 p.m., the Cedar medication cart was noted to be unlocked and unattended. The director of nursing (DON) confirmed the cart was not locked and when the trained medication administrator (TMA)-A returned to the cart, the DON informed TMA-A they had found the cart unlocked, and that was unacceptable. TMA-A acknowledged they had left the medication cart unlocked and unattended. During an interview on 5/1/25 at 2:13 p.m., TMA-A confirmed they had left the medication cart unlocked and unattended on 3/30/25 and indicated the DON had addressed it with them. TMA-A stated the medication cart should always be locked because it held narcotic medications and resident prescriptions medications. It was important to keep the cart locked to prevent others/residents from accessing resident medications, and to prevent diversion of medications like gabapentin and muscle relaxants that are more likely to be abused.	F 761	• Corrective Action • Cedar Medication cart remains secured/locked. • TMA-A was provided with 1:1 counseling to ensure medication carts are locked when unattended. • RN-C was provided with 1:1 counseling to ensure that medications/insulin/insulin pens are not left unattended and medication cart is secured/locked when unattended. • Medication storage policy was reviewed and updated. • Identifying other residents • Residents currently residing in the facility receiving medications ordered by physician have the potential to be affected. • Systemic Changes • IDT educated on F761 and Medication storage policy. • Staff responsible for medication administration educated on F761 and Medication storage policy. • Monitoring • DON/Designee shall audit medication carts to ensure carts are locked daily x 7 days then weekly x 3 weeks then monthly x 3 months or until sustained compliance	

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	245366	A. BUILDING _____ B. WING _____	C 05/02/2025

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F 761	Continued From page 32 During an interview on 5/02/25 at 10:47 a.m., the DON reviewed video footage of R60's bedtime insulin administration on 4/25/25. The DON confirmed RN-C and R60 were the subjects in the video. The DON confirmed RN-C had opened the medication cart, removed insulin, and then had left the cart open and unlocked, while attending to R60's insulin administration. In addition, the DON noted RN-C had also left insulin pens at the desk and the medication cart open when they had stepped away from the area. The DON stated they expected nurses to lock the medication cart each time they were done pulling medications and before they left the medication cart. RN-C should not have left medications on the desk unattended. The facility policy Medication - Storage dated 3/12/24, indicated all medications were to be stored in accordance with manufacturers recommendations and according to state and federal laws. All drugs and Biologics should be stored in locked compartments, and controlled substances should be stored with two locks.	F 761	is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16	F 809		5/20/25

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F 809	Continued From page 33 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently offer and provide a nutrient and/or calorie substantive snack after the dinner meal and before bedtime, leaving 15 hours between the evening and morning meals. This had the potential to affect all 107 residents at the facility. Findings include: During interview on 4/28/25 at 7:13 p.m., R60, whose quarterly Minimum Data Set (MDS) dated 3/6/25 identified intact cognition, stated the facility staff do not come and deliver a bedtime snack. During interview on 4/28/25 at 1:12 p.m., R5, whose quarterly MDS dated 1/22/25 identified intact cognition, stated no snacks were offered in the evening. During resident council meeting on 4/30/25 at 1:30 p.m., the following residents voiced concerns about snacks: -R9, whose quarterly MDS dated 4/2/25 identified intact cognition, stated staff never bring snacks around to residents. R9 also stated the snacks residents have received were not substantial	F 809	• Corrective Action • Schedule changed to be within 14 hour span o Cedar ¿ Breakfast 7:00AM ¿ Lunch12:00PM ¿ Dinner – 5:00PM o Willow ¿ Breakfast 7:15AM ¿ Lunch12:15PM ¿ Dinner – 5:15PM o Spruce ¿ Breakfast 7:30AM ¿ Lunch12:30PM ¿ Dinner – 5:30PM o Elm ¿ Breakfast 7:45AM ¿ Lunch12:45PM ¿ Dinner – 5:45PM • Updated posted menu notifying residents that snacks are available along with daily menu items. • Changed policy notification of snacks to be listed on weekly menu. • Identifying other residents • Potential to affect all 107 residents in the facility.	

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F 809	Continued From page 34 enough. -R39, whose quarterly MDS dated 2/3/25 identified intact cognition, stated staff do not bring snack around to residents. R39 also stated there was not enough snack at times, and there was not a good variety of snacks. During interview on 5/1/25 at 2:09 p.m., registered nurse (RN)-E stated snacks were available on the unit and residents have to ask for a snack. RN-E stated being unaware if there were snack carts. During interview on 5/1/25 at 2:15 p.m., certified nursing assistant (CNA)-B stated there were a good variety of snacks available to the residents at any time, and residents needed to ask for a snack. CNA-B further stated there were no snack carts brought to the residents. During interview on 5/2/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated residents were able to get a snack anytime. LPN-A further identified residents would ask staff for a snack, and was not sure if there were snack carts. During interview on 5/2/25 at 1:06 p.m., director of nursing (DON) stated expectation that snacks were offered to residents before bedtime. Hilltop Healthcare Meal Cart Delivery Times undated, identified the following times for meal cart delivery on different units: CEDAR BREAKFAST- 7:45 AM- 8:05 AM LUNCH- 11:45 PM-12:05PM DINNER 4:45 PM-5:05 PM	F 809	• Systemic Changes • Rescheduling meals to be within 14-hour period • Updated Snack policy • Monitoring • Dietary Manager will audit 7 days then weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F 809	Continued From page 35 WILLOW BREAKFAST- 8:05 AM-8:25 AM LUNCH- 12:05 PM- 12:25PM DINNER- 5:05 PM- 5:25 PM SPRUCE BREAKFAST-8:25 AM- 8:45 AM LUNCH- 12:25 PM- 12:45 PM DINNER-5:25 PM- 5:45 PM ELM BREAKFAST 8:45 AM-9:00 AM LUNCH 12:45 PM- 1:00 PM DINNER 5:45PM- 6:00PM Snack Availability policy, last reviewed 6/7/24, identified the purpose of the policy was to ensure that residents have access to nourishing snacks. Policy defined a nourishing snack "as a verbal offering of items, single or in combination from the basic food groups."	F 809		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/29/2025. At the time of this survey, Hilltop Healthcare Rehabilitation & Skilled Nursing was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2025

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hilltop Healthcare and Rehabilitation & Skilled Nursing is a 3-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 1985 an additions were constructed to the building that were determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as	K 000		

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K 000	Continued From page 2 one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 140 beds and had a census of 115 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 346	• Corrective Action • Add State Fire Marshal Division and deputy inspector phone numbers to the policy previously approved in last annual survey. • Systemic Changes • Policy Updated with phone numbers	5/19/25

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K 346	Continued From page 3 On 04/29/2025, between 11:00am and 3:00pm, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	of Fire Marshal Office and Inspector • Education – Maintenance and IDT Staff of K346 • Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is achieved. • Maintenance Director or designee will audit and update current emergency plan books to ensure updated. i. Audited weekly x 2 ii. Annual review of policies and procedures	
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of	K 354	• Corrective Action • Add State Fire Marshal Division and deputy inspector phone numbers to the	5/19/25

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K 354	Continued From page 4 service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	policy previously approved in last annual survey. • Systemic Changes • Policy Updated with phone numbers of Fire Marshal Office and Inspector • Education – Maintenance and IDT Staff of K346 • Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is achieved. • Maintenance Director or designee will audit and update current emergency plan books to ensure updated. i. Audited weekly x 2 ii. Annual review of policies and procedures	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010	K 355	Corrective Action: - Copy of Annual inspection report requested from Summit Fire Protection that was completed on June 25, 2024 and	5/19/25

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K 355	Continued From page 5 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	received. Systemic Changes: - Maintenance Director will upload inspections into TELS and kept in an organized section of the inspection log - Education of Maintenance Staff Monitoring: - All issues will be reported to the administrator and brought to QAPI. - Maintenance Director will monitor annual inspections within TELS annually and keep copies readily available in organized book for survey.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363		5/19/25

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K 363	Continued From page 6 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by observation that second floor Cedar Wing Soiled Utility door does not close and latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	Immediate Corrective Action: - Replaced door handle and strike plate. Systemic Changes: - Maintenance Director added annual inspection of door mechanics to TELS system for ovesight. Monitoring: - All issues will be reported to the administrator and brought to QAPI. - Maintenance Director will audit door mechanics 2 x first month and then annually thereafter.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		5/19/25

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	**2501 RICE LAKE ROAD DULUTH, MN 55811**

(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 372	Continued From page 7 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above the following doors:. 1) First Floor, Burch Wing 2) Second Floor, Cedar Wing 3) First Floor, Willow Wing An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	• Immediate Corrective Action • Fire caulked cable holes and cracks, and installed rockwool in open conduit and capped with fire caulk. • Systemic Changes • Implemented Post Project Inspections Policy • Education – Maintenance staff • Monitoring • Annual Policy Review • Maintenance Director audited the previous work of the cabling. • Annual review of post project inspection policy	

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2025**

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	**2501 RICE LAKE ROAD DULUTH, MN 55811**

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K 511	Continued From page 8	K 511		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by observation that the electrical panel located on the second floor Cedar Wing corridor was not locked. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	• Immediate Corrective Action • Locked second floor Cedar Wing electrical panel. • Systemic Changes • Added audits into TELS • Education – Maintenance staff • Monitoring • Weekly audits for the first month • Monthly thereafter	5/19/25

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K 712	Continued From page 9	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 04/29/2025, between 11:00am and 3:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 02/24/25 at 3:03 PM, 05/14/24 at 3:28 PM, and 08/16/24 at 3:00 PM. 2. On 04/29/2025, between 11:00am and 3:00pm, it was revealed by a review of available documentation that fire drills were not completed: third shift missing first shift, quarter (Apr-Jun), second shift, quarter (Oct-Dec) and third shift,	K 712	• Corrective Action • Schedule created with historical schedules to ensure varying times. • Copies of documents of missing drills available. • Systemic Changes • A schedule was created and kept by the maintenance department. • TELS task entered for updating schedule 1 year in advance • Education – Maintenance staff • Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is met.	5/19/25

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K 712	Continued From page 10 quarter (Jan-Mar) drills completely. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by observation that the following fire	K 761	• Corrective Action • Scheduled and paid for field inspection and labeling of fire door assembly with Intertek. Soonest date for this service would be the week of 5/19/25, but most likely the week of 5/26/25 per Heather Ziegler. • Systemic Changes • Education – Maintenance staff • Monitoring • All issues will be reported to the	5/19/25

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2025**

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K 761	Continued From page 11 doors and/or fire door frames were missing door rating tags. 1) Fire doors leading to Burch Wing - missing tags on door frame An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	administrator and brought to QAPI until compliance is met.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it	K 901	• Corrective Action • Utilities Risk Assessment that was presented to inspector at survey has been revised to include more details. • Updated copies have been placed in the emergency preparedness book. • Systemic Changes • Education – Maintenance staff and IDT	5/19/25

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K 901	Continued From page 12 was revealed during documentation review and an interview with the Environmental Services that the utility risk assessment document could not be provided at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 901	• Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is met. • Annual audits will be added to TELS for updating by Maintenance Director.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA	K 914	• Corrective Action • All the necessary items required will be in the binder easily identifiable for	5/19/25

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K 914	Continued From page 13 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	survey. • Document is available for review. • Systemic Changes • Organization of audits in a systemic approach for ease of finding. • Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is met. • Annual audits in TELS for updating.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		5/19/25

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K 918	Continued From page 14 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, readily identifiable, and separate from normal power circuits. 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Maintenance Manager verified these deficient findings at the time of	K 918	• Corrective Action • All the necessary items required will be in the binder easily identifiable for survey. • Document is available for review. • Systemic Changes • Organization of audits in a systemic approach for ease of finding. • Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is met. • 36 Month audits in TELS for updating.	

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K 918	Continued From page 15 discovery.	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility.	K 920	• Corrective Action • Education of maintenance team and IDT on use of power cords and extensions • Removed all power strips and used inappropriately. • Systemic Changes • Created a TELS auditing process for	5/19/25

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K 920	Continued From page 16 Findings include: On 04/29/2025, between 11:00am and 3:00pm, it was revealed by observation that there were electrical appliances plugged into a power strip in; 1) MDS Office = Refrigerator plugged into power strip 2) in patient room C217 = Use of non-UL Listed multi plugged outlet device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	quarterly audits of rooms for power cords and extensions. • Monitoring • All issues will be reported to the administrator and brought to QAPI until compliance is met. • Maintenance Director will audit 2x a month for 3 months, then quarterly.	