DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SXFD Facility ID: 00031

		10 22 00	CETED DI		I BOOK BINGENOI		1 uemity 115: 00051	
1. MEDICARE/MEDICAID PROVIDIO (L1) 245507 2.STATE VENDOR OR MEDICAID N (L2) 596340100		3. NAME AND AI (L3) HILLCRES' (L4) 714 SOUTH (L5) MANKATO	T HEALTH C BEND AVEN	ARE CEN	TER (L6) 56001	4. TYPE OF AC 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 01/1 8. ACCREDITATION STATUS:	5/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray	GORY 09 ESRD 10 NF 11 ICF/III	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC	FISCAL YEAR E	After Complaint	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia			And/Or Approved Waivers Of			
To (b):			equirements be Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope o 7. Medica	of Services Limit	
12. Total Facility Beds	85 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI 5. Life Safety Code		Room Size	
13.Total Certified Beds	85 (L17)		npliance with Properties and/or Appli		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF 85	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Kathryn Serie, Unit Supe	rvisor	1	/15/2015	(L19)	Kamala Fiske-Downing	, Enforcement S	Specialist 01/20/2015 (L20)	
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	Y	
19. DETERMINATION OF ELIGIBIL _X1. Facility is Eligible to F 2. Facility is not Eligible	articipate		MPLIANCE WITH	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	l:	(L30)	
OF PARTICIPATION 01/01/1988	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		DLUNTARY il to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fa	il to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	ОТП		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Pro	ovider Status Change	
(L27)	B. Rescind S	uspension Date:	(L44)			00-AC	Suve	
20 TERMINATION DATE.	20) INTERMEDIARY	(L45)		30. REMARKS			
28. TERMINATION DATE:	25	9. INTERMEDIARY/	CARRIER NO.		30. KEWARKS			
	(L28)	03001		(L31)	Posted 01/29/2015 (Co.		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE				
	(L32)	01/14/2015		(L33)	DETERMINATION APP	ROVAL		
				. ,				



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245507

January 20, 2015

Ms. Amy Porter, Administrator Hillcrest Health Care Center 714 Southbend Avenue Mankato, Minnesota 56001

Dear Ms. Porter:

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

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

Effective December 30, 2014 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Hillcrest Health Care Center January 20, 2015 Page 2

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Kamala Fishe Downing

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

January 16, 2015

Ms. Amy Porter, Administrator Hillcrest Health Care Center 714 Southbend Avenue Mankato, Minnesota 56001

RE: Project Number S5507024

Dear Ms. Porter:

On December 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective December 30, 2014 and therefore remedies outlined in our letter to you dated December 16, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245507	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/15/2015
Name	e of Facility		Street Address, City, State, Zip Code	
HI	LLCREST HEALTH CARE CENTER		714 SOUTHBEND AVENUE MANKATO, MN 56001	

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

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 12/30/2014	ID Prefix	F0280	Correction Completed 12/30/2014		ID Prefix	F0282	Correction Completed 12/30/2014
Reg. # LSC	483.20(d), 483.20(k)(1	<u>) </u>	Reg. # LSC	483.20(d)(3), 483.10(k)(2)			483.20(k)(3)(ii)	
ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Correction Completed 12/30/2014	ID Prefix Reg. # LSC	F0318 483.25(e)(2)	Correction Completed 12/30/2014				
ID Prefix Reg. #		Correction Completed	ID Prefix		Correction Completed		ID Prefix Reg. #		Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ъ "		
Reg. #			Reg. #						
Reviewed E State Agen		ed By S/KFD	Date: 1/15	/2015 Signature of Su		048		Date	e: 01/15/2015
Reviewed E	By Reviewe	ed By	Date:	Signature of Su	rveyor:			Date	e:
Followup t	o Survey Completed	on:		Check for any Unco Uncorrected Defic					S NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID.	SAID	
Faci	lity ID: 00031	

MEDICARE/MEDICAID PROVID (L1) 245507 2.STATE VENDOR OR MEDICAID (L2) 596340100 5. EFFECTIVE DATE CHANGE OF	3. NAME AND ADDRESS OF FACILITY (L3) HILLCREST HEALTH CARE CENT (L4) 714 SOUTHBEND AVENUE (L5) MANKATO, MN 7. PROVIDER/SUPPLIER CATEGORY		(L6) 56001 <u>02</u> (L7)	3. Termination 5. Validation 7. On-Site Visit	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other			
(L9) 6. DATE OF SURVEY 12/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2014 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/III 12 RHC	13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	8. Full Survey After Con FISCAL YEAR ENDING I 12/31		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	85 (L18) 85 (L17)	Complianc1. Ac	nce With equirements e Based On: cceptable POC	gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code	7. Medical Directo	es Limit r	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 85		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38) 16. STATE SURVEY AGENCY REL	(L39) MARKS (IF APPLIC	(L42) ABLE SHOW LTC C	(L43) ANCELLATION	I DATE):				
17. SURVEYOR SIGNATURE Date: Wendy Buckholz, HFE NE II PART II - TO BE COMPLETED BY HCFA REGION				(L19)	(220)			
19. DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCl e:	FA-1513)	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1988 (L24) 25. LTC EXTENSION DATE:			ENDING DA' (L25)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	INVOLUNTAL 05-Fail to Meet ement 06-Fail to Meet	RY Health/Safety Agreement	
(L27)	B. Rescind So	uspension Date:	(L44) (L45)			00-Active		
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2569

December 16, 2014

Ms. Amy Porter, Administrator Hillcrest Health Care Center 714 Southbend Avenue Mankato, Minnesota 56001

RE: Project Number S5507024

Dear Ms. Porter:

On December 4, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fishe Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 12/16/2014 FORM APPROVED OMB NO. 0938-0391

F DEFICIENCIES CORRECTION	INCIDENTIAL INTERPORT		FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	245507	B. WING		12	04/2014	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O			
THEALTH CARE C	ENTER		714 SOUTHBEND AVENUE MANKATO, MN 56001			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
NITIAL COMMEN	тѕ	F0	00			
s your allegation of epartment's acce ottom of the first p	of compliance upon the ptance. Your signature at the page of the CMS-2567 form will		el	adm.	fore	
evisit of your facili- alidate that substa- egulations has be- our verification. 83.20(d), 483.20(COMPREHENSIVI). facility must use o develop, review omprehensive pla the facility must de- lan for each resid bjectives and time nedical, nursing, a eeds that are ider ssessment.	ty may be conducted to antial compliance with the en attained in accordance with k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's and revise the resident's and force. Evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive	12/31/ F2	flutter and heart failure. The been utilizing Coumadin at since admission. It is import that the physician orders for have been implemented accordise monitoring with the aplaboratory testing since admiresident does not experience care or monitoring. A system that is in place is that the resplans now address monitoring effects such as signs and synbleeding. The facility will caudit for every resident recercoumadin to ensure that the	e resident had varying doses tant to note Coumadin urately with oppopriate ission. The any lack of mic change idents' care of for side inptoms of omplete an aiving care plans	prosektion literation	
ighest practicable sychosocial well-table sychosocial well-table 483.25; and any serequired under under to the resident 483.10, including ander §483.10(b)(4	physical, mental, and peing as required under services that would otherwise §483.25 but are not provided sexercise of rights under the right to refuse treatment		procedure was reviewed with staff on December 10, 2014. Additionally, in January and 2015, the nurse managers with audit of all new residents addiagnosed need for Coumand the Coumadin protocol is in	h licensed February, ill conduct an mitted with a in to ensure place. The Nurse	12/30/11	
	SUMMARY STY (EACH DEFICIENCY REQUILATORY OF IT (ITIAL COMMENT The facility's plan of a pour allegation of epartment's acception of the first period as verification. By our allegation of a pour receipt of an exisit of your facility alidate that substated as verification. By 20(d), 483.20(d),	AUTIAL COMMENTS The facility's plan of correction (POC) will serve epartment's acceptance. Your signature at the ottom of the first page of the CMS-2567 form will e used as verification of compliance with the equilations has been attained in accordance with cour verification. B3.20(d), 483.20(k)(1) DEVELOP OMPREHENSIVE CARE PLANS facility must use the results of the assessment of care. the facility must develop a comprehensive care lan for each resident that includes measurable beds that are identified in the comprehensive and mental and psychosocial eeds that are identified in the comprehensive care leads that are identified in the comprehensive eds that are identified in the comprehensive	A BUILDI 245507 A BUILDI 245507 A BUILDI 245507 A BUILDI A BUILDI 245507 A BUILDI B WING A BUILDI A BUILDI B WING A BUILDI A BUILDI B WING B WING B WING A BUILDI B WING B WINC B WING B WINC B WING B WINC B WING B WINC B WINC B WING B WINC B WINC B WING B WINC B	A BUILDING 245507 245507 245507 245007 246507 2474 SOUTHERNO ATENUE ANKATO, MN 55001 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SITIAL COMMENTS The facility's plan of correction (POC) will serve be your allegation of compliance upon the epartment's acceptance. Your signature at the cutom of the first page of the CMS-2567 form will be used as verification of compliance with the guilations has been attained in accordance with aur verification. 32.20(d), 483.20(k)(1) DEVELOP OMPREHENSIVE CARE PLANS facility must use the results of the assessment of develop, review and revise the resident's proprietensive plan of care. The facility must develop a comprehensive care lan for each resident that includes measurable objectives and timetables to meet a resident's needical, nursing, and mental and psychosocial each that are identified in the comprehensive seessment. The care plan must describe the services that are be furnished to attain or maintain the resident's ghest practicable physical, mental, and sychosocial well-being as required under 483.25; and any services that would otherwise e required under \$483.25 and any services that would otherwise e required under \$483.25 and any services that would otherwise e required under \$483.25 but are not provided us to the resident's exercise of rights under \$483.10, including the right to refuse treatment noder \$483.10, including the right to refuse treatment and including the right to refuse treatment and including the right to refuse treatment and including the right to refuse treatment including the right to refuse treatment including the right to refuse treatment includes the services of rights under \$483.10 (b)(4).	DENTIFICATION NUMBER: 245507 B. WING STREET ADDRESS, CITY, STATE, ZIP GODE 714 SOUTHBEND AVENUE MANKATO, MM \$6001 [REALTH CARE CENTER SUMMARY STATEMENT OF DEPICIENCIES [READ HERICIBNOY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ITTIAL COMMENTS The facility's plan of correction (POC) will serve a your allegation of compliance upon the partment's acceptance. Your signature at the ottom of the first page of the CMS-Z567 form will a used as verification of compliance with the guilations has been attained in accordance with aur verification. Bay.20(d), 483.20(k)(1) DEVELOP OMPREHENSIVE CARE PLANS OMPREHENSIVE CARE PLANS OMPREHENSIVE OARE PLANS The facility must use the results of the assessment develop, review and revise the resident's omprehensive plan of care. The facility must develop a comprehensive care fan for each resident that includes measurable bjectives and timetables to meet a resident's energiant of care. The care plan must describe the services that are obe furnished to attain or maintain the resident's gheet practicable physical, mental, and sychosocial well-being as required under 483.25; and any services that would otherwise to the resident's exercise of rights under 483.10(b)(4). Assuming the provided to the provided one to the resident's exercise of rights under 483.10(b)(4). The Director of Nursing and the Nurse The providence of the provided one to the resident's exercise of rights under 483.10(b)(4).	

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID; SXFD11

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5073876611

PRINTED: 12/16/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED		
		245507	B, WING			12/	04/2014
	PROVIDER OR SUPPLIER	ENTER		714	HEET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHBEND AVENUE ANKATO, MN 56001	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	facility falled to device Coumadin (a blood potential increased (R101) reviewed for Findings include: R101's diagnoses in abnormal heart rhy admission record factories and order to give Couthe evening on 12/2 recheck PT/INR (Phormalized Ratiothe effectiveness of Further review of the R101 had been utill doses since admissions of bleed When interviewed a registered nurse (R101's care plan la address the use of monitoring for side symptoms of bleed When interviewed a registered nurse (R101's care plan la address the use of monitoring for side symptoms of bleed When interviewed a registered nurse (R101's care plan la address the use of monitoring for side symptoms of bleed When interviewed a registered nurse (R101's care plan la addressed have been. When interviewed a director of nursing Coumadin use and	and document review the elop a care plan for use of thinner with side effect of bleeding) for 1 of 5 residents r unnecessary medications. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet. Included atrial flutter (an thm) and heart fallure per the ace sheet.	F2	279			

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DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	; 12/16/2014 APPROVED , 0938-0391
STATEMEN	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
•		245507	B. WING_		12/	04/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 (2/	U4/2014
HILLCRI	ST HEALTH CARE C			714 SOUTHBEND AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XI) COMPLETION DATE
F 280 F 280 SS _P D	483.20(d)(3), 483.11 PARTICIPATE PLAI The resident has the incompetent or other incapacitated under participate in planning changes in care and A comprehensive as within 7 days after the comprehensive assinterdisciplinary team physician, a register for the resident, and disciplines as determined, to the extent put the resident, the resident, the resident, the resident incomprehensive as determined.	O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 28	1	mpletion it. All re lated as rvices will new s an ere continue is on significant ider's tted on ognitive ervices	
	by: Based on Interview facility failed to revise resident (R10) revise intact cognition yet thad a moderate cognition interview on was able to appropried without difficulty and	and document review the set he care plan for 1 of 1 ewed who was assessed with the care plan indicated she unitive deficit. 12/1/14, at 4:46 p.m. R10 elately answer questions di was able to recall history and di There was no evidence				

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Manestoa Department of Health Marshall

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			IPLE CONBTRUCTION		(X3) DATE SURVEY		
<u> </u>		245507	B. WING _		<u>.</u>	12/04/2	014
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, C. 714 SOUTHBEND AV MANKATO, MN 56	/ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENGED TO THE APPROPI DEFICIENCY)	BE CO	(X5) APLETION DATE
F 280	the ability to recall identify her present identify her present During review of R annual comprehen 4/2/14, the quarterly and the quarterly a Brief Interview for I assessment identificating her cognintact. However, thidentified R10 with process related to moderate intellectus core on the BIMS moderate memory term memory impaired decision in During interview or services (SS)-A statiff were responsitative section of the assessment. SS-I having intact cognim MDS's but stated aways accurate or the consistent was accurate or the inconsistent she felt the MDS we cognition.	wwhich indicated R10 lacked recent events or the ability to a condition. 10's Minimum Data Set (MDS) sive assessment, dated by assessment, dated 7/3/14 ssessment dated 10/2/14, the Mental Status (BIMS) ied that R10 scored 15/15, altive status was completely ne care plan dated 4/10/14, an alteration in thought adult failure to thrive and used difficulties manifested by the assessment, which indicated impairment, long and short airment and moderately making. 12/03/14, at 2:19 p.m. social aff indicated that social service in MDS comprehensive a verified R10 was identified as the was not sure whether R10 ate with responses. SS-A excent quarterly MDS dated R10 with a BIMs score of 15/15 mood/behavior indicators, whether the MDS assessment e care plan was accurate, due documentation, SS-A stated was not a good tool to assess		30			
FORM CMS-2	R10's progress no		11	Facility 10: 00031	If continue	itlon sheet Pag	ga 4 of 18

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245507	B. WING			12/04/2	014
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP 714 SOUTHBEND AVENUE MANKATO, MN 56001	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E E APPROPRI		(X5) MPLETION DATE
F 280	(depression assess 15/15 on the BIMS is intact. Resident swhich indicates no Resident plans for no referral needed. (2.) 7/10/14, at 12: conference: Reside Resident is alert, o communicate need activitles and is inv Resident most rece (depression score) become confused large amounts of n forgets she has a transport (3.) 10/9/14, at 4:0 The resident attended spirits during concerns about he did not share any of the BIMS and PHI reviewed. The resident at the psychosocial concouring interview writes to be Comfort Carolike to remain at the psychosocial concouring interview writes was unable to between the MDS related to R10's colit was possible for during the assess same cognition at No further assessifurther cognitive as was requested from	p.m. BIMS and PHQ-9 sment): Resident scored a which indicates her cognition scored a 0/27 on the PHQ-9 symptoms of depression. a long term stay at this facility, 53 p.m. quarterly care ent attended care conference, riented, and able to is. Resident enjoys attending olved in life at this facility. Ent BIMs and PHQ-9 reviewed. Resident can about her finances, will request noney to keep in her room, rust account. If p.m. care conference note: ded the meeting and was in the visit. [R10] expressed no rroom when asked and she concerns about her roommate. Q-9 assessment scores were dent would like her code status es (DNR/DNI) and [R10] would is facility long term. No other erns reported at this time. If the director of nursing at approximately 10:30 a.m. explained the discrepancy assessment and the care plan ognitive status. The DON stated R10 to have intact cognition ment period but not have the	F		M continues	In oheat Pa	70 S of 18

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION	COMPLETED
	245507	B. WING _		12/04/2014
NAME OF PROVIDER OR SUPPLIES HILLCREST HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001	
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
as part of the MD Documentation wassessment that cognitive deficit a 483.20(k)(3)(ii) SI PERSONS/PER of The services proving the provided accordance with care. This REQUIREM by: Based on observe review the facility skin audits as ide for 1 of 3 resident dependent upon Findings include: R10's diagnoses Minimum Data Sidentified R10 at secondary to ove severe malnutritiand failure to thris R10's skin be moved when the moves with the R10's skin be moved with the R10's skin be moved with the R10's skin be moved weekly skin audit bath. The care pated 10/9/14, indeed 10/9/	ment which had been conducted S comprehensive assessment. as lacking to support the deemed R10 to have moderate is identified in the care plan. ERVICES BY QUALIFIED CARE PLAN wided or arranged by the facility by qualified persons in each resident's written plan of eather interview and document failed to provide grooming and intified in the written plan of care its (R10) reviewed who were staff for personal cares.		F 282 D Hillcrest does have a system in	dits as f care. On and by the nurse. rse was re- 0/14 this icensed tablished of r audit outcome. r the charge the skin eet and d. They will sistant any have noticed stants are to the ras created intor this e certain f nursing onitor on not to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245507	8. WING		12/	04/2014
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL 9C IDENTIFYING INFORMATION)	(Ď PREFÍ) TAG	PHOVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	as directed. During observation was observed in the assisted by staff to wheelchair. R10's 4 hand were observe toward the inside of interviewed and quimove the fingers of the first three fingers of the first three fingers grasped the 4th and her left hand extend by pulling them with extending the 4th a area, two indentation palm of R10's right had been pressing. Two days later, on registered nurse (Phand was observed dayroom. During the hand was observed dayroom. During the hand was observed dayroom. During the hand salso evide where R10's long fingernail on the finger) was approxilong and appeared RN-A was question trim R10's fingernail responsibility of star RN-A then checked R10 had received a (12/2/14). RN-A a	ge 6 e care plan was not followed on 12/1/14, at 6:00 p.m. R10 e dining room prior to being the day room in her th and 5th fingers on her right d to be curled and bent inward if the palm. At 6:02 p.m., when estioned about her ability to her right hand, R10 extended rs of her right hand and then d 5th fingers with the use of ding the fingers partially open her left hand. After nd 5th fingers from the palm on marks were observed in the hand where the two fingers (digging into the skin. 12/3/14, at 2:01 p.m. IN)-A was present when R10's is R10 was seated in the ne observation R10 was noted tely a 1 (one) centimeter (cm) right palm area where the 4th if pressed into the skin. A red nt in the palm of the hand ngernail pressed into the skin. The 5th finger ("pinky" or little mately 2 centimeters (cm) long and untrimmed. After led who was responsible to ils, she stated it was the lift assigned to bath duties. If the bath schedule and stated a bath the prior evening les stated there were no skin ble for review which identified	, .	82		

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245507	B, WING	B, WING			12/04/2014	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDAESS, CITY, STATE, ZIP CODE			
HILLOREST HEALTH CARE CENTER					14 SOUTHBEND AVENUE IANKATO, MN 56001			
(X4) ID PREFIX TAG	BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	the notable indental where the contracte skin nor were any or R10's bath day. RN performed nail care care plan. During interview with p.m. NA-C stated in fingers. NA-C stated residents during bacare and perform a know if any concern Review of a progres p.m. identified that shower the prior evand that the fingers	tions located on the right palm of fingers pressed into the oncerns identified during N-A verified that staff had not dyrooming as directed by the hNA-C on 12/3/14, at 12:10 to had not noticed R10's distaff who are caring for the time are expected to do nail skin audit and let the nurse his are identified. The ses note dated 12/3/14, at 7:00 NA-D, who had given R10 a tening, did not provide nail care on right hand were slightly	F 2	282				
F 312 SS≔D	the hand. This doc timed after the survicencerns related to the concern of the stresident's long fings 483.25(a)(3) ADL COEPENDENT RES A resident who is used all stresident who is used all stresident and oral hygiene. This REQUIREMENT by: Based on observations	ARE PROVIDED FOR	F3	312	F312 D Hillcrest does have a system in p provide ADL care for dependent residents. All residents are to rec care after a bath. It was an overs the charge nurse not to check the after a bath for resident number 1 charge nurse will complete an au resident on bath day. The assessa been clarified to include nail care weekly bath audit. On the check	ceive nai ight of nails 0. The dit of the nent has	170	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		245507	B. WING	3 <u> </u>	12/	12/04/2014	
	PROVIDER OR SUPPLIER EST HEALTH CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP COD 714 SOUTHBEND AVENUE MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		QULD BE	(X5) COMPLETION DATE	
F 312	services for 1 of 1 reviewed who did no bath. Findings include: R10's record was ridentified on the qui (MDS) assessment osteoarthrosis and The same quarterly required extensive hygiene needs, and assistance with all The care plan relation 10/9/14, identified the assistance of one substance o	eviewed and the diagnoses larterly Minimum Data Set to determined that R10 assistance with of staff for all direquired extensive activities of daily living (ADLs). The diagnose staff with all grooming tasks. I on 12/1/14, at 6:00 p.m. R10 e dining room prior to being the day room in her 4th and 5th fingers on her right and 5th fingers on her right hand, R10 extended that R10 extended and bent Inward of the paim. At 6:02 p.m., when the day room in her 4th and 5th fingers on her right hand, R10 extended the paim. At 6:02 p.m., when the staff hand. After and 5th fingers with the use of ding the fingers with the use of ding the fingers from the paim entation marks were observed to ressing/digging into the skin, the observation that she'd had see fingers for a long time and to the ring she wore on her	F3	nurse will indicate if the nail trimmed, did not need trimm resident refused. Changes in monitored by the nursing ass cares, and reported to the nurse managers will conaudits related to completion evaluation by the licensed nunail care. This audit will be of December 30th, 2014. The managers will complete a rangain in 30 days. This audit completed by January 30th, 2 decision to complete further will be made based on the of Director of Nursing and the manager will monitor complete of completion is not to the December 30th 2014.	ing, or the ROM will be istants during the charge of the skin arse including completed by the completed by the complete of the skin arse including the completed by the complete of the comple		

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	F CORRECTION	IDENTIFICATION I	JUNEOU III	A. BUILDING			COMPLETED	
		245507	7 B.	B. WING			12/04/2014	
	PROVIDER OR SUPPLIER	ENTER	1	7	TREET ADDRESS, CI 14 SOUTHBEND AV IANKATO, MN 56			
(X4) ID PŘEFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAĞ	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULE RENCED TO THE APPROP DEFICIENCY)		(XG) OMPLETION DATE
F 312	Continued From particles of the hand was observed was noted to have centimeter (cm) incarea where the 4th into the skin. A red palm of the hand w pressed into the skinger ("pinky" or lit centimeters (cm) lountrimmed. When was responsible to stated it was the rebath duties. RN-A schedule and state prior evening (12/2 no skin audit report bath day which ide contracted fingers palm of the hand. RN-A verified that care/grooming as care/grooming as care and perform a know if any concert. Review of a progrepum, identified that shower the prior evand that the fingers curled and did not the hand. This doctimed after the sur condition of the lors subsequent marks	12/3/14, at 2:01 p. RN)-A was present d. During the obser approximately a 1 dentation on her rig and 5th fingers had line was also evidenter R10's long fingern was appong and appeared RN-A was question trim R10's fingern esponsibility of staff then checked the best available for reventified any concern digging into and accepted during basish had not perform the performance of the control of th	when R10's vation R10 (one) that palm d pressed ent in the engernail on the 5th roximately 2 long and ned who ails, she assigned to eath da bath the there were lew after with the paint into the lentations. The dentations are detected to do nail the nurse level of the end to do nail the nurse level and care re slightly the palm of ated and led the ee	F 312				
FORM CMS-2	567(02-99) Previous Version	B Obsolets	Event ID; SXFD11	FB	cility ID: 00031	it continua	tion sheet Pa	ப்படை வாழ

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	245507	B. WING		12/04/2014
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE C	ENTER	71	TREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTHBEND AVENUE IANKATO, MN 56001	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
fingers. 483.25(e)(2) INCRE IN RANGE OF MOT Based on the compresident, the facility with a limited range appropriate treatme range of motion and decrease in range of motion (RC and fifth (5th) finger of 3 residents (R10) Findings include: The diagnosis ident Minimum Data Set (10/2/14, included os During an observati p.m. R10 was noted 5th digits on her right had the ability to fre fingers/digits but the curled inward and other right hand. During 12/1/14, at 4:46 p.m. have been that way	EASE/PREVENT DECREASE FION rehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion. IT is not met as evidenced lion, interview and document alled to identify a deficit in DM) to the right fourth (4th) is/digits of the right hand for 1 previewed with limited ROM. ified on R10's quarterly (MDS) assessment, dated	F 318	F318 D Hillcrest does have a system in pla prevent decrease in ROM. Resider has a diagnosis of osteoarthritis. As documented in the resident reconstruction and interventions were to a discovery. On 12/3/14, RNA who the mobility of these 2 finger short term and interventions were to a discovery. On 12/3/14, RNA who the mobility of the resident potential contracture to her right hupon assessment it is noted that the and 5th fingers of her right hand are and she is holding them in a flexed position. Resident states that because her ring she holds her hand that we resident noted to be wearing a lar costume jewelry ring to 4th finger tongued back. When asked how look finger has been this way resident stranger has been this way resident strangers get stiff from arthritis. Ask resident if she would allow a there look at her hand and she stated "Instated" I can move my own finger besides I use my hand just fine." In interviewed several staff members including three NA/R staff, two metaff, activity director, dietary director, dire	ord on rs was taken was t has a and. Le 4th e stiff it use of ay. ge with mg her states ates that sed apist to oo". She is and RN-A is ursing actor and noted of these tation in with

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245507	B, WING_		12/0	12/04/2014	
	PROVIDER OR SUPPLIER ST HEALTH CARE (STREET ADDRESS, CITY, STATE, ZIP CO 714 SOUTHBEND AVENUE MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES NY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 318	exactly when the fi stated she knew it Further, there was and/or padding pla R10's fingers from of the hand. During observation was wheeled into the R10 had her 4th a curled and bent impalm as they reste when interviewed to move the finger extended the first and then grasped right hand with the extended these first the fingers with he 4th and 5th fingers noted that two deet the palm of her habeen digging/pres R10 verbalized shingers for a long the ring she wore During interview or registered nurse (bilateral knee con unsure whether an implemented for R10 had not utilize contracture mana. During breakfast a.m. R10 was sea eating her meal. If	ingers became contracted but had been more than a year. no evidence of any splint need in the hand to prevent pressing/digging into the paim on 12/1/14, at 6:00 p.m. R10 the day room. It was noted that no 5th fingers on her right hand ward toward the inside of the don her lap. At 6:02 p.m., and questioned about her ability son her right hand, R10 three fingers of her right hand the 4th and 5th fingers on the use of her left hand. She use of her left hand. She igers partially open by pulling or left hand. After extending the afrom the palm area, it was ep indentation were present in and where these two fingers had sing into the skin layers. Again, e had difficulty moving these the and thought it was due to on her ring (4th) finger. In 12/1/14, at 5:08 p.m. RN)-A Identified R10 with tractures and stated she was my ROM program had been R10 and verified that currently and devices/splints for	F3	the first day she has noted a how resident was holding he Resident allowed ring to be hand and stored in her room agree to have PA-C assess fingers on rounds. Again sethat she would not go to the Because the surveyor stated contracture, the OTR was at The OTR assessed that the probably had not been like curied fingers may possibly secondary to an ill-fitting the resident enjoys costume jowell often find her with orn ears, in her hair, around her more than one finger. Per the OTR observed that nurstretch her 4th and 5th digits functional limits. OT feels resident holds her 4th and 5th flexion due to habit, arthrite 5th PIP joint, and muscle set this time, the OTR opinion not a contracture since resident the formational limits are commends a complete of for further assessment. The was not related to pressure over a long period of time, obviously short lived since of the ill-fitting ring or a material processure ulcer would have less than 2 hours. Upon discovery, the ring wand within the hour the national within the hour the national was not related to pressure and within the hour the national within th	er right hand. removed from n. Resident did hand and he stated erapies." I this was a sked to assess curled fingers that long. The have been light ring. This welry, and you aments on her r neck and on resident record sing was able to to within that the the digits in ic changes in nortening, At is that this is dents digits car imits. OT T evaluation indentation from the finger This was the application ore serious developed in was removed		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION ING		E SURVEY PLETED		
		245507	B. WING			12/04/2014		
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 714 SOUTHBEND AVENUE MANKATO, MN 56001	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	JEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(XE) COMPLETION DATE		
F 318	curled/folded into thate. During interview on stated she was unarange of motion/corstated, "If she has not aware of it. I kn not sure about her During a later intervent of the sure about her During a later intervent of the sure about her During a later intervent of the sure about her During a later intervent of the sure were no oper the indentation aga confirmed she continuicated the most 10/14/14 and no continuicated the most 10/14/14 and no continuicated the sure and NA-B on 12/03 NA-B stated they was not of the stated they was not of the sure when was noted that approximate (cm) incright palm area who (digits) pressed into evident in the palm fingernail pressed the 5th finger (little centimeters (cm) incrimeters (cm) increments (cm)	12/3/14, at 10:10 a.m. RN-A aware that R10 had any limited ntracture of her hands. RN-A a contracture on her hands I'm ow her legs are contracted but		A washeloth was applied wheremoved on her own often of hours to drink her coffee, or tasks of her choosing. Interventions of therapy were the resident. She continues the wash cloth on and off. She annoying. We will continue the wash cloth or sponge us nails cared for as she allows noted that upon discovery of digits, assessment, implement preventative measures were. This is evidenced by the docaptured by the licensed state intact and in good condition is annoyed with further interest has declined therapy. She is use the padding in her hand her fingers with her other has created to be implement both on 12/23/14, to be followed the charge nurse on each unit. In deficiencies were reviewed staff meeting. On 12/23/14 implemented with re-educant nursing assistants regarding subtle changes in range of change of condition. If pronoted during this audit, add and staff training will be conditioned to the condition of th	re declined by to use the finds this to encourage e and keep her is. It should be fithe flexed entation and implemented cumentation off. The skin is in The resident encouraged to an audit was a licensed an audit was tion for greporting	identific Rom is noted or icensed	any substaff	

FORM CMS-2567(02-99) Previous Versions Obsoloto

Event !D: 8XFD11

Facility ID: 00031

If continuation sheet Page 13 of 18

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DEC 3 0 2014.

1033 HILLCREST NORTH

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

PRINTED: 12/16/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	riple construction NG	COMPLETED			
		245507	8. WING		12/04/2014		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 714 SOUTHBEND AVENUE MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE . COMPLETION DATE		
F 318	observation reversingernail when so concern had bee 12/1/14. She ind when she assess stated this condit present too long, about the contract stated, "Oh it has since I came here stated in the present too long. During interview (CTR) stated she was unable to co and 5th fingers or questioned how controlled not be extended in the operation of the	aled she had not noticed the long he checked the hand after the in brought to her attention on licated she had removed the ring sed the hand, stating R10 had son [curled fingers] had not been When R10 was questioned sted appearing fingers, she sheen quite a long time, maybe e?" (admitted in 2012). RN-A sence of R10, that R10 was sed and indicated that earlier, to the time the right hand. When maded independently but only with posite hand), the OTR condition would take longer than a cut could not further comment of R10. The quarterly MDS dated is identified with bilateral lower mitations and free from any emity limitation. The MDS further than Brief Interview for Mental ore of 15/15, indicating intact contified her free from any edicators. The gress notes were documented in gress notes were documented i		Tx started an approve to QA - 4 report to QA - 4	RIO 2/5/14 for RIO 3 x/wh por amended A by her. Your the results	, , , , , , , , , , , , , , , , , , ,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; SXFD11

Facility ID: 00031

If continuation sheet Page 14 of 18

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PRINTED: 12/16/2014 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245507	B. WING			12/04/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 8 714 SOUTHBEND AVENU MANKATO, MN 56001	UE		
(X4) ID PREFIX TAG	· (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION FIVE ACTION SHOULD DED TO THE APPROP FICIENCY)	BE COMPLÉTION	
F 318	by a state surveyor contracture to her assessment it is not her (R) hand are steed position. Reher ring she holds noted to be wearing to 4th finger with to finger. When aske this way resident states he asked resident if slook at her hand an "I can move my ow hand just fine". Into members including staff, activity direct administrator to as in ROM to (R) han have noted no limiterview with activity esterday was the change in how resended and stored [ring] in to have PA-C assed on rounds however to therapies. (2.) Entry dated 12 occupational thera of resident's (R) has she does not want would attempt a sore due to possible conduction of the store due to possible conduction.	2/3/14- 11:30 a.m. Was notified a that resident had a potential right (R) hand. Upon oted that 4th and 5th fingers of tiff and she holding them in sident states that because of her hand that way. Resident g a large costume jewelry ring ongued back that digs into d how long her finger has been tates "oh not terribly long" or fingers get stiff from arthritis, he would allow a therapist to had she stated "no". She stated on fingers and besides I use my erviewed several staff g three NA/R staff, two nursing for, dietary director and sess if they had noted change d. All of these staff members tation in ROM to (R) hand. On rity aide she stated that first day she has noted a ident was holding her (R) hand. In her room. Resident did agree as hand and fingers tomorrow or again stated she would not go 2/3/14- 12:09 p.m. Updated py (OT) Department on status and and that resident states therapies. Asked OT if they breening with resident today.	F3				
FORM CMS-2!	567(02-99) Previous Version	s Obsolete Event ID: SXFD1	1	Facility ID: 00031	If continuati	on sheet Page 15 of 18	

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PRINTED: 12/16/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		COMPLETED		
		245507	245507 B. WING			12/04/2014	
	PROVIDER OR SUPPLIER			STF 714 MA			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTICIENCY)	D BE	(X5) COMPLETION DATE
F 318	OT observed that 4th and 5th digits the feels that resident flexion due to hability in the feels that the resident's digits callimits. OT recomm for further assess (4.) Entry dated 12 allowed washcloth time. Set-up treatm hand as resident v (5.) Entry dated 12 recreation director having more difficulty in card greards but is having trump is and what trump and then called. She forgets and will ask when attended begins. Timpairment to RN-16.) Entry dated 12 approximately 8:00 to resident (R) har her hand. Spoke view she stated that he ourled that way he what everyone is gottoned.	nursing was able to stretch her o within functional limits. OT holds her 4th and 5th digits in t, arthritic changes in 5th PIP shortening. At this time, my OT is not a contracture since in be stretched to functional ends a complete OT evaluation nent. 2/3/14-4:00 p.m. Resident to be placed to (R) hand at this nent to keep padding in right will allow. 2/3/14- 4:43 p.m. therapeutic (TRA) reported to therapeutic (TRA) that resident was playing the part of the	F	318			
	was observed sea	ted in the dayroom participating					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SXFD11

Facility ID: 00031

if continuation sheet Page 16 of 18

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DEC 3 0 2014.

PRINTED: 12/16/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245507	B. WING	B. WING		12/04/2014	
	PROVIDER OR SUPPLIER			71	REET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTHBEND AVENUE ANKATO, MN 56001	,	
(X4) ID PHEFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
F 318	hand resting on he digits/fingers were the inside surface. During observation R10 was seated in R10 was noted to right hand. The was prior to the surveyon the curled/contract that her right hand. "Yes, everybody elewas observed with was noted that an the palm of the har location of the 5th skin was also note pressed into the paindentation was not without a wash clonotable with the part of the paindentation was not without a wash clonotable with the part of the paindentation was not without a wash clonotable with the part of the paindentation was requested able to freely externight hand but grab (pinky) fingers with extension of both for freely extend bowas observed that attempted to fully extended finger. Documentation was to indicate that star of motion of the 4th observed on 12/1/	s noted that R10 had her right or lap and the 4th and 5th curled and pressing against	F3	318			

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: SXFD11

Facility ID: 00031

If continuation sheet Page 17 of 18

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DEC 3 0 2014

Minnestoa Department of Health Marshall

PRINTED: 12/16/2014	
FORM APPROVED	
OMB NO. 0938-0391	
VALDATE SUBVEY	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COI	COMPLETED		
		245507	B. WING	B. WING			12/04/2014	
	PROVIDER OR SUPPLIER	ENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001	-		
(X4) ID . PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ID PROVIDER'S PLAN OF CORRECT REFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ILD BE	(XS) COMPLETION DATE	
F 318	were the result of th	ge 17 se fingers curled and pressed the right hand of R10.	F	318				

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: SXFD11

Facility ID: 00031

If continuation sheet Page 18 of 18

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Printed: 12/08/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245507

B. WING

12/04/2014

NAME OF PROVIDER OR SUPPLIER

HILLCREST HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

714 SOUTHBEND AVENUE MANKATO. MN 56001

MANKATO, MN 56001						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	INITIAL COMMENTS	K 000				
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on December 04, 2014. At the time of this survey, Hillcrest Health Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Hillcrest Health Care Center is a 1-story with a partial basement facility was constructed in 1957, with one building addition constructed in 1963. Both buildings were determined to be of Type II(000) construction. The facility is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 75 at time of the survey.	3				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2569

December 16, 2014

Ms. Amy Porter, Administrator Hillcrest Health Care Center 714 Southbend Avenue Mankato, Minnesota 56001

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5507024

Dear Ms. Porter:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to Kathryn Serie, Unit Supervisor at the Minnesota Department of Health, 1400 E Lyon St Marshall, MN 56258-2529.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00031	B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
HILLCRE	EST HEALTH CARE C	ENIER	HBEND AVE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of worrected requires requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff, the following corrections are con make a copy of the original to the Minn	TS: 4th, 2014, surveyors of this visited the above provider and ction orders are issued. When appleted, please sign and date, are orders and return the esota Department of Health, ance Monitoring, Licensing and		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

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

(X6) DATE TITLE

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL		
		00031	B. WING		12/04	4/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
HILLCREST HEALTH CARE CENTER 714 SOUTHBEND AVENUE MANKATO, MN 56001							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 1	2 000				
	Certification Progra MN 55164-0900	m, P.O. Box 64900 St. Paul,		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficienc column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the survindings are the Suggested Method Correction and the Time Period For Correction.	Tag." the tute/rule ies" ply" nis s which after the s /eyors d of		
				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TFEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS' STATUTES/RULES.	THIS ON FOR		
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560				
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The o	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan					

Minnesota Department of Health

STATE FORM SXFD11 If continuation sheet 2 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1			DATE SURVEY COMPLETED	
			D WING				
		00031	B. WING		12/0	4/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
HILLCRE	EST HEALTH CARE C	FNIFR	THBEND AVE O, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 560	subdivision 14, parabular by: Based on interview facility failed to dev Coumadin (a blood potential increased (R101) reviewed for Findings include: R101's diagnoses in abnormal heart rhy admission record face R101's physician of an order to give Counted the evening on 12/2 recheck PT/INR (Pormalized Rational the effectiveness of Further review of the R101 had been utiled doses since admissional R101's care plan lated address the use of monitoring for side symptoms of bleed	ota Statutes, section 626.557, agraph (b). ent is not met as evidenced and document review the elop a care plan for use of thinner with side effect of bleeding) for 1 of 5 residents r unnecessary medications. ncluded atrial flutter (an thm) and heart failure per the ace sheet. rders dated 12/2/14, revealed rumadin 13 milligrams (mg) in 2/14, and 12/3/14, then rothrombin time/International blood tests used to monitor of Coumadin) on 12/4/14. ne physician orders revealed izing Coumadin at varying sion. est reviewed 9/10/14, did not Coumadin including effects such as signs and	2 560				
	registered nurse (R Coumadin use and was not addressed have been.	N)-B confirmed R101's monitoring for side effects on the care plan and should					
		on 12/04/14, at 1:21 p.m. the (DON) confirmed R101's					

Minnesota Department of Health

STATE FORM SXFD11 If continuation sheet 3 of 20

Minnesota Department of Health

	DI AN OF CORRECTION IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00031	B. WING		12/0	4/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 .2,0	.,
HILLCREST HEALTH CARE CENTER 714 SOUTHBEND AVENUE MANKATO, MN 56001						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 3	2 560			
		monitoring for side effects ncluded on the care plan.				
	The director of nurs staff to develop a ca	THOD OF CORRECTION: sing could in-service licensed are plan to include appropriate identified care needs. The could monitor staff				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the .				
	by: Based on observatireview the facility faskin audits as ident for 1 of 3 residents	ent is not met as evidenced on, interview and document illed to provide grooming and ified in the written plan of care (R10) reviewed who were aff for personal cares.				
	Findings include:					
	Minimum Data Set 10/2/14, included: 1 and moderate intelliplan related to skin	entified on the quarterly (MDS) assessment, dated failure to thrive, osteoarthrosis ectual disability. The care integrity dated 7/18/13, gh risk for skin breakdown				

Minnesota Department of Health

STATE FORM SXFD11 If continuation sheet 4 of 20

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00031 B. WING	12/04/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY		
secondary to overall decline in functional mobility, severe malnutrition, history of pressure ulcers and failure to thrive. The care plan directed that R10's skin be monitored daily during cares and a weekly skin audit to be completed during the bath. The care plan related to self care deficit, dated 10/9/14, identified that R10 required extensive assistance of one staff with all grooming tasks. The care plan was not followed as directed. During observation on 12/1/14, at 6:00 p.m. R10 was observed in the daining room prior to being assisted by staff to the day room in her wheelchair. R10's 4th and 5th fingers on her right hand were observed to be curled and bent inward toward the inside of the palm. At 6:02 p.m., when interviewed and questioned about her ability to move the fingers on her right hand, R10 extended the first three fingers of her right hand and then grasped the 4th and 5th fingers with the use of her left hand extending the fingers partially open by pulling them with her left hand. After extending the 4th and 5th fingers from the palm area, two indentation marks were observed in the palm of R10's right hand where the two fingers had been pressing/digging into the skin. Two days later, on 12/3/14, at 2:01 p.m. registered nurse (RN)-A was present when R10's hand was observed. R10 was seated in the dayroom. During the observation R10 was noted to have approximately a 1 (one) centimeter (cm) indentation on her right palm area where the 4th and 5th fingers had pressed into the skin. A fed line was also evident in the palm of the hand where R10's long fingermail pressed into the skin. Tred line was also evident in the palm of the hand where R10's long fingermail pressed into the skin. Tred line was also evident in the palm of the hand where R10's long fingermail pressed into the skin. Tred line was also evident in the palm of the hand where R10's long fingermail pressed into the skin. Tred line was also evident in the palm of the hand where R10's long fingermail pressed into the skin.		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00031	B. WING		12/0	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HILLCRI	EST HEALTH CARE C	ENTER	THBEND AVE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	RN-A was question trim R10's fingernal responsibility of sta RN-A then checked R10 had received a (12/2/14). RN-A all audit reports availa the notable indental where the contractes skin nor were any created and care care plan. During interview with p.m. NA-C stated hingers. NA-C stated hingers. NA-C state residents during bacare and perform a know if any concern. Review of a progree p.m. identified that shower the prior evand that the fingers curled and did not a the hand. This doctimed after the survice concerns related to the concern of the sresident's long fingers. SUGGESTED MET The director of nurs revise facility policies care plan implement to staff to address the each resident's care.	ed who was responsible to ills, she stated it was the ff assigned to bath duties. If the bath schedule and stated a bath the prior evening so stated there were no skin ble for review which identified tions located on the right palmed fingers pressed into the concerns identified during N-A verified that staff had not exgrooming as directed by the the NA-C on 12/3/14, at 12:10 the had not noticed R10's distaff who are caring for the thin time are expected to do nail skin audit and let the nurse has are identified. The sense of the palm of the the failure to provide nail care the failure to provide nail care the skin indentations related to the	2 565			

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Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00031	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	FNTER 714 SOU	DRESS, CITY, STHBEND AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	could establish a sy	estem to audit care plans and ent implementation, to ensure e.	2 565			
2 570	Plan of Care; Revision. Subp. 4. Revision. care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on interview facility failed to revise resident (R10) revise intact cognition yet moderate cognitive Findings include: During interview on was able to appropriate without difficulty and events of the facility	and document review the se the care plan for 1 of 1 ewed who was assessed with the care plan indicated she a deficit. 12/1/14, at 4:46 p.m. R10 riately answer questions d was able to recall history and of the care was no evidence which indicated R10 lacked				

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Minnesota Department of Health

00031 B. WING 12/04/201	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
12/04/20		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PROVIDER OR SUPPLIER	
HILLCREST HEALTH CARE CENTER 714 SOUTHBEND AVENUE MANKATO, MN 56001	HILLCREST HEALTH CARE O	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH DEFICIENC	
the ability to recall recent events or identify her present condition. During review of R10's Minimum Data Set (MDS) annual comprehensive assessment, dated 4/2/14, the quarterly assessment, dated 4/2/14, the quarterly assessment dated 10/2/14, the Brief Interview for Mental Status (BIMS) assessment identified that R10 scored 15/15, indicating her cognitive status was intact (perfect score). The care plan dated 4/10/14, identified R10 with an alteration in thought process related to adult failure to thrive and moderate intellectual difficulties manifested by the score on the BIMS assessment, which indicates moderate memory impairment, long and short term memory impairment and moderately impaired decision making. During interview on 12/03/14, at 2:19 p.m. social services (SS)-A staff indicated that social service staff complete the cognitive status section of the MDS comprehensive assessment. SS-A verified R10 was identified as having intact cognition (15/15) on the past three MDS's but was not sure whether R10 is always accurate with responses. SS-A verified the most recent quarterly MDS dated 10/2/14, identified R10 with a BIMs score of 15/15 and free from any mood/behavior indicators. When questioned whether the MDS assessment was accurate or the care plan was accurate, due to the inconsistent documentation, SS-A stated she felt the MDS was not a good tool to assess cognition. SS-A had the following notes documented in R10's progress notes:	the ability to recall present condition. During review of R annual comprehen 4/2/14, the quarterly a Brief Interview for I assessment identifindicating her cogniscore). The care plan date an alteration in the failure to thrive and difficulties manifes assessment, which impairment, long a impairment and making. During interview or services (SS)-A stastaff complete the MDS comprehensi R10 was identified (15/15) on the pass whether R10 is alw SS-A verified the m dated 10/2/14, ider 15/15 and free fror indicators. When gassessment was a accurate, due to the SS-A stated she fe to assess cognition.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: A. BUILDING: B. WING (X3) DATE SURVEY COMPLETED 12/04/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES MANKATO, MN 56001 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE DATE COMPLETE DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
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HILLCREST HEALTH CARE CENTER 714 SOUTHBEND AVENUE MANKATO, MN 56001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
DATE
DEFICIENCY)
2 570 Continued From page 8 2 570
(depression assessment): Resident scored a
15/15 on the BIMS which indicates her cognition
is intact. Resident scored a 0/27 on the PHQ-9
which indicates no symptoms of depression.
Resident plans for a long term stay at this facility,
no referral needed.
(2.) 7/10/14, at 12:53 p.m. quarterly care
conference: Resident attended care conference.
Resident is alert, oriented, and able to
communicate needs. Resident enjoys attending
activities and is involved in life at this facility.
Resident most recent BIMs and PHQ-9
(depression score) reviewed. Resident can
become confused about her finances, will request
large amounts of money to keep in her room,
forgets she has a trust account.
3. 10/9/14, at 4:01 p.m. care conference note:
The resident attended the meeting and was in
good spirits during the visit. [R10] expressed no
concerns about her room when asked and she
did not share any concerns about her roommate. The BIMS and PHQ-9 assessment scores were
reviewed. The resident would like her code status
to be Comfort Cares (DNR/DNI) and [R10] would
like to remain at this facility long term. No other
psychosocial concerns reported at this time.
During interview with the director of nursing
(DON) on 12/4/14, at approximately 10:30 a.m.
she was unable to explained the discrepancy
between the MDS assessment and the care plan
related to R10's cognitive status. The DON stated
it was possible for R10 to have intact cognition
during the assessment period but not have the
same cognition at all times.
No further assessment was provided when
further cognitive assessment and documentation
was requested from the facility staff. The only
cognitive assessment available for review was
the BIMS assessment as part of the MDS
comprehensive assessment. Documentation was

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			72525			
		00031	B. WING		12/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HILLCRE	EST HEALTH CARE C	FNTFR	THBEND AVE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	lacking to support t R10 with moderate in the care plan. SUGGESTED MET The Director of Nur educate all the app importance of revis care in a timely ma monitoring system revised to reflect th TIME PERIOD FOR (21) days.	he assessment that deemed cognitive deficit as identified THOD OF CORRECTION: sing (DON) or designee could ropriate staff on the ing each residents' plan of nner, and could develop a to ensure all care plans are e current status. R CORRECTION: Twenty-one	2 570			
2 860	860 MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.		2 860			
	by: Based on observation review the facility factories for 1 of 1 or reviewed who did not bath. Findings include:	ent is not met as evidenced on, interview and document alled to provide grooming dependent resident (R10) ot receive nail care following a				
	identified on the qu (MDS) assessment	eviewed and the diagnoses arterly Minimum Data Set , dated 10/2/14, included: moderate intellectual disability.				

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AND DI AN OF CORRECTION IN INDENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00031	B. WING		12/0	04/2014
	PROVIDER OR SUPPLIER EST HEALTH CARE C	FNTER 714 SOUT	DRESS, CITY, S FHBEND AVE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 860	The same quarterly required extensive hygiene needs, and assistance with all and subserved in the assisted by staff to wheelchair. R10's 4 hand were observed toward the inside of interviewed and que move the fingers or the first three fingers grasped the 4th and her left hand extend by pulling them with extending the 4th a area, two deep indein the palm of R10's fingers had been pr R10 stated during the difficulty moving the thought it was due tring (4th) finger. Two days later, on registered nurse (R hand was observed was noted to have a centimeter (cm) indiarea where the 4th into the skin. A red palm of the hand w pressed into the skifinger ("pinky" or litt centimeters (cm) lo untrimmed. When was responsible to	MDS identified that R10 assistance with of staff for all	2 860			

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PRINTED: 12/16/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 00031 12/04/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **714 SOUTHBEND AVENUE** HILLCREST HEALTH CARE CENTER MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 8 6 0 Continued From page 11 2 860 bath duties. RN-A then checked the bath schedule and stated R10 had received a bath the prior evening (12/2/14). RN-A stated there were no skin audit reports available for review after

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During interview with NA-C on 12/3/14, at 12:10 p.m. he stated staff who are caring for the residents during bath time are expected to do nail care and perform a skin audit and let the nurse know if any concerns are identified.

bath day which identified any concern with the contracted fingers digging into and againt into the palm of the hand, causing notable indentations. RN-A verified that staff had not performed nail care/grooming as expected during bath day.

Review of a progress note dated 12/3/14, at 7:00 p.m. identified that NA-D, who had given R10 a shower the prior evening, did not provide nail care and that the fingers on right hand were slightly curled and did not appear to dig into the palm of the hand. This documentation was dated and timed after the surveyor had questioned the condition of the long fingernail and the subsequent marks in the palm of the right hand related to the curled/contracted 4th and 5th fingers.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff on performing activities of daily living including finger nail care for residents. The director of nursing or designee could schedule audits to monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED	
		00031	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER	FNTER 714 SOUT	HBEND AVE			
240.15	CLIMANA DV CTA		D, MN 56001		ON	0.(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 12	2 895			
2 895	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	2 895			
	that is directed towal through positioning implemented and momprehensive results of nursing services development of a nursing services development of services development of a nursing services development of services develop	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which the a limited range of motion the treatment and services to notion and to prevent further of motion.				
	by: Based on observati review, the facility farange of motion (RG and fifth (5th) finger of 3 residents (R10) Findings include: The diagnosis ident Minimum Data Set	ent is not met as evidenced on, interview and document ailed to identify a deficit in DM) to the right fourth (4th) rs/digits of the right hand for 1) reviewed with limited ROM. tified on R10's quarterly (MDS) assessment, dated				
	p.m. R10 was noted 5th digits on her rig had the ability to fre fingers/digits but the curled inward and c her right hand. Dur	ion on 12/01/2014, at 4:45 d to have contracted 4th and ht hand. It was noted that R10 ely extend/open the first three e 4th and 5th fingers were contracted against the palm of ing interview with R10 on n. R10 stated, "My fingers				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00031	B. WING		12/0	4/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE			
HILLCRE	ST HEALTH CARE C	FNTFR	HBEND AVE D, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE	
2 895	Continued From pa	ge 13	2 895				
2 895	have been that way be due to my ring?" exactly when the fir stated she knew it h Further, there was and/or padding place R10's fingers from of the hand. During observation was wheeled into the R10 had her 4th and curled and bent inweather and then grasped the right hand with the extended the first the and then grasped the fingers with her 4th and 5th fingers noted that two deep the palm of her hand been digging/press R10 verbalized she fingers for a long tirthe ring she wore of During interview on registered nurse (R bilateral knee contrunsure whether any	for a long time. I think it might R10 was unable to recall agers became contracted but had been more than a year. The evidence of any splint and been more than a year. The evidence of any splint are din the hand to prevent bressing/digging into the palm on 12/1/14, at 6:00 p.m. R10 are day room. It was noted that did 5th fingers on her right hand are did toward the inside of the ston her lap. At 6:02 p.m., and questioned about her ability on her right hand, R10 are fingers of her right hand are 4th and 5th fingers on the use of her left hand. She gers partially open by pulling left hand. After extending the from the palm area, it was a indentation were present in did where these two fingers had and into the skin layers. Again, had difficulty moving these me and thought it was due to an her ring (4th) finger. 12/1/14, at 5:08 p.m. N)-A identified R10 with actures and stated she was a ROM program had been of and verified that currently didevices/splints for	2 895				
	a.m. R10 was seate	bservation on 12/3/14, at 8:15 ed in the small dining room was again noted the 4th and					

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AND DI AN OF CORRECTION IN INDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
		00031	B. WING		12/0	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HILLCRE	EST HEALTH CARE C	FNTFR	THBEND AVE	-		
	I	MANKAI	O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 14	2 895			
		her right hand were ne palm of her hand while she				
	stated she was una range of motion/cor stated, "If she has a	12/3/14, at 10:10 a.m. RN-A ware that R10 had any limited attracture of her hands. RN-A a contracture on her hands I'm ow her legs are contracted but hand."				
	During a later interview on 12/3/14, at 11:50 a.m. RN-A stated she had looked at R10's fingers on her right hand and noted that her pinky (5th) and ring (4th) fingers were contracted. RN-A stated there were no open skin areas on the hand, just the indentation against the palm. RN-A, who confirmed she conducted the MDS assessments, indicated the most recent assessment was dated 10/14/14 and no contractures were evident during that assessment. RN-A further stated she had questioned other staff and they were unaware of any contracture.					
	and NA-B on 12/03, NA-B stated they w	h nursing assistant's (NA)-A /14, at 11:55 a.m. NA-A and ere not aware of a contracture ated on the right hand.				
	was present when I was noted that appropriate centimeter (cm) individual right palm area where (digits) pressed into evident in the palm fingernail pressed in the 5th finger (little) centimeters (cm) lo	p.m. registered nurse (RN)-A R10's hand was observed. It roximately a 1 (one) entation was evident on the ere the 4th and 5th fingers of the skin. A red line was also of the hand where R10's long into the skin. The fingernail on was approximately 2 ng and appeared long and ew with RN-A at the time of the				

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	AND DIANIOE COPPECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00031	B. WING		12/0	04/2014	
	PROVIDER OR SUPPLIER EST HEALTH CARE C	FNTER 714 SOUT	DRESS, CITY, S THBEND AVE D, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 895	observation reveals fingernail when she concern had been to 12/1/14. She indicated when she assessed stated this condition present too long. We about the contracted stated, "Oh it has to since I came here? stated in the present sometimes confused R10 had said that it long. During interview on 2:40 p.m. the regist (OTR) stated she has unable to compand 5th fingers on to questioned how quiexperience contract could not be extend the use of the opports of days, but without assessing F	ed she had not noticed the long is checked the hand after the brought to her attention on ated she had removed the ring it the hand, stating R10 had in [curled fingers] had not been when R10 was questioned diappearing fingers, she been quite a long time, maybe if (admitted in 2012). RN-A fince of R10, that R10 was ad and indicated that earlier, is hadn't been contracted so in 12/3/14, at approximately the ered occupational therapist and never evaluated R10 and ment on the status of the 4th he right hand. When ckly a resident would tures of the fingers (which led independently but only with site hand), the OTR dition would take longer than a could not further comment	2 895	DEFICIENCY)			
	10/2/14, R10 was id extremity ROM limi upper ROM extrem identified R10 with Status (BIMS) score	dentified with bilateral lower tations and free from any ity limitation. The MDS further a Brief Interview for Mental e of 15/15, indicating intact tified her free from any					
	R10's medical reco	ess notes were documented in rd on 12/4/14: /3/14- 11:30 a.m. Was notified					

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winnesc	ita Department of He	aitri				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
	00031		B. WING		12/0	4/2014
		00031			12/0	14/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IIII I CDI		714 SOUT	HBEND AVE	NUE		
HILLORI	EST HEALTH CARE C	MANKATO	D, MN 56001	l		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IOIEINOT)		
2 895	Continued From pa	ige 16	2 895			
	by a state surveyor	that resident had a potential				
		ight (R) hand. Upon				
		ted that 4th and 5th fingers of				
		iff and she holding them in				
		sident states that because of				
		ner hand that way. Resident				
		g a large costume jewelry ring				
		ngued back that digs into				
		how long her finger has been				
		ates "oh not terribly long"				
	Resident states her	fingers get stiff from arthritis.				
	Asked resident if sh	ne would allow a therapist to				
	look at her hand an	d she stated "no". She stated				
	"I can move my ow	n fingers and besides I use my				
	hand just fine". Inte	rviewed several staff				
		three NA/R staff, two nursing				
		or, dietary director and				
		sess if they had noted change				
		All of these staff members				
		ation in ROM to (R) hand. On				
		ty aide she stated that				
		first day she has noted a				
		dent was holding her (R) hand.				
		ng to be removed from hand				
		her room. Resident did agree				
		ss hand and fingers tomorrow				
		again stated she would not go				
	to therapies.					
	(2) Entry dated 12	/3/14- 12:09 p.m. Updated				
		by (OT) Department on status				
		nd and that resident states				
		therapies. Asked OT if they				
		reening with resident today.				
	would altempt a Sol	Tooming with resident today.				
	(3.) Entry dated 12	/3/14- 2:30 p.m. OT				
		with nurse manager, RN-A,				
		tractures in right hand/digits.				
		ursing was able to stretch her				
		within functional limits. OT				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20.22				
		00031	B. WING		12/	04/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
HILLCRE	EST HEALTH CARE C	FNTFR	JTHBEND AVE TO, MN 5600°				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
2 895	Continued From pa	age 17	2 895				
	flexion due to habit joint, and muscle sl opinion is that this i resident's digits car limits. OT recomme for further assessm (4.) Entry dated 12 allowed washcloth time. Set-up treatm hand as resident wi (5.) Entry dated 12 recreation assistant recreation director having more difficulty in card grocards but is having trump is and what we trump and then can called. She forgets and will ask when the	2/3/14-4:00 p.m. Resident to be placed to (R) hand at the nent to keep padding in right ill allow. 2/3/14- 4:43 p.m. therapeutic t (TRA) reported to therapeut (TRD) that resident was lity remembering where an east month has had great oup. Resident enjoys playing difficulty remembering what was layed. At times she will cannot remember what she what activities she is attending the proported this memory	is c				
	approximately 8:00 to resident (R) hand her hand. Spoke wishe stated that her curled that way her	2/3/14- 10:36 p.mAt p.m. had applied warm pack d and massaged the palm of ith res about her fingers and "fingers have always been whole life and doesn't know etting excited about."					
	was observed seate in an activity. It was hand resting on her	on 12//14, at 10:00 a.m. R10 ed in the dayroom participatins noted that R10 had her right r lap and the 4th and 5th curled and pressing against	g				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		00031	B. WING		12/0	4/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
HILLCR	EST HEALTH CARE C	FNTFR	HBEND AVE				
0(0.15	CLIMMA DV CTA		D, MN 56001		ONI	()(5)	
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE		
2 895	Continued From page 18		2 895				
	the inside surface of her palm.						
	, •						

Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00031	B. WING		12/0	4/2014
	PROVIDER OR SUPPLIER EST HEALTH CARE C	FNTER 714 SOUT	THBEND AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	The facility could we and therapy departs programming for remotion services or facility could develor motion services for QA Committee.	ge 19 ork with the QA Committee ment to identify and develop sidents in need of range of those at risk for decline. The p systems to audit range of completion and report to the R CORRECTION: Twenty-one	2 895			

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