Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 9, 2025

Administrator
Hillcrest Care & Rehabilitation Center
714 SOUTHBEND AVENUE
MANKATO, MN 56001

RE: CCN:245507
Cycle Start Date: August 14, 2025

Dear Administrator:

On August 14, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, 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 November 14, 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 February 14, 2026, (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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	**714 SOUTHBEND AVENUE , MANKATO, Minnesota, 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 8-11-25 through 8-14-25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		09/24/2025
F0000	INITIAL COMMENTS On 8-11-25 through 8-14-25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55071760C (iQIES # 1077449), H55071761C (iQIES #1077448), H5507162C (iQIES #1077446) and H55071763C (iQIES #1077440). NO deficiencies were cited. 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 regulations has been attained.	F0000		09/24/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to	F0584	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those	09/24/2025

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 reverse for further 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.

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

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F0584 SS = D	Continued from page 1 receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a wheelchair in a clean and sanitary manner for 1 of 1 resident (R32) and ensure fans in resident rooms were kept clean for 3 of 3 residents (R2, R52 and R21) reviewed for safe, clean, comfortable, and home-like environment.	F0584	Continued from page 1 residents found to have been affected by the deficient practice: -R32, R2, R52 and R21 are current residents of the facility. R32's wheelchair and R2, R52 and R21 fans were reviewed and cleaned. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -An initial audit of resident fans and wheelchairs was completed, looking at cleanliness. Nursing department staff will be educated to clean wheelchairs on a resident's indicated bath day, and as needed. Housekeeping will be educated on the deep cleaning checklist, which includes cleaning resident's fans. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will audit resident wheelchairs 2x/week x 2 months to ensure cleanliness. Administrator or designee will audit resident fans 2x/week x 2 months to ensure cleanliness. Audits will be reported to the QA committee for further review and recommendations.	

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F0584 SS = D	Continued from page 2 Findings include: R32's face sheet received on 8/13/25, included diagnosis of Parkinson's disease (a movement disorder of the central nervous system). R32's admission Minimum Data Set (MDS) assessment dated 5/19/25, indicated intact cognition. R32 had unclear speech, was usually understood and could understand. R32 required substantial assistance or was dependent upon staff for activities of daily living (ADLs) and did not walk. R32's care plan did not include use of a wheelchair. During an observation on 8/11/25 at 7:18 p.m., while seated in her wheelchair at a table in the great room, observed a heavy grayish/white film over the blue brackets under and alongside R32's wheelchair. The film was hardened onto the brackets and was not able to be wiped off with a finger. During an interview on 8/12/25 at 2:08 p.m., the director of nursing (DON) stated there was not a wheelchair cleaning schedule, that staff cleaned them on a resident's bath day, and the cleaning was not documented. During an interview on 8/12/25 at 2:13 p.m., nursing assistant (NA)-E stated wheelchairs were cleaned on a resident's bath day with disposable wipes. NA-E did not know if wheelchair cleaning was documented. During an interview on 8/13/25 at 7:31 a.m., NA-C stated wheelchairs were cleaned when staff had time, or the night shift did it. NA-C was asked to look at R32's chair under the light in the hallway and stated the heavy whitish/grayish film on the surfaces of the bars alongside and under the wheelchair was from R32's food. During an interview on 8/13/25 at 7:36 a.m., licensed practical nurse (LPN)-C, who was also the care coordinator approached while speaking to NA-C. LPN-C stated R32's wheelchair was hers from her home. LPN-C stated R32 was a new resident and that was the condition of her wheelchair at the time she was admitted to the facility. R32 was admitted three months prior, on 5/13/25. During an interview on 8/14/25, at 11:05 a.m., R32 stated she was unaware her wheelchair had a film on it. The film was described to her, and she indicated she didn't know what it was from.	F0584		

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F0584 SS = D	Continued from page 3 During an interview on 8/14/25, at 11:30 a.m., the DON stated she would expect staff to notice dirty wheelchairs and clean them. Facility wheelchair cleaning policy was requested. In an email dated 8/13/25, at 5:12 p.m., the administrator indicated wheelchair cleaning would follow the residents bill of rights. DIRTY FANSR2's face sheet received on 8/13/25, included diagnosis of dementia. R2's quarterly Minimum Data Set (MDS) assessment dated 7/5/25, indicated R2 was cognitively intact, clear speech, was able to understand and be understood. R52's face sheet received on 8/13/25, included diagnosis of dementia. R52's quarterly MDS assessment dated 7/3/25, indicated moderately impaired cognition, clear speech, was able to understand and be understood. R21's face sheet received on 8/13/25, included diagnoses of recurrent c. diff (clostridioides difficile - inflammation of the colon caused by bacteria), cancer of the rectum and receiving chemotherapy. R21's quarterly MDS assessment dated 5/19/25, indicated intact cognition, clear speech, was able to understand and be understood. R21 was ambulatory per self. R21's care plan dated 7/10/25, indicated isolation precautions related to recurrent C-diff infection. During an observation and interview on 8/11/25 at 3:18 p.m., in R2’s room observed a black standing fan in operation in the corner of R2’s room directed at R2’s recliner where he had been sitting and where he also slept. Observed a significant amount of whitish/gray fuzzy material hanging off the front and back grates of the fan. R2 stated he had not noticed, didn’t know if it had ever been cleaned and stated it should probably be cleaned, but staff were busy. During an observation and interview on 8/11/25 at 6:37 p.m., in R52’s room observed a white standing fan in operation about two - three feet in front of R52’s recliner where she had been sitting and where she also slept. Observed a significant amount of fuzzy whitish/gray material on the back grate of the fan and heavy dark material on edges of the fan blades. R52 stated she did not think it had ever been cleaned. During an observation on 8/12/25 at 8:40 a.m., in R21’s	F0584		

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F0584 SS = D	Continued from page 4 room observed a standing white fan in operation about three feet from R21's bed as he sat on the side of the bed. The fan had a buildup of fuzzy grayish material on the front and back grates and dark material on the edges of the fan blades. R21 stated he hadn't noticed and that he thinks he brought the fan from home. During an interview and observation on 8/12/25 at 12:11 p.m., along with housekeeping manager-in-training (HM)-B and housekeeping regional supervisor (HS)-C looked at the fan in R52's room. HS-C stated housekeeping was responsible for cleaning fans, adding it was not done on a routine basis, just when housekeeping noticed them needing to be cleaned. HS-C stated they were behind on some routine work due to staffing but would make sure to address fans. Together also looked at the fans in R21 and R2's rooms. Both HM-B and HS-C acknowledged potential health concerns for residents with dirty fans blowing air in their rooms. During an interview on 8/13/25 at 8:07 a.m., registered nurse (RN)-E, who was also the assistant director of nursing and infection preventionist in training was informed of dirty fans. RN-E stated dirty fans were not good for anyone, but in particular not good for residents with allergies, respiratory issues or asthma due to the potential particles in the air getting in their respiratory tract. RN-E stated she was not aware of dirty fans and would expect housekeeping to monitor and clean the fans. Facility policy was requested for maintaining clean fans in resident rooms. On 8/13/25 at 3:33 p.m., the administrator provided a deep cleaning list that including cleaning fans, but no policy regarding regular/routine cleaning of fans.	F0584		
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider	F0628		09/24/2025

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F0628 SS = A	Continued from page 5 must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be	F0628		

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F0628 SS = A	Continued from page 6 endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email	F0628		

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F0628 SS = A	Continued from page 7 address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or	F0628		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = A	Continued from page 8 therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a written notification and reason for transfer to a hospital was provided to the resident or resident representative for 2 of 2 residents (R31 and R38) reviewed for transfer/discharge. In addition, the facility failed to ensure 1 of 2 residents (R31) had been informed of bed hold rights at the time of transfer/discharge to the hospital. Findings include: R38's annual Minimum Data Set (MDS) assessment dated 5/28/25, identified R26 had intact cognition. R38’s Bed-Hold Notice And Hospital Transfer/Therapeutic Leave Form dated 8/9/25, failed to include where R38 was transferred and the reason for transfer. R38's EMR (electronic medical record) included a progress note dated 8/9/25 at 6:26 a.m., send to the ER to be evaluated…ambulance called and the resident taken in, bed hold form signed by the resident. On 8/13/25 at 9:48 a.m., registered nurse (RN)-D stated the transfer form was the responsibility of the nurse	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0628 SS = A	Continued from page 9 and the form with where and why the resident was transferred was expected on the form. RN-D stated R38's transfer form 8/9/25, did not include where and why R38 was transferred. On 8/13/25 at 10:52 a.m., the director of nursing (DON) stated the nurse transferring R38 to the ER or hospital was expected to fill out the form completely including where and whyR38 was transferred. The DON confirmed R38's transfer from dated 8/9/25, did not include where or why R38 was transferred. R31's admission MDS assessment dated 7/22/25, included severe cognitive impairment, slurred speech and rarely if ever understood or understands. A progress note dated 8/4/25, at 3:01 p.m., indicated R31 was transferred to the emergency department for evaluation. The resident returned to the facility on 8/5/25. The medical record lacked evidence a written notice of transfer and a bed hold policy was given and had been offered or provided to the resident and/or the resident representative. During interview on 8/11/25, at 6:32 p.m., family member (FM)-A indicated R31 was sent to the hospital because he was wandering and agitated. FM-A stated staff told her why he was being sent but never mentioned a bed hold or explained what a bed hold was. FM-A stated she never received anything in writing. During interview on 8/13/25, at 2:14 p.m. licensed practical nurse (LPN)-D, also identified as unit manager, indicated bed hold/transfer notification should be given to all residents when transferred to the emergency department for evaluation. LPN-D added if resident is cognitively impaired, the family should be contacted and verbal permission or refusal for bed hold and transfer should be gotten and documented in the medical record. LPN-D confirmed there was no bed hold/transfer agreement form present and no documentation a bed hold was discussed or offered with FM-A. During interview on 8/13/25, at 2:16 p.m. RN-B indicated necessary paperwork is sent including face sheet, diagnosis list, medication administration record, advanced directive and bed hold/transfer agreement. RN-B added most times the bed hold is discussed with the family and verbal permission is received and documented in the medical record. During interview on 8/14/25, at 8:15 a.m. DON, stated	F0628		

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F0628 SS = A	Continued from page 10 all transfers require notification of bed hold and transfer agreement be given to the resident and/or family member. The DON stated if the family isn't present at the time of transfer, verbal permission will be requested from the family for transfer and a bed hold if desired. The DON added if we find out none was given we will notify the family at the time of the discovery. The DON confirmed no bed hold or transfer notice was given to FM-A for R31's 8/4/25 transfer to the hospital. Facility Transfer or Discharge Notice for Discharges policy dated 1/2025, included: The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged; d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including: (1) the name, address, email and telephone number of the entity which receives appeal hearing requests; (2) information about how to obtain, complete and submit an appeal request; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and	F0628		

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F0628 SS = A	Continued from page 11 i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. - The reasons for the transfer or discharge are documented in the resident's medical record.	F0628		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure professional standards of practice were followed during catheter insertion and follow up from emergency department visit for 1 of 1 resident (R24) reviewed for urinary catheter. In addition, the facility failed to ensure only licensed nursing staff administered medication to 1 of 1 resident (R23) reviewed for routine cares. Findings include: R24's face sheet printed 8/14/25, indicated diagnoses off flaccid neuropathic bladder (underactive bladder), retention of urine, and chronic prostatitis (inflammation of the prostate). R24's care plan printed 8/14/25, indicated alteration in elimination related to generalized weakness, diabetes, urine retention, resident has an indwelling catheter, followed by urology. Resident will be free from signs/symptoms of urinary tract infection. Monitor foley catheter output, change foley catheter per policy, foley catheter care per policy. R24's physician's order dated 5/27/25, indicated change foley catheter monthly and PRN (as needed) in the morning on the 27th of every month. R24's quarterly Minimum Data Set (MDS) assessment dated 7/28/25, indicated intact cognition, no rejection of care, neurogenic bladder, and presence of indwelling	F0658	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -Staff involved with R24 and R23's alleged deficient practice were provided re-education and/or corrective action regarding the professional standards of catheter insertion and medication administration only by appropriate nursing staff, ie Trained Medication Aides (TMAs) and licensed nurses. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -A full house audit was completed to ensure there were no other current catheter insertion issues and to ensure medications were being administered by appropriate nursing staff. The Indwelling Urinary Catheter Insertion Competency and Medication Administration Policy were reviewed. Education was provided to nurses regarding the professional standards of practice for catheter insertion, the catheter competency was reviewed, and facility expectations. Education was provided to nursing staff regarding medication administration is only done by appropriate	09/24/2025

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F0658 SS = D	Continued from page 12 urinary catheter. During observation and interview on 8/11/25 at 4:17 p.m., R24 was seated in a wheelchair in his room with foley catheter tubing and drainage bag attached to his right leg. R24 stated he had to go to the emergency room at the end of June 2025 because a nurse inserted his catheter wrong. R24 stated he was in pain for over 10 hours before going to the emergency room. R24 stated a scan at the emergency department showed the catheter was not in the right place. Review of the facility's treatment administration record (TAR) for R24 printed 8/13/25, indicated R24's catheter was changed on 6/27/25 by registered nurse (RN)-C. Review of facility progress notes dated 6/27/25 included the following: 6/27/25, 9:34 p.m., -resident sat on bed pan for about an hour, given miralax and Milk of Magnesia with no results. Will wait to see if these produce results. 6/27/25, 10:57 p.m., -resident requested to be evaluated at the emergency department for abdominal pain, believed to be constipation. Absent bowel sounds, abdomen distended. 6/28/25, 5:15 a.m., - writer called emergency department and spoke with nurse for an update. Nurse stated that they discovered the problem, when his catheter was changed yesterday the balloon was inflated before it was in his bladder. This caused the distended abdomen and pain. They replaced the foley and released one liter of urine out of the bladder. Resident was also constipated. Waiting for van to transport back to facility in morning. Review of emergency department after visit summary dated 6/28/25, indicated R24 was evaluated in the emergency department for abdominal pain. X-ray revealed the catheter balloon was inflated prior to reaching the bladder, causing pain and urine retention of one liter. During interview on 8/14/25 at 11:09 a.m., RN-C stated she remembered changing R24's catheter on 6/27/25. RN-C stated the physician's order was not specific and did not indicate which catheter she should use, and further stated it appeared to her the catheter had not ever been changed since R24's admission to the facility. RN-C stated after getting clarification on the order, she inserted the new catheter around 8:00 a.m. and did not think anything went wrong with the insertion but	F0658	Continued from page 12 nursing staff, ie Trained Medication Aides (TMAs) and licensed nurses. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee with complete random audits on catheter insertions and medication passes by TMAs to ensure compliance 3x/week x 2 months and will report to QAPI committee for further review and recommendations.	

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F0658 SS = D	Continued from page 13 could not remember specifics. RN-C stated R24 did not complain about pain to her during the insertion or throughout her shift. RN-C stated she rarely works at the facility and was only aware of R24's emergency department visit because R24 told her about it the next time she worked. RN-C said no one from the facility asked her about the catheter insertion or provided her further education on catheter insertion. During interview on 8/13/25 at 3:00 p.m., licensed practical nurse (LPN)-E also known as south care coordinator, stated the catheter was inserted incorrectly on a Friday (6/27/25), and she heard about it on following Monday when she returned to work. LPN-E stated she informed director of nursing (DON) about R24's incorrect catheter insertion and emergency department visit on Monday and had not heard any more about it since then. LPN-E stated she would not be responsible for follow up with a nurse unless directed by DON. During interview on 8/13/25 at 2:45 p.m., DON stated she was not aware of R24's incorrect catheter insertion and emergency department visit. DON stated R24 had frequent concerns about his catheter and his catheter would now be changed only by the urology department to avoid conflict and pain. DON stated she did not do any follow up with RN-C to ensure competency in catheter insertion. DON further stated she would expect to know about this incident and was not sure why she was not made aware. DON stated she would have expected to discuss R24's emergency room visit with the interdisciplinary team (IDT) because they discuss all emergency room visits and hospitalizations. DON further stated she would have expected to have talked to RN-C to learn more about the situation and determine whether there was a competency concern and provide education if needed. Review of document titled Temp Agency Staff Orientation signed by RN-C on 4/17/25, indicated the following: You will be oriented to the following prior to working on the nursing units: competencies for specific job duties. A competency evaluation was requested but not received. A facility provided procedure checklist titled Monarch Indwelling Urinary Catheter Insertion printed 8/14/25, indicated the following: Once urine starts to flow, inflate the balloon using the water-filled syringe attached to the inflation	F0658		

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F0658 SS = D	Continued from page 14 port, instilling the recommended amount of sterile water specified on the catheter. Gently pull the catheter until the inflated balloon is snug against the bladder neck. Nursing alert: never inflate a balloon without first establishing urine flow, which confirms that the catheter is in the bladder. - MEDICATION ADMNISTATION R23's face sheet received on 8/13/25, included diagnosis of low back pain. R23's quarterly MDS assessment dated 6/27/25, indicated R23 had severe cognitive impairment, clear speech, could understand and be understood. R23 relied on staff for most all activities of daily living (ADLs). R23 did not walk and used a wheelchair for mobility. R23's orders dated 12/27/24, included Lidocaine External Patch 4 % (Lidocaine). Apply to low back topically related to low back pain. R23's care plan dated 8/6/24, indicated R23 had an alteration in comfort, and pain medication would be administered per physician order. During an observation on 8/13/25 at 8:14 a.m., observed nursing assistant (NA)-C assist R23 out of bed and into her wheelchair. Once in her wheelchair, NA-C picked up a patch (which had been removed from its original packaging) from the overbed table, unfold it and placed it on R23’s lower back. During an interview on 8/13/25, at 8:26 AM, NA-C stated it was a pain patch she applied to R23’s lower back. NA-C stated she was not a TMA (trained medication aide). NA-C stated she applied the patch when (TMA)-A asked her to and had not been told she couldn’t. During an interview on 8/13/25 at 9:10 a.m., TMA-A, stated she had placed a lidocaine pain patch on R23’s overbed table so that when the NA's got her up, they could apply it. TMA-A stated she thought it was okay for a NA to apply a medication patch, adding “we always do that” and “I didn’t know we shouldn’t.” During an interview on 8/13/25 at 9:22 a.m., the DON was informed of the observation and stated it was not acceptable for a NA to apply a lidocaine patch or administer medications. The DON was not aware this had	F0658		

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F0658 SS = D	Continued from page 15 been happening and stated she would address it. During an interview on 8/13/25 at 12:42 p.m., TMA-A stated she documented the lidocaine patch on the MAR (medication administration record) as being administered at 8 a.m. and acknowledged she did not know the actual time NA-C had applied it. Facility Medication Administration – General Guidelines policy dated May 2022, indicated medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Five Rights - right resident, right drug, right dose, right route and right time, are applied for each medication being administered. Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) were compared with the medication label. Medications were administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.	F0658		
F0684 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 implement physician orders for a TLSO (thoracolumbar sacral orthosis) brace for 1 of 1 resident (R42) reviewed for mobility. Findings include: R42's face sheet received on 8/14/25, included diagnosis of fracture of neck of left femur (thigh bone). R42's admission Minimum Data Set (MDS) assessment dated	F0684	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R42's TLSO brace was discontinued by the provider. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents with TLSO brace orders have the potential to be affected. Currently, no other resident residing at the facility have TLSO brace orders. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:	09/24/2025

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F0684 SS = D	Continued from page 16 6/3/25, indicated R42 had intact cognition, clear speech, could understand and be understood. R42 required supervision or partial assistance for activities of daily living. R42 did not walk independently and used a wheelchair or walker for mobility. R42 had no behaviors and no rejection of care. R42's physician orders did not include R42's TLSO brace. R42 care plan dated 5/29/25, indicated R42 had an alteration in mobility related to diagnosis of left femoral neck fracture. Intervention/task dated 5/30/25, indicated TLSO brace on at all times when out of bed or if HOB (head of bed) was elevated greater than 30 degrees. Intervention/task dated 6/24/25, indicated R42 was independent in halls with TLSO on and using FWW (front wheeled walker). R42's Kardex (a document used by nursing assistants indicating directions for resident cares) posted on the back of R42's door dated 7/7/25, indicated brace on at all times when out of bed or HOB elevated more than 30 degrees. Progress note dated 5/24/25 at 3:53 p.m., indicated: called the hospital for an update on the resident. Resident has confirmed fracture of left femoral neck femur. For surgery today 5/24. Resident also has L2 (second lumbar bone in the lower back) spine compression fracture and a TLSO brace. A scanned documented in R42's electronic medical record (EMR) titled Brace Weaning Instructions, undated, indicated how many hours each week R42's brace should be off. The 16-week list listed each week from 6/20/25, to 10/2/25, identifying how long the brace should be off that week. This week (week of 8/11/25) would be week eight on the document and indicated R42 should have his brace off 2 hours in the morning and afternoon and one hour in the evening. During an observation on 8/11/25 at 4:07 p.m., in R42's room, observed a plastic torso brace on a chair. R42 stated he was supposed to wear it when out of bed, but staff did not put it on him. R42 had been observed self-propelling his wheelchair in the hallway earlier in the afternoon when he stopped to visit and did not have the brace on. During an interview on 8/12/25 at 3:45 p.m., nursing assistant (NA)-E stated R42 used to be on another unit and wore his brace more, but on current unit, didn't	F0684	Continued from page 16 -A full house audit was completed to ensure no other residents had orders for a TLSO brace. Nursing leadership to be re-educated to check TLSO treatment orders are transcribed into the TAR. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee with complete random audits for TLSO orders to ensure compliance 1x/week x 2 months and will report to QAPI committee for further review and recommendations.	

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F0684 SS = D	Continued from page 17 wear it as much. NA-E stated she did not know if he was supposed to wear it. During an interview on 8/12/25, at 3:52 p.m., NA-B stated R42 put on and took off the brace himself. During an interview on 8/14/25 at 8:40 a.m., the director of nursing (DON) stated instructions for R42's TLSO brace was on his AVS (after visit summary - a document provided by the hospital) dated 5/28/25, following hospitalization for femur fracture. The DON read the following: "Continue to use the brace for three months, wearing it at all times when up and about, and when sitting at greater than 30 degrees. No lifting more than 5-10 pounds, and avoid any excessive pushing, pulling, bending, or twisting. The brace may be applied when sitting at edge of bed. Brace may be off for shower or sleep. Wear a light cotton shirt under the brace to prevent skin irritation. Check skin in shower or at night for redness or open sores." The DON stated this order had not been added to R42's physician orders but part of it had been added to R42's care plan and Kardex. The DON stated she would have added the specific physician instructions to the TAR (treatment administration record) to ensure the orders were carried out by nursing staff. The DON stated when a resident was admitted or readmitted, it was the responsibility of the nurse care coordinator to review orders and documents from the hospital and enter orders onto the MAR (medication administration record) or TAR for nurses to carry out. Further, if R42 had refused to wear the brace, the DON stated she would have expected documentation of the refusals. The DON admitted there was no documentation of R42 refusing to wear the brace. If there had been refusals, the DON stated nursing would notify the physician to determine next steps. In addition, a document scanned into R42's EMR titled Brace Weaning Instructions was pointed out to the DON, who stated that was the first time she had seen it. The DON stated it was her expectation that care coordinators review all resident documents from providers thoroughly and to implement the orders as written. At 9:02 a.m., licensed practical nurse (LPN)-C who was also the care coordinator for the unit R42 resided on, was brought into the conversation. LPN-C was aware of the AVS but had never seen the Brace Weaning Instructions. LPN-C stated she had seen the brace in R42's room and had helped him remove it one time when she did wound care, but thought it was something he wore when he wanted to. LPN-C admitted R42 had not been wearing the brace per physician order and had not been weaned according to the instructions. LPN-C stated, "I didn't read through the AVS well enough to catch that" (i.e., the detailed physician	F0684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 18 instructions for the TLSO brace). LPN-C stated registered nurse (RN)-A who was also the regional nurse consultant had reached out to neurosurgery to ask what should be done now with the brace. Progress note dated 8/13/25 at 3:50 p.m., written by registered nurse (RN)-A who was also the regional nurse consultant indicated: message left for neurosurgery for clarification on TLSO brace weaning schedule and to update on resident's refusals. During an interview on 8/14/25, at 11:10 a.m., RN-A was asked about her progress note regarding notifying neurosurgery and R42's refusals to wear the brace. RN-A stated LPN-C had told her R42 refused to wear the brace. RN-A was informed during interviews, no staff stated R42 refused to wear the brace. R42's MDS did not indicate rejection of care, nor were there any refusals documented in R42's EMR indicating he refused to wear the brace. The facility did not have a policy on processing physician orders for new admissions and readmissions to ensure all orders were identified and addressed by staff.	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 3 residents (R6) who developed an unstageable pressure ulcer to the	F0686	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R6 no longer resides at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential of being affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:	09/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0686 SS = D	Continued from page 19 sacrum (small, triangular bone located at the bottom of the spine) and bilateral heels area. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage II Pressure Ulcer: Partial-thickness skin loss into but not deeper than the dermis (middle layer of the skin), which may include intact or ruptured blisters. Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of wound bed and often includes undermining and tunneling. Deep-Tissue Injury (DTI): Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent tissue. Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.) R6's Face Sheet printed 8/13/25, included diagnoses of normal pressure hydrocephalus (fluid buildup inside or around the brain), benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, pressure ulcer of right and left heels, unstageable, pressure ulcer of sacral regions stage IV, abnormal weight loss, and dementia. R6's admission Minimum Data Set (MDS) assessment dated 8/9/24, indicated R6 was at risk for pressure ulcers (PU), had no unhealed PU's and no interventions in place to prevent pressure ulcer development. R6's end of Part A stay MDS assessment dated 8/19/25, indicated R6 had no unhealed PU's or skin injuries. R6 was dependent on staff for toileting, and dressing and required partial to moderate assist with bed mobility, and substantial to maximal assistance for transfers. R6's end of Medicare Part A stay dated 9/13/25, indicated R6 had 2 unstageable pressure ulcers present. Has pressure reducing device for chair and bed, nutrition or hydration interventions in place and PU injury/care.	F0686	Continued from page 19 -A full house audit was completed to ensure at risk residents have the appropriate pressure relieving interventions in place. The Skin Assessment and Wound Management policy was reviewed. Education was provided to the nursing department regarding pressure relieving interventions, reporting of skin concerns, and facility expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee with complete random audits to ensure compliance 3x/week x 2 months and will report to QAPI committee for further review and recommendations.	

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F0686 SS = D	Continued from page 20 R6's initial Care Area Assessment (CAA) dated 8/9/24 included potential risk for skin breakdown related to hydrocephalus, benign prostatic hyperplasia, mild cognitive impairment and Alzheimer's disease. Resident required 1-2 assist for transfers and activities of daily living. Resident is noted to have incontinence of bowels. R6's initial baseline care plan dated 8/6/24, did not include skin/PU prevention or interventions. R6's plan of care dated 8/23/24, included alteration in skin integrity related to impaired mobility and function with interventions including low air loss air bed, pressure redistribution mattress, dietary interventions, including encourage supplements, weekly measurement and assessment of wound, heel lift boots, monitor skin integrity daily during cares with weekly skin inspection by nurse, treatment to open areas per order. R6's Braden skin assessments (standardized tool use to assess a patient's risk of developing pressure ulcers) included: 8/9/24: Occasionally moist skin, resident is chairfast and has limited ability to change and control body position. Nutrition is adequate and friction and sheer potential problems. Score of 16 which is at risk. 8/21/24: Slightly limited sensory perception, rarely moist skin, chairfast with very limited ability to change and control body position, adequate nutrition and friction and shear being a problem. Score of 15 resident is at risk. 9/12/25: Very limited sensory perception, skin rarely moist, chairfast with very limited mobility. Probably inadequate nutrition, with friction and shear a problem. Score of 13 which is moderate risk for skin breakdown. R6's Weekly Skin Inspections included: 8/8/24: Skin is dry with flakes of his feet. Applied lotion. No open areas noted. Completed by registered nurse (RN)-B. 8/15/24: Skin is intact with no open areas noted. Completed by RN-B. 8/30/24: Resident has an open wound to the coccyx 2 cm x 2 cm. No drainage or signs of infection. Closed blister to the left heel. Wound care performed on both	F0686		

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F0686 SS = D	Continued from page 21 areas. Completed by RN-B. A Wound Assessment dated 8/21/24, for left heel included new in house acquired pressure ulcer to left heel. Family, provider and dietitian notified. Additional care included customized shoe wear, heel suspension/protection device, incontinence management, moisture barrier, moisture control, nutrition/dietary supplementation and turning repositioning program. Wound care nurse practitioner consult and evaluation. Mepelix (soft and conformable wound dressing) applied. Heavy bloody drainage. No measurements of wound was present. A wound assessment dated 8/27/24, included left heel unstageable pressure ulcer (due to slough and or escar (dead tissue covering wound). Measurements included Length 4.8 cm x 3.3 cm. Wound is deteriorating. No documentation present on wound appearance or drainage. A wound assessment dated 8/29/24, included new unstageable pressure ulcer to sacrum measuring 6.85 cm x 4.23 cm. Slough present on 100% of wound. Moderate serosanguinous (normal wound fluid that appears as light pink, thin watery discharge) drainage present. A wound assessment dated 9/4/24, included unstageable sacral PU (slough and/or eschar 100% of wound bed) measuring 4.6 cm x 2.2 cm. with no drainage present. Wound is deteriorating and wound care nurse practitioner notified. A wound assessment 9/4/25, included unstageable pressure ulcer to left heel. Wound was 4.37 cm x 3.94 cm. A wound assessment dated 9/4/24, for right heel indicated new Stage II PU in house acquired measured 2.2 cm x 1.7 cm blister present. A progress note dated 9/5/25 at 3:48 p.m., by registered nurse (RN)-B included resident was sent to the hospital ED for bloody urine. A progress note dated 9/9/24 at 9:56 p.m. included R6 returned to the facility earlier in the day, but now running temperature of 103.1 at 4:30 p.m. Physician was notified and R6 sent to the emergency department (ED) at 6:00 p.m. and returned to the facility around 9:35 p.m. Upon return from hospitalization wound assessments were completed 9/11/25:	F0686		

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F0686 SS = D	Continued from page 22 Sacral pressure ulcer was unstageable and measured 5.4 cm x 3.1 cm with no drainage present. Right heel blister present 3.3 cm x 2.7 cm. No open areas. Left heel was unstageable measuring 4.7 cm x 3.8 cm with 100% eschar present. Wound assessments and evaluations with various treatments and debridement's were completed with slow healing progress noted through 8/13/25. Sacral PU stage IV, on 8/13/25 included depth of 0.5 cm x 2.71 cm x 2.71 cm. Left heel remains unstageable 1.14 cm x 1.04 cm covered with eschar 100%. Right heel remains unstageable and measured 1.1 x 0.7 cm covered with eschar 100%. On interview and observation on 8/13/25 at 9:45 a.m., nurse practitioner (NP)-C, also a certified wound care nurse, performed wound care on right and left heel and sacrum for R6 and stated the wounds are slowly improving. NP-C stated she has been doing weekly evaluations on the wounds since they started in August 2024 and the wounds worsened after R6's hospital stay in September 2024. At that time, NP-C ordered a wound vacuum on his sacral area but that was discontinued when hospice services started 12/24. NP-C stated R6 has had many episodes of infection where his physical condition deteriorates and then he will recover which can cause the wounds to stall with healing. NP-C stated it is hard to say if these wounds were preventable but with proper interventions, all pressure ulcers are preventable. On observation and interview 8/13/25 at 10:18 a.m., nursing assistant (NA)-F and NA-G entered R6's room and checked pad, completed peri-care and positioned R6 on his left side. NA-F and NA-G stated they reposition R6 every 1.5 to 2 hours. NA-F stated he used to wiggle himself onto his back but hasn't done that in awhile. R6 had on bilateral heel protectors. NA-F and NA-G indicated R6 has been cooperative with repositioning. NA-F stated R6 has always required assistance for transfers and repositioning. Continuous observation was started at 10:28 a.m. and NA-F and NA-G returned and completed pad check and repositioned R6 to his right side at 12:22 p.m. On interview 8/13/25 at 1:46 p.m., licensed practical nurse (LPN)-B, unit manager stated R6 was initially an EZ stand (sit to stand machine) for transfers. LPN-B confirmed R6 required assistance for moving in bed.	F0686		

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F0686 SS = D	Continued from page 23 LPN-B confirmed there was no preventative skin plan in place when R6 was admitted until the PU's developed. LPN-B stated she is responsible for the baseline care plan and they do have the option of putting skin prevention in place, but this was not part of R6's initial care plan. LPN-B stated when R6 went to the hospital 9/5/24 and returned 9/9/24 the PU on the sacral area went from a small open area, likely a Stage II pressure ulcer to a Stage IV. LPN-B indicated the PU's got worse even after interventions were put in place and was not sure if these wounds were preventable or not. On interview 8/13/25 at 2:25 p.m., registered nurse (RN)-B stated R6 came with red heels and believes he had an area on his sacrum on admit. RN-B stated R6 has always required assistance with turning and repositioning since he arrived at the facility and believes skin prevention interventions were in place on admission but wasn't sure. On interview 8/13/25 at 2:08 p.m., RN-A, also identified as regional nurse consultant, indicated all residents admitted generally are a PU risk and should have basic interventions for skin prevention implemented on admission. RN-A indicated the facility does not do tissue tolerance tests. On interview 8/14/25 at 8:20 a.m., the director of nursing (DON) confirmed there was no skin prevention plan of care initiated on admission for R6 but should have been. The DON indicated since the wounds were discovered a wound care specialist has been assessing, evaluating and directing treatment of the wound and the wounds are gradually improving. Facility Skin assessment and Wound Management policy dated 2/2025 included: Prevention and Identification: A PU risk assessment (Braden Scale) will be completed per Assessment Schedule/Grid. Implement appropriate preventative skin measures. Examples include but are not limited to nutritional interventions, mobility and repositioning plan, pressure redistribution plan. Skin evaluation and skin risk factors form is completed before initial MDS, annually and upon significant change. Staff will perform routine skin inspections (with daily care). Nurses are to be notified if skin changes are identified. A weekly skin inspection will be completed by licensed staff.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does	09/24/2025

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F0689 SS = D	Continued from page 24 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure care planned interventions to prevent falls were implemented and failed to complete an assessment for electric recliner use for 1 of 3 residents (R53) reviewed for falls. Findings include: R53's quarterly Minimum Data Set (MDS) assessment dated 8/12/25, indicated R53 was admitted 3/3/25, indicated severe cognitive impairment, no behaviors, no rejection of care, utilized a walker and wheelchair, required substantial/maximal assistance with toileting hygiene, shower/bathe self, dressing, personal hygiene; required supervision or touching assistance sit to lying, lying to sitting on side of bed; required substantial/maximal assistance sit to stand, chair/bed to chair transfer, toilet transfer; partial/moderate assistance walk ten feet, diagnoses included non-traumatic brain dysfunction, aphasia, stroke, non-Alzheimer's dementia, psychotic disorder, insomnia, restlessness and agitation, falls since admission/entry or prior assessment, two or more falls with no injury, and two or more falls with injury (not major). R53's Care Area Assessment (CAA) Summary dated 3/10/25, indicated potential risk for falls r/t (related/to): stroke with right sided hemiplegia, dementia, anxiety, heart failure, aphasia, received antidepressant medication which can increase the risk of falls, required 1-2 assist for transfers and ADL's, alert with cognitive impairments, makes some needs known, noted to have continence of bladder and bowels, working with PT/OT (physical therapy/occupational therapy) for strengthening and ADL function, staff will follow therapy recommendation for ambulation/transfer/ADL (activities of daily living) status and update charge nurse and therapy of any concerns. Staff will alert	F0689	Continued from page 24 not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R53 was assessed for appropriate and safe use of electric recliner and ensured care planned fall interventions were implemented. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents with electric recliners and those with care planned fall interventions have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -A full house audit was completed to ensure residents with an electric recliner have been appropriately assessed and that care planned fall interventions were implemented. The facility Lift Chair Assessment process, Fall Prevention and Management, and Care Planning policies were reviewed. Facility staff were educated on processes, policies, and expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee with complete random audits to ensure compliance 3x/week x 2 months and will report to QAPI committee for further review and recommendations.	

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F0689 SS = D	Continued from page 25 charge nurse and therapy of any unintended changes in position, and update plan of care as needed. See plan of care for current fall interventions. Goal is for resident to be free from falls daily through the review date. R53's care plan last review printed 8/14/25, indicated fall risk related to vascular dementia, morbid (severe) obesity; pain in knee; edema and interventions included 04/24/25, grip strips in bathroom 3/24/25, anti-rollbacks; 30 minute checks, 5/8/25, grip strips by closet 7/11/25, wait for assistance signs, Dycem (non slip pad) in w/c (wheelchair), do not leave the resident unattended in the bathroom, grab bars in bathroom to reach with non-affected L (left) side in event he self- transfers to the bathroom, grip strips to the floor in front of recliner, neon tape to call light, urinal to be next to resident recliner at all times, monitor and document on safety, review information on past falls and attempt to determine cause of falls, record possible root causes, alter remove any potential causes if possible, educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. R53's care plan further indicated on 8/13/25, interventions added included alteration in mobility interventions R53 sleeps in electric recliner, per choice, safe to operate electric recliner for positioning to sit up and lay down. R53's Kardex dated 8/14/25, indicated 30-minute checks, 7/11/25: IDT team reviewed: dycem in w/c, do not leave the resident unattended in the bathroom, dycem to wheelchair to help prevent resident from slipping out of the wheelchair, grip strips to the floor in front of recliner. R53's therapy alert document dated 3/4/25, indicated R53 was not safe for power recliner, the document had a section for nursing follow up that was not filled out and did not indicate nursing addressed the communication form. R53's Occupational Therapy (OT) note dated 8/13/25, indicated presents with difficulty with spatial awareness, decrease fine motor, strength and sensory skills, not able to locate remote independently, once placed in hand using tactile feel and able to push first 2 buttons of the remote, needed 50% more time to locate recline button, able to use left hand to push button but unable to maintain pressure so takes 4-5 times to move from recline to sitting position, showed difficulty to operate proper button on cue , which was expected due to aphasia and difficulty with following cues and communication, able to change direction when	F0689		

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F0689 SS = D	Continued from page 26 realizing that chair is not going in the wanted direction, based on this assessment, seems to be at low risk of falling out of the recliner lift chair due to inability to operate remote , poor vision , decrease strength and fine motor, needing time and trial and error technique, showed great ability to stop pressure to stop the mechanisms as observed 4/4 times during this assessment, proper sitting balance to sit, recent decline with transfer ability currently addressed by P/T (physical therapy), no OT services recommended as not compliant in the past and no significant concerns with safety when using lift chair or sleeping. No changes in current POC (plan of care) recommended. R53's fall review evaluation dated 3/10/25, indicated no history of fall in the last six months, highly impaired vision, at risk for falls due to right sided weakness, currently independent with transfers uses w/c for ambulation. R53's Incident Review Analysis indicated: 3/22/25, fall from chair or wheelchair R53 stated that he was trying to get to his recliner but that he hit his head really "hard on the wall", walker was to the left side of the wheelchair, R53 stated that his legs "gave out" and that he was sore from PT this week, unsteady gait, was agitated, has dementia, has impaired memory. IDT Reviewed: anti-rollbacks; sent resident to ED (emergency department) d/t (due to) being on Eliquis (blood thinner). 4/2/25, found on floor attempting to ambulate from the bathroom to his recliner when he lost his balance and slowly fell to the floor, did not use his call light to alert staff of his need for assistance diagnosed with hx (history) of cerebral infarction, hemiplegia, knee pain and vascular dementia. R53 impaired cognition, impaired mobility and impaired safety awareness Signs have been placed on the walls in the resident's room to call for help before getting up, and neon tape placed on the call light to alert the resident easier of where his call light is to encourage use of the call light. 4/18/25, R53 assisted to the toilet, staff left the resident on the toilet, R53 told the aid to get out. The aid told R53 to put his light on when finished. The CNA (certified nursing assistant) was in the room next to the resident's room and heard the thud. Opened the shared bathroom door and noted the resident on the floor. The resident did not put his call light on and was attempting to get himself off the toilet. Staff will not leave the residents room while he is on the toilet. They may step outside the bathroom to give the	F0689		

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F0689 SS = D	Continued from page 27 resident some privacy, but they must stay right outside the door. 4/24/25, found on floor found lying on his right side on the ground in the doorway of his bathroom, in room. IDT Reviewed: Grip strips in bathroom. 5/1/25, …. turned his wheelchair, stood and put himself onto the floor hitting his left shoulder on the cabinet, continued with the behavior attempting to stand and threatening to put himself back on the floor. Staff continued to attempt to de-escalate the situation. Staff got social services who has a good rapport with the resident to assist in the de-escalation. 5/6/25, found on floor housekeeper alerted staff that res was on the floor. Res found lying on his right side alongside the wall near the closet. Res head facing the door side and legs extended out towards the closet. Res reports walking to his laundry basket/hamper and slipped and fell. Resident has an unsteady gait, has a history of falls, not always able to realize limitations, has gait imbalance, CVA IDT Reviewed: Grip strips by closet. 5/28/25, R53 found on floor appears to have been transferring either from his wheelchair to recliner or recliner to his wheelchair. The resident was found sitting on the floor next to the recliner. The resident is diagnosed with dementia, history of CVA, anxiety disorder, depression, delirium, psychosis and aphasia. The resident is very hard to understand, he speaks in word salad. He is quick to anger when staff is not able to understand what he is trying to express. The resident did not use his call light to alert staff of need to transfer prior to attempting to self-transfer. The resident has impaired cognition, impaired mobility and impaired safety awareness. Grip strips to the floor in front of the resident recliner. 6/4/25, R53 self-transferring from toilet to w/c in bathroom was assessed and additional grab bar was placed where resident can reach with his non effected L arm to facilitate safer self-transfers as resident will not always notify staff of need to toilet or refuses cares at times. 6/21/25, R53 attempting to self-transfer in his bathroom. It was noted that the resident floor was damp with moisture and may have added to the resident slipping. The resident was given a commode to use to avoid the bathroom. A dehumidifier was placed in his room. The resident was encouraged to use the EZ stand	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 SOUTHBEND AVENUE , MANKATO, Minnesota, 56001

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F0689 SS = D	Continued from page 28 (mechanical lift) for transfers. 6/22/25, R53 was found lying on the floor on his right side near this dresser. The resident stated he was attempting to change his underwear when he fell to the floor. He stated he was not sure what happened, it appears he lost his balance, related to his hemiparesis. The resident did not use his call light, nor did he attempt to alert staff of his need to change his cloths. resident refused to use the EZ-stand. Therapy did evaluate today. They have recommended that the resident be assist of 1 with use of Hemi walker and for staff to not leave the resident unattended in the bathroom. Will attempt this as the resident will allow. 7/11/25 at 12:50 p.m. fall from chair or wheelchair nursing assistant responded to the call light and found the resident already on the toilet, requested assistance with perineal care and transfer to the wheelchair. While staff turned off the call light, the resident stood up independently. Staff assisted with perineal care, and the resident turned to sit in the wheelchair. During the transfer, the resident did not sit fully back in the wheelchair and began leaning to the left side. Staff attempted to reposition the resident by holding his pants and pulling the wheelchair back. During this process, the resident slipped and landed on his left hip on the floor in front of the wheelchair. Resident stated he was getting in the wheelchair and did not get all in. He was trying to get back in the chair but didn't get all in. The staff was trying to hold him in the chair, and he went on the floor. IDT Reviewed: dycem immediate intervention, Grip strips in bathroom; anti-rollbacks; sent resident to ED for further evaluation d/t being on Eliquis; Grip strips by closet; DO not leave the resident unattended in the Bathroom; Dycem to wheelchair to help prevent resident from slipping out of the wheelchair; Grab bars in bathroom to reach with non-affected L side in event he self- transfers to the bathroom; Grip strips to the floor in front of recliner; Neon tape to call light; Top of the hour checks for safety; Urinal to be next to resident recliner at all times. 7/11/25 at 1:15 p.m., Fall from chair or wheelchair, found on the floor in front of his recliner, lying on his left side. Wheelchair was nearby with brakes not engaged, activated his call light, stated he was getting in his recliner. IDT Reviewed: 30 minute checks Grip strips in bathroom; anti-rollbacks; sent resident to ED for further evaluation d/t being on Eliquis; Grip strips by closet; DO not leave the resident unattended in the Bathroom; Dycem to wheelchair to help prevent	F0689		

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F0689 SS = D	Continued from page 29 resident from slipping out of the wheelchair; Grab bars in bathroom to reach with non-affected L side in event he self- transfers to the bathroom; Grip strips to the floor in front of recliner; Neon tape to call light; Top of the hour checks for safety; Urinal to be next to resident recliner at all times 7/11/25 at 9:30 p.m., found on floor on his stomach in front of his recliner, previously had 2 falls that day. IDT Reviewed: Wait for assistance signs. On 8/11/25 at 6:09 p.m., R53 was observed in his room, seated in a wheelchair positioned next to an electric recliner. The recliner was plugged into the wall, and the remote was affixed to a cord and located on the left hand side of the seat of the recliner. R53 stated he used the recliner daily and was unable to articulate if he transfers to the recliner independently or with staff assistance. On 8/13/2025 at 4:05 p.m., licensed practical nurse (LPN)-A, stated R53 was a fall risk and stated used his electric recliner to recline in the chair and uses an EZ stand with staff assist for transfers, and stated more recently his falls have decreased. On 8/13/2025 at 4:08 p.m., R53 was sleeping in electric recliner chair in his room and legs elevated on chair and chair reclined to flat position, remote for recliner positioned in seat of chair next to residents left leg and call light with pink neon tape also in seat of recliner, wheelchair located next to the recliner with dycem on the wheelchair seat, urinal on the floor next to the recliner, bedside table located to the left of recliner, Kardex on the back of the resident's door was dated 7/14/25, outlined that 30-minute checks were to be completed, dycem was to be used in the wheelchair to prevent slipping, grip strips were to be placed in front of the recliner, the resident should not be left unattended in the bathroom, and that staff were to maintain his routine evening shower, required assist of one with gait belt and hemi walker for ambulation. However, at the time of observation, there were no grip strips in front of the recliner and no signage posted to instruct the resident to wait for assistance. On 8/13/2025 at 4:16 p.m., nursing assistant (NA)-A, stated that R53 uses his call light for assistance and knows how to operate the remote control to raise and lower the recliner. On 8/13/2025 at 4:19 p.m., NA-B stated R53 knows how to use the remote to recline and stand.	F0689		

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F0689 SS = D	Continued from page 30 On 8/13/2025 at 5:19 p.m., R53 remained in the recliner sleeping, still with no grip strips in front of the chair, no signage posted, urinal still on the floor next to recliner, call light and bed remote were within reach on seat of recliner, and the wheelchair with dycem remained next to the recliner. On 8/13/2025 at 5:25 p.m., director of nursing (DON) stated that Occupational Therapy (OT) was asked to assess R53's electric recliner today (8/13/25), due to the prior assessment in March that indicated the R53 was not safe use electric recliner, and a nursing assessment was not found for the electric recliner. The DON confirmed that she would have expected the IDT and therapy teams to evaluate the recliner before it was used. The DON acknowledged that no grip strips or safety signage were in place, and that R53 has a history of removing posted signs. The DON stated she was unaware that the signs were missing and confirmed that no new intervention had been implemented to address the removal of signage. The DON acknowledged that there was no nursing assessment documented regarding the recliner's safety prior to its use and stated R53 was a fall risk however had no falls from the electric recliner. On 8/14/25 at 7:49 a.m., LPN-B stated that R53 was a fall risk on 30-minute checks, attempts to self-transfer, and that his wheelchair and walker are to be kept out of reach and stated R53 was able to use the remote for the electric recliner with no concerns. On 8/14/25 at 7:51 a.m., R53's door was observed partially closed and the room dark. R53 was in flat lying in electric recliner, urinal on the floor next to the recliner, wheelchair on the right side, and the call light and chair remote in the chair seat touching R53's left leg. Grip strips were observed only in front of the closet and in the bathroom, not in front of the recliner and not signs were posted to wait for assistance. On 8/14/25 at 7:57 a.m., NA-C stated that R53 should not be considered a fall risk anymore since he now used the EZ stand with staff assist and no longer self-transfers. NA-C stated she had not documented the 30-minute safety checks since arriving at 6:00 a.m., and the last recorded check was at 4:30 a.m., however she had checked on R53 every 30 minutes since arriving at the facility at 6:00 a.m. NA-C was observed to find the paper document and stated the document was used to write the time R53 was last checked.	F0689		

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F0689 SS = D	Continued from page 31 On 8/14/25 at 7:59 a.m., NA-D stated R53 had 30 minute checks and he had not completed any room checks on R53 yet today. On 8/14/25 at 8:05 a.m., during an interview with LPN-C, known as the north wing care coordinator and registered nurse (RN)-A, known as the regional nurse consultant. LPN-C stated that R53 was a fall risk due to his diagnoses, hemiparesis, and behavioral demeanor, describing him as very stubborn and prone to not adhering to safety precautions that have been implemented. LPN-C explained that R53 was originally admitted to the facility into a room on the locked unit and was unsure whether the electric recliner currently in R53's room had been brought in by the family at the time of admission. LPN-C stated R53 was moved out of the locked unit after one week due to issues with being confined and, because he was not an elopement risk, was placed in room 502B briefly before being moved to his current private room. LPN-C stated she was not aware that R53 had an electric recliner prior yesterday (8/13/25) and acknowledged that she should have been aware. Both LPN-C and RN-A described the facility's fall management procedures, which include completing a root cause analysis (RCA) after each fall and implementing new interventions after each fall. LPN-C stated R53's falls had not been directly attributed to the electric recliner. LPN-C confirmed that grip strips were expected to be in place in front of R53's recliner and recalled that they had been there at one time but did not know why they were no longer present. LPN-C further stated that R53 was known to remove wait for assistance signs from his wall and acknowledged that she was not aware the signs were currently missing. LPN-C confirmed that no alternative intervention had been implemented to address the resident's known behavior of removing the signs. RN-A and LPN-C confirmed that the facility's process for electric lift chairs requires a nursing assessment prior to use and confirmed that no nursing assessment for R53's recliner could be found prior to 8/13/25. LPN-C reported that she completed an assessment with R53 on yesterday, 8/13/25 and had no concerns, stating that R53 was able to operate and manipulate the recliner remote at that time. RN-A stated that OT was also asked to complete an assessment 8/13/25, ensure that OT documentation aligned with the nursing assessment. LPN-C stated that 30 minute checks were expected for R53 and were to be documented on paper when completed. LPN-C that during a review of R53's room, neither grip strips nor wait for assistance signage were posted and was an expected intervention. On 8/14/25 at 9:33 a.m., during an telephone call	F0689		

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F0689 SS = D	Continued from page 32 occupational therapist (OT)-AT had worked with R53 previously and assessed R53 on 8/13/25, following a referral from the facility. OT-A stated an assessment on 3/4/25, by a different OT staff, had found R53 unsafe with the recliner due to decreased problem-solving skills. OT-A stated on 8/13/25, she observed that R53 was unable to find or use the remote independently and concluded R53 would require staff assistance to use the lift chair safely, particularly to locate and operate the remote control but was not a fall risk from the chair due to the inability to use the chair without assistance. At 10:15 a.m., R53 continued to sleep in the recliner and LPN-C was observed to ask R53 to operate the chair and R53 refused and stated staff should do it for him, and while he eventually grabbed the remote, he did not use it. LPN-C stated yesterday when she completed the assessment, R53 could identify the correct buttons and operate the device appropriately. LPN-C stated R53 cooperation varied and would require regular assessments that were expected quarterly and as needed, chair quarterly, or if fall pertains to the fall. On 8/14/25 at11:08 a.m., RN-A stated that although there is no policy specific to recliner assessments, nursing assessments are expected at admission, quarterly, annually, with significant changes, and as needed. Facility Fall Prevention and Management policy dated 2/24, indicated: Facility staff will identify interventions related to the resident’s specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident’s response to interventions intended to reduce falling or the risks of falling.	F0689		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the	09/24/2025

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F0880 SS = D	Continued from page 33 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with	F0880	Continued from page 33 regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R17 & R41 currently reside in the facility. No negative outcome occurred to these residents. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents requiring assistance with eating have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Education will be completed with nursing department staff and paid feeding assistants to follow proper hand hygiene. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Director of Nursing or designee will audit hand hygiene when assisting a resident with eating 3x/week x 2 months. Audits will be reported to the QA committee for further review and recommendations.	

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F0880 SS = D	Continued from page 34 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was performed when feeding 2 of 2 residents (R17 and R41) observed for dining. Findings include: R17's face sheet received on 8/14/25, included diagnoses of Parkinson's disease (a movement disorder of the nervous system) and dementia. R17's quarterly Minimum Data Set (MDS) assessment dated 6/27/25, indicated severe cognitive impairment, clear speech, could understand and be understood. R17 required substantial/maximal assistance with eating. R17's diet order dated 8/12/25, indicated regular diet, pureed texture and thin liquids. R17's care plan dated 11/11/24, indicated assistance with consumption of meals by nursing staff. R41's face sheet provided on 8/14/25, included diagnosis of dementia. R41's quarterly MDS assessment dated 6/4/25, indicated intact cognition, clear speech, could understand and be understood. R41 was dependent upon staff for eating.	F0880		

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F0880 SS = D	Continued from page 35 R41's diet order dated 1/3/25, indicated consistent carbohydrate diet, pureed texture. R41's care plan dated 5/7/20, indicated total assist with eating and drinking. During an observation on 8/13/25 at 9:30 a.m., observed nursing assistant (NA)-C in great room dining area sitting between R17 and R41 feeding them. NA-C used one hand to feed R17 and her other hand to feed R41. No hand sanitizer was on the table. At no time during the observation did NA-C clean her hands. At 9:39 a.m., NA-C wiped R17's mouth with a towel with her right hand then immediately resumed feeding R41 with her right hand. During an interview on 8/13/25 at 10:13 a.m., with the director of nursing (DON) and registered nurse (RN)-E who was also the assistant DON and infection preventionist in training, the DON stated staff were expected to feed one resident at a time and to perform hand hygiene prior to feeding. Further, the DON stated when feeding multiple residents consecutively, staff should perform hand hygiene between each resident. Additionally, the DON stated she expected staff to use hand sanitizer after wiping a resident's mouth and before handling utensils or feeding another resident to prevent cross-contamination. During an interview on 8/13/25 at 11:126 a.m., NA-C stated to prevent cross-contamination when feeding more than one resident at a time, she used one hand for one resident and the other hand for the other resident. NA-C admitted wiping R17's mouth with a towel, then resumed feeding R41 with the same hand, stating, "I did do that." NA-C admitted at no time while feeding both R17 and R41 did she clean her hands. Policy on hand hygiene was requested and not received.	F0880		
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure a clean and comfortable environment in the	F0921	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R47's room was deep cleaned and dirty clothes were removed.	09/24/2025

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F0921 SS = E	Continued from page 36 secured unit where urine odors permeated the area. This deficient practice had the potential to affect all 18 residents, staff, and visitors on the secure unit. Findings include: R47's quarterly minimum data set (MDS) dated 6/18/25, included R47 understands but has severe cognitive impairment. R47 requires supervisor and is independent with dressing and personal hygiene. For bathing documentation included refuses. Behaviors indicated no refusals of care. On observation 8/11/25 at 1:05 p.m., the secured unit had an odor of urine present upon entering through the locked doors. On interview 8/11/25 at 2:49 p.m., family member (FM)-C stated there is an odor of urine in the entire secured unit every time she comes to visit her family member. On interview 8/11/25 at 3:31 p.m., FM-A stated there is an awful urine smell in the secured unit. FM-A stated “it is so strong it about knocks you over” when you enter the area. On observation and interview 8/11/25 at 4:13 p.m., R47 was in his room. Odor of urine present in the room. R47 was sitting in his wheelchair with television on and refused to talk to surveyor. R47’s hair was greasy but combed. Clothes were in good condition without stains noted on them. Room appeared clean without visible debris on floors. On observation 8/12/25 at 9:10 a.m., the secured unit continued to have an odor or urine present once entering through the locked doors. On interview 8/12/25 at 10:47 a.m., housekeeper (H)-A stated she informed her supervisor today there is an odor in the secured unit. H-A stated R47 doesn’t allow housekeeping to clean his room but does allow us to empty his garbage. H-A stated she doesn't generally work in this area but has not reattempted to clean R47's room since he refused this morning. On observation and interview 8/12/25 at 10:53 a.m., H-C was asked to enter the secured unit and stated she could also smell urine odor upon entering. H-C continued down the hallway stating it got stronger until got to R47’s room where it was the strongest. H-C entered R47’s room (R47 was in dining room at the time) and observed the bathroom. H-C stated the back of toilet had old urine and stool present and she would	F0921	Continued from page 36 How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents on the wing have the potential to be impacted. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nursing staff and housekeeping will be educated to check for dirty clothes under R47’s bed and in his closet. Monitoring added to the TAR every shift to check room for soiled clothing. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will audit R47’s room for cleanliness 1x/week x 2 months. Audits will be reported to the QA committee for further review and recommendations.	

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Hillcrest Care & Rehabilitation Center	714 SOUTHBEND AVENUE , MANKATO, Minnesota, 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0921 SS = E	Continued from page 37 get a toothbrush and scrub it. H-C stated R47 does frequently refuse housekeeping in his room, and they have implemented twice a day attempts at a minimum. H-C stated removing bedding, towels and clothes is nursing responsibility. On observation and interview 8/12/25 at 11:07 a.m., H-B, also identified as housekeeping supervisor, stated she was notified this morning that there was an odor from R47's room. H-B stated she is aware he doesn't always let staff in to clean. H-B stated they do what they can to eliminate odors, and all staff have odor eliminators on their carts. On interview 8/12/25 at 11:10, H-C stated she sanitized and cleaned R47's back of the toilet with a toothbrush and stated the odor has lessened. On observation 8/13/25 at 7:04 a.m., upon entering the secured unit, an odor of urine was present. On interview 8/13/25 at 7:50 a.m., licensed practical nurse (LPN)-D, manager of secured unit, stated she does not smell an odor in the area. LPN-D confirmed she does get complaints from residents and families and stated we clean and clean, but the odor doesn't seem to change. LPN-D stated R47 doesn't allow housekeeping into his room. LPN-D stated R47 rarely showers and when asked by staff to shower, he gets angry which isn't safe for staff. LPN-D stated she does think housekeeping could do more to prevent the odors in the area. On interview 8/13/25 at 8:09 a.m., nursing assistant (NA)-H stated she does notice the odor of urine in the secured unit. NA-H stated he does let the aides in his room but rarely lets them assist him with personal hygiene or showers. NA-H stated the other day she was in there and his closet was full of dirty clothes and old washcloths hidden in his closet. NA-H stated she forgot to go back and get them out that day and wonders if they are still in his room. On observation and interview 8/13/25 at 8:16 a.m., H-B stated she does not smell an odor today in the secured unit. H-B stated she has instructed the housekeeping staff to try multiple times throughout the day if R47 refuses to let them clean his room. On observation and interview 8/13/25 at 9:24 a.m., NA-G was exiting R47's room with a bag full of dirty clothes, wash clothes and towels. NA-G stated when R47 went to the dining room, she went into his room and found it all stuffed under his bed. NA-G stated she	F0921		

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F0921 SS = E	Continued from page 38 does notice a smell in the secured unit from time to time and stated sometimes it is worse than other times. On interview 8/13/25 at 10:43 a.m., NA-F stated she does notice a smell of urine in the secured unit from time to time. NA-F stated it seems like it comes and goes but currently doesn't smell anything. On interview 8/14/25 at 8:22 a.m., the director of nursing (DON) stated she has noticed at times an odor in the secured unit. The DON stated R47 does frequently refuse cleaning of his room and offers of personal hygiene. The DON stated R47 is seeing psychiatry due to behaviors and refusals of care. A policy on cleaning of residents rooms was requested but none received.	F0921		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/12/2025 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Hillcrest Care and Rehabilitation Center 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		09/24/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	Continued from page 1 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. Hillcrest Care & Rehab Center is a one-story with partial basement facility that was constructed in 1957, with one building addition constructed in 1963. Both buildings were determined to be of Type II(000) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered with a fire pump. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Resident rooms are also outfitted with battery operated smoke alarms, these are not connected to the building fire alarm system. The facility has a capacity of 80 beds and had a census of 64 at the time of the survey.	K0000		

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K0000	Continued from page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections	K0321	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished: -The maintenance director added a self-closing device was added to the door for room 518. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Education completed with maintenance that rooms being used to store combustible items need a self-closing device on the door. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -A one-time audit was completed to ensure the door closes and latches. Audits will be reported to the QA committee for further review and recommendations.	09/24/2025

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K0321 SS = D	Continued from page 3 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/12/2025 at 10:38 AM, it was revealed by observation that room 518 was being used to store combustible items and did not have a self-closing device on the door. An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K0321		
K0363 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 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	K0363	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished: -Maintenance director filled the hole in the door for room 510 with a through bolt. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Education completed with maintenance that any holes found in doors need to be filled. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -510 door was examined to ensure the hole was filled. Audits will be reported to the QA committee for further review and recommendations.	09/24/2025

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K0363 SS = D	Continued from page 4 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD 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 19.3.6.3.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/12/2025 at 10:37 AM, it was revealed by observation that the door labeled 510 had a hole in it allowing the passage of smoke. An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K0363		
K0712 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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7 and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/12/25 at 10:00 AM, it was revealed by a review of available documentation that fire drills had not been conducted in the months of September and November of 2024.	K0712	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished: -September and November 2024 have passed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Education was completed with maintenance that fire drills need to be completed and documented monthly. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator will audit monthly to ensure a fire drill is completed 1x/month x 6 months. Audits will be reported to the QA committee for further review and recommendations.	09/24/2025

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K0712 SS = F	Continued from page 5 An interview with the Maintenance Director and Regional Maintenance Director verified this deficient finding at the time of discovery.	K0712		
K0920 SS = F Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include:On 08/12/2025 at 10:45 AM, it was revealed by observation that a nebulizer was plugged into a power strip in room 505.On 08/12/2025 at 10:49 AM, it was revealed by observation that a nebulizer was plugged into a power strip in room 504.On 08/12/2025 at 11:06 AM, it was revealed by observation that a nebulizer was plugged into a power strip in room 406An interview with the Maintenance Director and Regional Maintenance Director verified these deficient findings at the time of discovery.	K0920	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished: -Medical equipment was moved to a proper outlet in the affected rooms; 406, 504 and 505. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Staff were educated that medical equipment cannot be plugged into power strips. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will audit 8 random rooms/week x 2 months for appropriate use of power strips. Audits will be reported to the QA committee for further review and recommendations.	09/24/2025

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K0920 SS = F Bldg. 01		K0920		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 5, 2026

Administrator
Hillcrest Care & Rehabilitation Center
714 SOUTHBEND AVENUE
MANKATO, MN 56001

RE: CCN: 245507
Cycle Start Date: August 14, 2025

Dear Administrator:

On September 29, 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