DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA ` I - TO BE COM					ID: ZN4M Facility ID: 00798		
MEDICARE/MEDICAID PROVIDER N (L1) 245358 2.STATE VENDOR OR MEDICAID NO. (L2) 764975000 5. EFFECTIVE DATE CHANGE OF OWN (L9) 05/01/2002		(L3) HILLTOP CA (L4) 410 LUELLA (L5) WATKINS, M	STREET			L6) 55389 (L7) 22 CLIA	 TYPE OF ACTION Initial Termination Validation On-Site Visit Full Survey After C 	2. Recertification 4. CHOW 6. Complaint 9. Other	
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 ADA 2 AOA 1 Other 	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	E	FISCAL YEAR ENDING	G DATE: (L35)	
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 	50 (L18) 50 (L17)	B. Not in Com Requirements a	nce With quirements Based On: acceptable POC pliance with Program and/or Applied Waive	rs:	2. 3. 4. 5. * Code: 15. FACILIT	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code <u>A*</u> TY MEETS	Following Requirements: 6. Scope of Ser 7. Medical Dira 8. Patient Room 9. Beds/Room (L12)	vices Limit ector	
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e) (1	1) or 1861 (j) (1):	(L15)		
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) S (IF APPLICABLE S	(L42) HOW LTC CANCELL	(L43) ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY API	PROVAL	Date:	
Kathryn Serie, U	Init Supervis	sor	10/14/2016	(L19)	Kate J	ohnsTon, Pro	ogram Speciali	<u>St</u> 11/21/2016 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE O	OR SINGLE STAT	EAGENCY		
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible 	icipate (L21)		IPLIANCE WITH CI ITS ACT:	VIL	21.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCI	FA-1513)	
22. ORIGINAL DATE OF PARTICIPATION 10/01/1986	23. LTC AGREEMI BEGINNING		4. LTC AGREEMEN ENDING DATE		<u>VOLUNTAF</u> 01-Merger, C	Closure	<u>INVOLUN</u> 05-Fail to N	Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o	of Admissions:	(L25) (L44)		03-Risk of In	action W/ Reimbursemer woluntary Termination ason for Withdrawal	OTHER	Meet Agreement r Status Change	
(L27)	B. Rescind Sus	pension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	KS			
	(L28)	00140		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (10/28/2016	OF APPROVAL DAT	E	Post	ed 11/30/2016 Co.			
	(L32)	10/20/2010		(L33)	DETERM	INATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245358 November 21, 2016

Mr. Fred Struzyk, Administrator Hilltop Care Center 410 Luella Street Watkins, MN 55389

Dear Mr. Struzyk:

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 October 28, 2016 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Hilltop Care Center November 21, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 21, 2016

Mr. Fred Struzyk, Administrator Hilltop Care Center 410 Luella Street Watkins, MN 55389

RE: Project Number S5358025

Dear Mr. Struzyk:

On October 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 4, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 28, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2016, effective October 28, 2016 and therefore remedies outlined in our letter to you dated October 7, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Hilltop Care Center November 21, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /		MULTIPLE CONSTRUCTION		DATE OF REVISIT	-
IDENTIFICATION NUMBER		A. Building			
245358	Y1	B. Wing	Y2	11/4/2016	Y3
NAME OF FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP CARE CENTER			410 LUELLA STREET		
			WATKINS. MN 55389		

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).

ITE	м	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. #	F0157 483.10(b)(11)	Correction Completed	ID Prefix <u>F0309</u> Reg. #	Correction Completed	ID Prefix Reg. #	F0314 483.25(c)	Correction Completed
LSC		10/28/2016	LSC	10/28/2016	LSC		10/28/2016
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. # LSC		Completed	Reg. #	Completed	Reg. # LSC		Completed
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC					LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) BF/KJ	date 11/21/2016	SIGNATURE OF SURVEYOR	03048	date 11/04	/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/22/2016			ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN				

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /		MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER		A. Building 01 - MAIN BUILDING 01			
245358	Y1	B. Wing	Y2	10/13/2016	Y3
NAME OF FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP CARE CENTER			410 LUELLA STREET		
			WATKINS, MN 55389		

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).

ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0062	09/22/2016			LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
REVIEWE STATE AG			DATE	SIGNATURE OF SURVEYOR	-	DATE
		(INITIALS) BF/KJ	11/21/2016		19251	10/13/2016
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/21/2016			ANY UNCORRECTED DEFICIENCI ED DEFICIENCIES (CMS-2567) SE			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

November 4, 2016

Mr. Fred Struzyk, Administrator Hilltop Care Center 410 Luella Street Watkins, MN 55389

Subject: Hilltop Care Center - Informal Dispute Resolution (IDR) Provider # 245358 Project # S5358025

Dear Mr. Struzyk:

This is in response to your letter of October 18, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F329 S/S-D § 483.25(I), issued pursuant to the survey event ZN4M11, completed on September 22, 2016.

The information presented with your letter, the CMS 2567 dated September 22, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F329 S/S – (D) 42 CFR § 483.25(I) Unnecessary Drugs

(Rev. 130; Issued: 12-12-14, Effective: 12-12-14, Implementation: 12-12-14)

1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- (i) In excessive dose (including duplicate therapy); or (ii) For excessive duration; or
- (iii) Without adequate monitoring; or
- (iv) Without adequate indications for its use; or
- (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (vi) Any combinations of the reasons above.

Summary of the facility's reason for IDR of this tag: The facility disputed the finding based on the surveyor's request for information with specific date parameters of 3/15/16 to exit date of 9/22/16 in regards to a physician ordered annual Lipid Panel blood test in order to determine whether the current use of Simvastatin (a cholesterol lowering medication) was effective. The facility provided a copy of a Lipid Profile which had been completed on 3/14/16 (previous Lipid Profile dated 3/15/15.)

Summary of findings: R34 had received daily Simvastatin medication for several years. R34's physician had ordered a Lipid Profile to be done annually. A Lipid Profile was completed on 3/15/15 and again on

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		OMB NC	0. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245358	B. WING _		09	/22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00		
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.		æ		
	revisit of your facilit validate that substa	acceptable POC an on-site y may be conducted to Intial compliance with the en attained in accordance with		R		
F 157 SS=D	"Revised CMS2567 Dispute Resolution. 483.10(b)(11) NOT (INJURY/DECLINE	IFY OF CHANGES	F	57		10/28/16
	consult with the res known, notify the res or an interested fan accident involving ti injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of treat consequences, or to treatment); or a deo the resident from th §483.12(a).	ediately inform the resident: ident's physician; and if esident's legal representative nily member when there is an he resident which results in octential for requiring physician ificant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in so promptly notify the resident esident's legal representative				
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 10/21/2016

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

PRINTED: 11/04/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
				0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245358	B. WING _		09/2	22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	HILLTOP CARE CENTER			410 LUELLA STREET		
	OANE OENTEN			WATKINS, MN 55389		
(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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	change in room or in specified in §483.1 resident rights under regulations as spect this section. The facility must react the address and philegal representative This REQUIREMENT by: Based on observation review the facility far physician of the oper bony prominence's (R18) reviewed who Findings include: R18's annual Minima assessment dated Interview for Menta indicating severe co assistance of 2 staff and does not walk. (CAA) dated 7/25/1 risk for pressure uld ulcer present. Progress notes dates skin/problem areas and were described and measured 1.5 co middle area open m and (#3) bottom areas	member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced tion, interview and document iled to immediately notify the en wounds located on the of the spine 1 of 1 resident of developed pressure upers.	F 15	Resident 18's physician was notifie 9/6/16 regarding pressure ulcers. Physician is updated on wound progon rounds and if wound shows no progress in 2 weeks or if wound deteriorates. Staff was provided education on wounds and to notify t physician upon discovery of a woun DON or designee will audit resident pressure ulcers to ensure the physi notified upon discovery and as need The DON will present to the Quality Assurance Committee the audit find on physician notification and the Qu Assurance Committee will determine continuing periodic auditing.	gress the nd. ts with cian is ded. , dings uality	

If continuation sheet Page 2 of 18

PRINTED: 11/04/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/04/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245358	B. WING _		09/	22/2016
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HILLTOP	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	Continued From pa open to the air.	ge 2	F 15	7		
	adhesive foam dress spine; three bony p breakdown were: has pinkness that is wound located on th 0.2 cm yellow scab located on the spine Wounds occurred w toilet during sitz bat discontinued 8/15/1 indicated the daugh this time, no physic wound observation the problem areas of upper wound-(#1) a (a purple or maroor intact skin or blood- underlying soft tissu shear) and the lowe PU (full thickness ti the ulcer is covered green or brown) and black) in the wound Documentation indi notified of the ident though it was first id documentation date wound located on the due to deep tissue was documented as Review of the care R18 at risk for skin present to bony pro	6. Although documentation iter was updated on wounds at ian notice was evident. The tool dated 8/22/16, described on the spine of R18 as noted: a suspected deep tissue injury n localized area of discolored filled blister due to damage of ue from pressure and/or er wound (#3) an Unstageable ssue loss in which the base of I by slough (yellow, tan, gray, d/or eschar (tan, brown or l bed. cated the physician was ified PU on 9/6/16 even dentified on 8/16/16 and ed 8/22/16, indicated the ne upper part of the spine was injury and the lower wound s unstageable PU. plan revised 8/26/16, identified breakdown and open area				

If continuation sheet Page 3 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO						
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3)	3) DATE SURVEY COMPLETED	
		245358	B. WING		09/22/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 LUELLA STREET		
HILLTOP	CARE CENTER			WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157 F 309 SS=D	least every 6 hours repositioning at night spine. A review of the nurs 9/6/16, identified 2 of area of skin breakd R18 was identified a repositioned during staff encouraged he in healing the spine During interview on registered nurse (R sores started as a r toilet for longer peri RN-D confirmed the on 8/15/16; howeve on 8/16/16, and the until 9/6/16. RN-D have been notified a 483.25 PROVIDE Of HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	ng order, turn and reposition at when sitting and every 2 hour nt due to skin breakdown to sing home rounds note dated closed areas and one open own on R18's spinal column. as quite resistant to being the night; however, nursing er to allow repositioning to aid 9/22/16, at 11:46 a.m. N)-D stated she thought the esult of R18 sitting on the ods of time due to sitz baths. e sitz baths were discontinued er, the PU's were first identified physician was not notified verified the physician should sooner. CARE/SERVICES FOR	F 15	RIDR	10/28/16	
	by: Based on observat	NT is not met as evidenced ion, interview and document iled to assess and monitor		Resident's 15 and 41 have daily monitoring of bruises documented in the	eir	

Facility ID: 00798

If continuation sheet Page 4 of 18

PRINTED: 11/04/2016

				FORM	APPROVEI . 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
	245358	B. WING		09/	22/2016
PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETIO DATE
significant bruising R60) reviewed for r problems and failed implement timely in for 1 of 1 resident (bunion wound. Findings include: R15 Current diagnosis li 7/12/16, for R15 ind pulmonary disease hypertension, deme fibrillation. The Min assessment dated Interview of Mental indicating no cognit On 9/19/16, at 3:53 have large bruises knees. R15 had ar indicated she has a elbow. It was noted of the wound. Whe explained, "those a just roll you over, th observation of R15 noted: The left arm a skin tear located was wrapped with a bruising which appe purple in color. This circumference of th extending to the are inches. The backsie	for 3 of 3 residents (R15, R41, non- pressure related skin d to assess, revise and treventions to promote healing R24) reviewed who had a isted on the care plan dated cluded chronic obstructive (COPD), hypothyroid, entia, obesity and atrial imum Data Set (MDS) 8/10/16, indicated R15's Brief Status (BIMS) score was 15, tive impairment. 6 p.m. R15 was observed to on both forearms, hands and m protectors donned and a skin tear located on the left t that a dressing covered a part n interviewed at this time, R15 re all from the hospital, they hey don't care." During further 's arms, the following was n had a Vaseline dressing over at the left elbow area, which a soft gauze. The arm had eared dark maroon to dark s bruising extended around the ie arm from the fingers ea above the elbow, 4.5 de (posterior) of the upper arm	F 30	9 electronic medical record. Resid discharged. Resident 24 has da monitoring of bunion wound in e medical record. Staff was provide education on daily monitoring of and non-pressure related wound when to notify physician. DON of designee will audit residents with and non-pressure related wound to ensure that daily documentation completed. The DON will prese Quality Assurance Committee th findings on bruise and non-press related wound documentation an Quality Assurance Committee wound to ensure that daily documentation and guality Assurance Committee wound	aily lectronic ded bruises ds and or n bruises ds weekly on is nt to the ne audit sure nd the ill	
,	S FOR MEDICARE OF DEFICIENCIES F CORRECTION CARE CENTER CARE CENTER COntinued From particulation Findings include: R15 Current diagnosis I 7/12/16, for R15 inception pulmonary disease hypertension, dement fibrillation. The Min assessment dated Interview of Mental indicating no cognit On 9/19/16, at 3:53 have large bruises knees. R15 had ar indicated she has ar elbow. It was noted of the wound. Whe explained, "those ar just roll you over, th observation of R15 noted: The left arm a skin tear located was wrapped with a bruising which apper purple in color. This circumference of th extending to the arm inches. The backsin had a rectangle sha 3.5 x 5 inches. Brui	DF CORRECTION IDENTIFICATION NUMBER: 245358 PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 significant bruising for 3 of 3 residents (R15, R41, R60) reviewed for non- pressure related skin problems and failed to assess, revise and implement timely interventions to promote healing for 1 of 1 resident (R24) reviewed who had a bunion wound. Findings include:	AS FOR MEDICARE & MEDICAID SERVICES (X2) MULTI OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: 245358 B. WING	SEFOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIERCIAL IDENTIFICATION NUMBER: (X2) MULTIFLE CONSTRUCTION A BUILDING 245358 B. WING CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 410 LUELLA STREET WATKINS, MN 55389 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRECENCE TAG D PRECENCE CARE CENTER Continued From page 4 significant bruising for 3 of 3 residents (R15, R41, R60) reviewed for non- pressure related skin problems and failed to assess, revise and implement timely interventions to promote healing tor 1 of 1 resident (R24) reviewed who had a bunion wound. F 309 R15 Current diagnosis listed on the care plan dated 712/16, for R15 included chronic obstructive pulmonary disease (COPD), hypothyroid, hyportension, dementia, obseity and trial tibrilation, The Minimum Data Set (MDS) assessment dated 81/016, indicated R155 Brief indicating no cognitive impairment. F 309 On 9/19/16, at 3:53 p.m. R15 was obserged to have large bruises on both forearms, hand e and head and no repressing over a skin tear located on the left observation of R15's and the forearms, hand e and hordicated she has a skin tear located on the left observation of R15's and the diary document and a was wrapped with a soft use. The value dark maroon to dark was wrapped with a soft to follow area, which was wrapped with a soft to follow area, which was wrapped with a soft use. The tarm had bruising which appeared dark maroon to dark was wrapped with a soft was noted on the tops of	St FOR MEDICARE & MEDICAID SERVICES OMB NO. OP DEFICIENCIES CORRECTION (X) PROVIDERSUPPLIERCLA BENING (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) AUX (X2) AUX

Facility ID: 00798

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	H AND HUMAN SERVICES			FORM	11/04/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	245358	B. WING		09/2	22/2016
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 hand, circumferei extended to abow The outer forearn wound, measurin appeared to be of a weepy base wa The surrounding was peeling. Review of the cur identified R15 at a decreased mobili present to right for skin tear to the le R15 bruises easil (blood thinner), o protective sleeve Documentation in hospitalized from sepsis and pneur dated 9/16/16, ide bruising to the bo knees, sides of b Documentation in Coumadin and as was discharged of Review of the adin 9/16/16, also ider bruising to both u knee, bruising to tear to the left elb measuring 7 cent length. Steri-strip were applied. 	which started at the top of the nees the arm at the wrist and e the elbow approx. 2 inches. In revealed an uncovered open g 1.5 x 2 inches. The wound bed ben and a ½ inch opening with s evident through the dermis. issue was very dry and the skin rent care plan dated 7/12/16, isk for skin breakdown due to by and incontinence; ulcer rearm from a hematoma and it elbow. Interventions indicated y, had been on Coumadin hy on aspirin now and to apply a daily. the record revealed R15 was 9/6/16-9/16/16 for treatment of nonia. The hospital transfer form entified that R15 had large dark dy; involving the arms, hands, reasts and abdomen. dicated R15 nad been on pirin prior to hospitalization but	F 309			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/04/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245358	B. WING _		09/	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(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) COMPLETION DATE
F 309	the hospital stay with upper extremities, f knee and bruising t She confirmed door to review related to and/or status of the R41 R41 had diagnoses dated 9/22/16, which Lewy body disease multiple falls. R41 r 9/16/16 with bruisin lower extremities; b bruising to dorsal hat to toes. On 9/20/16, at 10:4 have bruises on both arms, both wrists an were dark purplish in size. Interview with he was unsure of w bruises. The identiff both arms, wrists an hand revealed one second and third firr right hand there wa top of the wrist had sides of the wrist). bruises: 2 x 3 inche Located above the purple bruise. On t inch bruises and the measuring 3.5 x 4 i	 N)-A stated R15 returned from th bruising to bilateral (both) ading bruises on the right o dorsal (posterior) hands. Unentation was not available any ongoing assessment extensive bruising. according to the face sheet th included dementia with (2/8/16) and history of eturned from the hospital on g noted to bilateral upper and ruising faded to right knee, ands, purplish color from shins 8 a.m. R41 was observed to the elbows, top of both lower nd both hands. These bruises to maroon in color and varied th R41 at this time indicated then or how he obtained these ied bruises varied in size on nd hands. The top of the right bruise 1.5 inches between the nge. On the top surface of the s another 2 inch bruise. The a 3 inch bruise, (involving the The forearm had 3 more es, 1 x 1 inch and 2 x 3 inches. elbow was a 3 x 4 inch dark op of the left hand were two 1 e left forearm had 2 bruises 	F3			

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		AND HUMAN SERVICES				FORM	11/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245358	B. WING	i		09/:	22/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOF	CARE CENTER				110 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	months. The care p spouse brought in I wear to reduce the The care plan also sleeves have been removing them so t When interviewed of RN-B indicated she on the arms, wrists indicated R41 alwa on his arms and co been monitored on any other format. R seen any monitorin the facility. Interview with RN-E confirmed R41 freq and hands from fall staff have attempte protectors, but R41 confirmed staff had monitoring any of F deterioration. R60 It was observed on R60 had significant hands and arms ha bruises. The top of 1.5 inch bruises. Th bruises which invol- arm. Located abov bruise. The left arm and the forearm ha two 1.5 inch bruises purple to maroon in	age 7 blan intervention identified the ong sleeve shirts for R41 to risk of skin tears with falls. revealed that arm protector attempted but R41 kept they were discontinued. on 9/22/16, at 12:23 p.m. was aware of R41's bruises and hands. RN-B further ys has some kind of bruising nfirmed these bruises had not the treatment sheets nor in N-B confirmed she had never g for bruises while working at 0 on 9/21/16, at 12:27 p.m. uently has bruises on his arms s. She further indicated that d in the past to don sleeve removed them, RN-D not had a system for A1's bruises for healing and/or 9/19/16, at 11:49 a.m. that bruising on his arms. R60's d dark purple to maroon color his right hand revealed two he forearm had 4 x 4 inch we the circumference of the re the elbow was a 3 x 4 inch n revealed two 1 inch bruises d one 3 x 4 inch bruise and s. The bruises were all dark in color. Interview with R60 at he was unsure of how he got	F	309	RIP		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245358	B. WING	à		09/3	22/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				10 LUELLA STREET VATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	bruising. The quarter indicated R60 had a Status (BIMS) score impairment. Review of the R60 of 7/14/16, identified h	ge 8 has a history of easily erly assessment dated 7/7/16, a Brief Interview of Mental e of 15, indicating no cognitive current care plan dated him as having a potential for to the dying process and end	F	309	R		
	of life and decrease revealed diagnosis fibrillation, malignar anemia due to cher disease. Review of observations for Ju 2016 identified the	ed mobility. The care plan which included: atrial nt neoplasm of the lung, notherapy and chronic kidney	Ś		Sr.		
	RN-B stated that up a bruise and/or a st the nursing assistant alert is electronicall which subsequently treatment and/or m confirmed that mon	on 9/22/16, at 10:17 a.m. oon discovery of a new wound, kin tear, an alert is created by nt in the software system. The y sent to the charge nurse y triggers an assessment, onitoring program. RN-B itoring bruising to identify thealing would be a good					
	confirmed there wa significant bruising	9/22/16, at 10:10 a.m. RN-D s no system to monitor the on the arms of R60. RN-D s experienced bruising since 16.					
	director of Nursing	on 9/22/16, at 12:12 p.m. the (DON) confirmed there is not ited to monitor skin bruising.					

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		AND HUMAN SERVICES				FORM	11/04/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245358	B. WING	i		09/3	22/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	DON stated that if t condition of a woun the progress notes process for daily/we confirmed there is r of non-pressure rela During a subsequed 9/22/16, at 1:00 p.m picture of a monitor facility software and implement this syst assessing resident educated. Review of the facilit 5/2011, indicates sk treatments institute oversees each resid with the comprehen The facility staff rec and standard protor documentation and care or problems. R24 Review of R24's ad 7/28/16, identified ti cm open area to ca Scant weeping drai approximately 1 cm dressings were place protection at the tim The admission MDS identified a Brief Int (BIMS) score of 14 assistance of two s at risk for PU and th	ge 9 here was a change in di t would be documented in but there was no current eekly skin monitoring. She no policy to address monitoring ated wounds or bruises. Int interview with the DON on n. the DON presented a ring system to be set up in the d indicated she would em for monitoring and bruises after staff were by skin care policy dated kin problems are identified and d promptly. A registered nurse dents skin care in accordance sive assessment/care plan. eeive education on skin care col to assure accurate timely interventions for skin mission assessment dated hat H24 had a 0.2 cm by 0.2 illused area on left bunion; nage and bilateral bunion with a pinkness was present. Foam ced on both bunion for ne of admission, (7/28/16). S assessment dated 8/4/16, erview of Mental Status (intact cognition), extensive taff with bed mobility/transfers, ne presence of a lesion on the ed 8/4/16, included: no	F	309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/04/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245358	B. WING			09/2	22/2016
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				10 LUELLA STREET VATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 309	Continued From pa pressure ulcers, a s bunion and the care turn/repositioning se monitor skin. Review of the show R24 were as noted: (1) 8/1/16-small are (2) 8/5/16- open left (3) 8/12/16-bunion p (4) 8/19/16-open left The nurse progress included: open area with foam dressing; edges; no pressure infection symptoms with skin prep to wo visit" physician note identify the presence area. A fax sent to the ph p.m. identified: sma despite adding foan 0.5 cm by 0.5 cm.; a The fax was noted, faxed back to the fa The 8/19/16, wound open area as: mea moist area with 100 treatment was to co dressing every 3 da A nurses progress r	ge 10 scab to hammer toe and e plan indicated a chedule every 2 hours and er day worksheet audits for a to left bunion, bink, sore to left bunion and t bunion. a notes dated 8/19/16, a to left bunion despite padding red round with well-defined noted from shoes; no ; and foam dressing replaced bund edges. A "get acquainted e dated 8/10/16, did not be of a bunion nor any open ysician dated 8/19/16, at 4:38 Il open area to left bunion in padding to area; measured and continue foam dressing. signed by the physician and acility on 8/22/16, at 1:52 p.m. d observation tool identified the surement-0.5 cm by 0.5 cm 1% granulation tissue. The ontinue adhesive foam	1	309		RIATE	DATE
	measurements wer	e documented. The wound ted 8/25/16, identified: area					

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		AND HUMAN SERVICES				FORM	: 11/04/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245358	B. WING	i		09/;	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	P CARE CENTER				10 LUELLA STREET VATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	worsening, measur moist with 100% gr. A nurses note dated an appointment sch 8/31/16, but the app rescheduled for 9/8 well. The wound ob identified the area a granulation tissue a measuring 0.8 cm b treatment plan was changes 2 times pe identified worsened was noted to worse documentation date revisions and/or rea ensure healing occi During interview on stated the bunion w more she had thera She stated, "you an time and it hurt." R until 9/9/16. Docun indicate the plan of the offloading of the R24's regular shoe. Review of a podiatr identified a full thick foot bunion, approx ulceration was debr surgical shoe utilize for Bacitracin ointm foot, surgical shoe ulcer and return in a evaluation tool date	ed 0.5 cm by 0.5 cm, and anulation. d 8/31/16, indicated R24 had neduled with the podiatrist on pointment was canceled and 8/16 due to R24 not feeling bservation tool dated 9/1/16, as worsening with 50% and 50% slough tissue and by 1.3 cm. The current to continue foam dressing er week. The evaluation d sore. Although the wound en according to the ed 8/25/16 and 9/1/16, no assessments occurred to urred. 9/21/16, at 8:03 a.m. R24 vas not sore initially but the apy the more it started to hurt. e working your shoe all the 24 received physical therapy nentation was lacking to care was revised to address e foot to remove pressure from	F3	309	JEFICIENCY)		

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		AND HUMAN SERVICES				FORM	11/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245358	B. WING	i		09/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Bacitracin, gauze a A physician visit not ulceration on the bu 0.6 cm and pink arc observation tool da unchanged, 10 % g slough tissue and n cm and 0.1 cm dep identified as Bacitra A nursing progress p.m. identified the a being red, warm to macerated/non-blan pain to area with pa noted dated 9/17/16 increased drainage site. The dressing w with soaked throug identified at red and drainage. A nursing progress that R24 was receiv Cipro for a possible culture was pending day). A fax from the indicated to continu foot infection and a bunion was ordered Documentation on dated 9/21/16, iden slough tissue, 0.7 c infection suspected present. Treatment	em by 1.2 cm and treatment of nd kerlex daily change. te dated 9/14/16, identified the union as measuring 0.6 cm by bund the edge. The wound ted 9/16/16, identified: area granulation tissue and 90 % neasurements-0.9 cm by 0.9 th. Current treatment acin and gauze wrap daily. note dated 9/17/16, at 2:34 area on R24's left foot ulcer as touch , nch-able with R24 expressing alpation. Nursing progress 6, at 9:50 a.m. identified noted to left foot at bunion vas saturated with drainage gh R24's socks. The site was d warm to touch with purulent note dated 9/19/16, identified ving the antibiotic medication e urinary tract infection (a urine g, but no growth after one e physician dated 9/19/16, te Cipro which would cover the culture of the open area on	F	309			

Facility ID: 00798

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	FIPLE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245358	B. WING		09/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309 F 314 SS=D	twice daily on 9/16/ 9/17/16 and culture During interview on registered nurse (R R24 had an open a and the physician w by fax on 8/19/16. the fax on 8/22/16 w physician should ha area when identified "we just covered it w shoes didn't seem t pressure or anythin 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil	16; bunion became inflamed was obtained on 9/19/16. 9/22/16, at 12:21 p.m. N)-D verified the left bunion of rea when admitted (7/28/16) vas notified of the open area The physician responded to with "noted". RN-D verified the ave been notified of the open d on admission. She stated with a foam dressing; [R24's] ight like they were adding g." ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores	F 3			10/28/16
	individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores This REQUIREMEN by: Based on observat interview the facility appropriate treatment deterioration of press	ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing. NT is not met as evidenced tion, document review and failed to provide the ent to prevent further ssure ulcers for 1 of 1 (R18) with facility acquired pressure		Resident 18 had reassessment of sitting and lying assessments. Res 18 had OT evaluation to review positioning and make recommenda Resident 18's plan of care was upd Staff was provided education on pre ulcers and facility policy on treatme pressure ulcers. DON or designee	ident tions. ated. essure nt of	

Event ID: ZN4M11

Facility ID: 00798

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		AND HUMAN SERVICES				FORM	: 11/04/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245358	B. WING			09/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HILLTOP	CARE CENTER				IO LUELLA STREET /ATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	assessment dated Interview for Menta indicating severe co assistance of 2 staf and does not walk. (CAA) dated 7/25/1 risk for pressure uld identified, is turned and tolerates this p Progress notes data skin/problem areas and were described and measured 1.5 of middle area open m and (#3) bottom area cm by 1 cm. The a open to the air. A pri identified adhesive lower spine. Three identified with skin h has pinkness that is wound has 0.2 cm of the lower wound ha Wounds occurred w toilet during Sitz bar discontinued 8/15/1 During observation was lying supine (o R18 was resting in had a pillow position wedge under legs. the same position b than side.	num Data Set (MDS) 7/23/16, identified a Brief I Status (BIMS) score of 4 ognitive impairment, extensive if with transfers/bed mobility The Care Area Assessment 6, identified R18 as being at cers, no pressure ulcer (PU) a minimum of every 6 hours er assessment. ed 8/16/16, identified 3 located on the spine of R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 rea was cleansed and left rogress noted dated 8/22/16, foam dressing applied to bony prominence's were breakdown: (#1) upper wound as resolving, (#2) middle x 0.2 cm yellow scab and (#3) is 0.5 cm x 0.8 cm scab. with longer period of sitting on ths; Sitz baths were		314	audit residents with pressure ulcers weekly to ensure that assessments completed and facility policy is follo The DON will present to the Quality Assurance Committee the audit fin on pressure sores and the Quality Assurance Committee will determine continuing periodic auditing.	s are wed. / dings	

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		AND HUMAN SERVICES				FORM	: 11/04/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245358	B. WING	i		09/:	22/2016
NAME OF	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HILLTOP	CARE CENTER				I10 LUELLA STREET NATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	bathroom seated of hooked up. R18's I against the toilet se curved and kyphotik R18 was assisted fi into the wheel chair lambs wool over the observed seated in registered nurse (R wound treatment to (#1) was reddened middle area (#2) ha bottom (#3) open a R18 had a rolled ba back. RN-A stated from her back and implemented. At 1 the toilet hooked up back/spine was aga toilet seat cover uni- bed at approximate padding/protection hard surface. On 9/22/16, at 12:4 toilet, hooked up to appearing back/spi the toilet seat cover and put to bed at ap The wound observa described the probl as noted: upper wo tissue injury (a purp discolored intact sk damage of underlyi and/or shear) and t an Unstageable PL	ge 15 In the toilet with EZ stand back was resting/pressing that cover. R18's spine was c. At approximately 7:15 a.m. from the toilet and transferred which had a thin piece of the back. At 9:30 a.m. R18 was a recliner. At 10:20 a.m. N) A was observed doing a R18's spine. The top wound and did not appear open, the ad an open area and the rea was covered with slough. Ath blanket behind her lower this was to relieve pressure had just (9/20/16) been 26 p.m. R18 was observed on to EZ stand. R18's ain pressing up against the til she was assisted back to between the resident and the S p.m. R18 was seated on the EZ stand. R18's kyphotic ne remained pressed against r. R18 was taken off the toilet oproximately 12:55 p.m. ation tool dated 8/22/16, em areas on the spine of R18 bund (#1) as a suspected deep ble or maroon localized area of in or blood-filled blister due to ng soft tissue from pressure he lower spine wound (#3) as U (full thickness tissue loss in he ulcer is covered by slough		314			

Facility ID: 00798

If continuation sheet Page 16 of 18

		AND HUMAN SERVICES				FORM	: 11/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245358	B. WING	ì		09/	22/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HILLTOP	CARE CENTER				410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	(tan, brown or black Review of the care R18 at risk for skin present to bony pro Interventions includ treatment per nursi least every 6 hours repositioning at nigl spine. No reassess interventions revise A review of the nurs 9/6/16, identified 2 area of skin breakd identified as quite re during the night; ho encouraged her to a healing the spine. The wound observation identified the spine area (#3) as being tissue loss. Subcuta bone, tendon or mu- may be present but tissue loss. May in- tunneling). Docume physician was notifi- ulcers on 9/6/16. The wound observa- identified the upper being a Stage II PU- wound as a Stage II During interview on	plan revised 8/26/16, identified breakdown and open areas ominence's to back. led: air mattress on bed, ng order, turn and reposition at when sitting and every 2 hour ht due to skin breakdown to ments were conducted and/or ed after noted skin breakdown. sing home rounds note dated closed areas and one open lown on R18's spine. R18 was esistant to being repositioned wever, nursing staff allow repositioning to aid in ation tool for R18 dated 9/9/16, wound located on the lower a Stage III PU (Full thickness aneous fat may be visible but uscle are not exposed. Slough a does not obscure the depth of clude undermining and entation indicated the ied of the identified pressure ation tool dated 9/21/16, wound on the spine (#1) as J and the lower spine (#3) III PU. 9/22/16, at 12:43 p.m.	F	314			
		NA) A verified R18's back					

Facility ID: 00798

If continuation sheet Page 17 of 18

		AND HUMAN SERVICES				FORM	: 11/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245358	B. WING	à		09/2	22/2016
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				110 LUELLA STREET NATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	seat while seated o routinely sits for 5-1 position. During interview on registered nurse (R sores started from I longer periods of tir She stated the sitz 8/15/16, but she co baths were started. had been doing the discontinued them. areas were identifie put a foam dressing the lambs wool place implemented this w blanket behind back implemented on 9/1 didn't really think at and also confirmed spine were open ag (#1) was healed on re-opened. RN-D v to the open areas/b and resting against She verified R18 we back from the toilet had not been reass PU developed and	ge 17 does press against the toilet n the toilet. She stated she 0 minutes at a time in this 9/22/16, at 11:46 a.m. N)- D stated she thought the R18 sitting on the toilet for ne due to having sitz baths. baths were discontinued on uld not identify when the sitz She stated she thought they m maybe 2 weeks before they She verified the pressure ed on 8/16/16, and stated she gon right away. She stated ced on the wheel chair was reek and the rolled bath k in recliner had been 19/16. RN-D further stated 1 bout them being from pressure that all three areas on the gain. RN-D stated the top one Friday (9/16/16) but had verified R18 still had pressure ony prominence when toileted the seat due to her kyphosis. build have pressure on her ing and sitting. She stated R18 essed for positioning since the repositioning every 6 hours that as defined in the plan of	F	314			
	back from the toilet had not been reass PU developed and would not be adequ	ing and sitting. She stated R18 essed for positioning since the repositioning every 6 hours					

Facility ID: 00798

If continuation sheet Page 18 of 18



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

October 27, 2016

Mr. Fred Struzyk, Administrator Hilltop Care Center 410 Luella Street Watkins, MN 55389

Subject: Hilltop Care Center - Informal Dispute Resolution (IDR) for Licensing ordersProvider # 245358Project # S5358025

Dear Mr. Struzyk:

This is in response to your letter received on 10/11/16, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F329 where corresponding correction orders were issued pursuant to the survey completed on September 22, 2016.

The information presented with your letter, the CMS and State 2567s dated September 22, 2016, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

1540 - MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring

Refer to summary outlined in the MDH letter dated October 27, 2016, addressing the IDR for federal deficiencies.

This is not a valid correction order and will be removed from the 2567 State Form.

The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

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

Sincerely,

Sary gederhoff

Gary Nederhoff, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 507-206-2731 Fax: 507-206-2731 gary.nederhoff@state.mn.us

cc: Office of Ombudsman for Long-Term Care Maria King, APM, Assistant Program Manager Licensing and Certification File Gary Nederhoff, St. Cloud Team A District Office Unit Supervisor

S5358025ltr.

An equal opportunity employer.

Minnesc	ta Department of He	alth				(ITTOVED
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00798	B. WING		09/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	CARE CENTER	410 LUEL	LA STREET			
THELTOP	CARE CENTER	WATKINS	, MN 55389			
(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 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 correputsion of a survey found that the defice herein are not corrected shall with a schedule of a the Minnesota Deputsion of which a schedule of a the Minnesota Deputsion of the Minnesota Deputsion of the Minnesota Deputsion of the Minnesota Deputsion of the Number and MN Reputsion of the area of the area of the Minnesota Deputsion with any of lack of compliance. In the assession of the assession of the area of the assession of the area of the	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was hearing on any assessments in non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. TS: participate in the electronic insure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
Vinnesota D	epartment of Health		<u> </u>			()(0) D :==
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed		6899 7	7N////11	If continuatio	10/21/16

AME OF PROVIDER OR SUPPLIER IILLTOP CARE CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PRE REGULATORY OR LSC IDENTIFYING	STREET A 410 LUE WATKIN FICIENCIES CEDED BY FULL		CONSTRUCTION	COM	E SURVEY PLETED 22/2016
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2 000 Continued From page 1		2 000			
Department of Health orders be you electronically. Although no is necessary for State Statutes/ enter the word "corrected" in the text. You must then indicate in t State licensure process, under completion date, the date your of corrected prior to electronically Minnesota Department of Healt	plan of correction Rules, please e box available for he electronic the heading orders will be submitting to the		PR		
On September 19-22, 2016, su Department's staff, visited the a the following correction orders a Please indicate in your electron correction that you have review and identify the date when they	bove provider and are issued. ic plan of ed these orders,		st.		
Minnesota Department of Healt the State Licensing Correction federal software. Tag numbers assigned to Minnesota state sta Nursing Homes.	Orders using have been				
The assigned tag number apper column entitled "ID Prefix Tag." statute/rule out of compliance is "Summary Statement of Deficie and replaces the "To Comply" p correction order. This column a findings which are in violation o after the statement, "This Rule evidence by." Following the sum are the Suggested Method of C Time period for Correction.	The state listed in the ncies" column ortion of the lso includes the f the state statute is not met as veyors findings				
PLEASE DISREGARD THE HE FOURTH COLUMN WHICH ST "PROVIDER'S PLAN OF CORF APPLIES TO FEDERAL DEFIC THIS WILL APPEAR ON EACH	ATES, RECTION." THIS IENCIES ONLY.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00798	B. WING		09/22/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET S, MN 55389			
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2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
	"Revised STATE FO	DRM as a result of an Informa "				
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265		10/28/16	
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:		S.		
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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IILLTOP	CARE CENTER		LLA STREET S, MN 55389			
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2 265	Continued From pa	age 3	2 265			
	D. a decision resident from the n	to transfer or discharge the ursing home; or				
	E. expected ar	nd unexpected resident deaths		\mathbf{O}		
	by: Based on observat review the facility fa physician of the op bony prominence's	ent is not met as evidenced ion, interview and document ailed to immediately notify the en wounds located on the of the spine 1 of 1 residents o developed pressure ulcers.		Corrected		
	Findings include:					
	assessment dated Interview for Menta indicating severe c assistance of 2 sta and does not walk. (CAA) dated 7/25/1 risk for pressure ul ulcer present.	num Data Set (MDS) 7/23/16, identified a Brief al Status (BIMS) score of 4 ognitive impairment, extensive ff with transfers/bed mobility The Care Area Assessment 16, identified R18 as being at cers (PU) and no pressure				
	and were described and measured 1.5 middle area open r and (#3) bottom are	s located on the spine for R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 area was cleansed and left				
	adhesive foam dre spine; three bony p breakdown were:	dated 8/22/16, identified ssing was applied to the lower prominence's with skin (#1) upper wound on spine s resolving, (#2) middle				

STATEMENT OF DEPICIENCIES AND PLAN OF CONFECTION (21) MARCHARMERIA IDENTIFICATION NUMBERS IDENTIFICATION NUMBERS I	Minnesc	ota Department of He	ealth			FORM	APPROVED
NME OF PROVIDER OR SUPPLIE DOUGL DOUGL DOUGL MALE OF PROVIDER OR SUPPLIE STREET ADDRESS, CITY, STATE, ZIP CODE 10 LUELLA STREET MULTOP CARE CENTER SUMMARY STATEMENT OF DEPRIEMONS IP PREEN SUMMARY STATEMENT OF DEPRIEMONS IP SUMMARY STATEMENT OF DEPRIEMONS IP IP PREEN SUMMARY STATEMENT OF DEPRIEMONS IP SUMMARY STATEMENT OF DEPRIEMONS IP IP SUMMARY STATEMENT OF DEPRIEMONS IP IP SUMMARY STATEMENT OR LOS DENTIFYNS INFORMATION IP IP 2285 Continued From page 4 2285 285 2285 Continued From page 4 2285 285 2285 Continued From page 4 2285 285 010161 durin sitz banke N. DON	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
Interpreter Display Image: Note of the second			00798	B. WING		09/2	22/2016
HILLIOP CARE CENTER WATKINS, MN 55389 Image: Contract of the spine status of conservation in the spine status of conservation in the spine status of conservation in the spine status of conservation indicated on the spine measured 0.2 cm x Description Provide status of conservation is the spine measured 0.2 cm x Description is the spine status of conservation is the spine status of the spine spine status of the spine s	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
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Preprint TAG TAG (EACH DEPRICENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE EQUATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CONFIGURE DEPCIENCY) (EACH CORRECTIVE ACTION SHOULD BE DEPCIENCY) DEPCIENCY) (EACH CORRECTIVE ACTION SHOULD BE DEPCIENCY) DEPCIENCY) DEPCIEN	(X4) ID	SUMMARY ST		-	PROVIDER'S PLAN OF	CORRECTION	(X5)
 wound located on the spine measured 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on tollet during sitz baths; Sitz baths were discontinued 81/5/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filed bilser due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grav, green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician was notified of the identified PU on 9/6/16 even though it was first identified N0 and/16 even wound located on the upperpart of the spine was due to deep tissue injury and the lower wound was documented as uustapeable PU. Review of the care plan twised 8/26/16, identified R18 at risk for skin breakdown and open area present to bony promience's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spinal colum. 	PRÉFIX			PREFIX	CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLETE
 0.2 cm yellow scale and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scale. Wounds occurred with longer period of sitting on toilet during sitz baths; Sitz baths were discontinued 8/15/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled biliser due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician was due to deep tissue injury and the lower wound was documented as unstageable PU. Review of the care plan byised 8/22/16, identified R18 at risk for skin breakdown and open area present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spinal column. 	2 265	Continued From pa	age 4	2 265			
		 0.2 cm yellow scab located on the spin Wounds occurred w toilet during sitz ba discontinued 8/15/- indicated the dauge this time, no physic wound observation the problem areas upper wound-(#1) a (a purple or marood intact skin or blood underlying soft tiss shear) and the low PU (full thickness t the ulcer is covered green or brown) an black) in the wound Documentation ind notified of the ident though it was first i documentation dat wound located on t due to deep tissue was documented a Review of the care R18 at risk for skin present to bony pro Interventions includ treatment per nursi least every 6 hours repositioning at nig spine. A review of the nursi 	and (#3) the lower wound e has 0.5 cm x 0.8 cm scab. with longer period of sitting on ths; Sitz baths were 16. Although documentation neter was updated on wounds at cian notice was evident. The tool dated 8/22/16, described on the spine of R18 as noted: a suspected deep tissue injury n localized area of discolored -filled blister due to damage of ue from pressure and/or er wound (#3) an Unstageable issue loss in which the base of d by slough (yellow, tan, gray, id/or eschar (tan, brown or d bed. dicated the physician was tified PU on 9/6/16 even dentified on 8/16/16 and ed 8/22/16, indicated the the upper part of the spine was injury and the lower wound is unstageable PU. plan revised 8/26/16, identified breakdown and open area ominence's to back. ded: air mattress on bed, ing order, turn and reposition at is when sitting and every 2 hour ht due to skin breakdown to		RIDR		
		-		6899 7	ZN4M11	If continuat	tion sheet 5 of 21

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00798	B. WING		09/:	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET S, MN 55389			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
2 265	Continued From pa	age 5	2 265			
	repositioned during	as quite resistant to being the night; however, nursing er to allow repositioning to aid e.				
	registered nurse (F sores started as a toilet for longer per RN-D confirmed th on 8/15/16; howeve on 8/16/16, and the	9/22/16, at 11:46 a.m. N)-D stated she thought the result of R18 sitting on the iods of time due to sitz baths. e sitz baths were discontinued er, the PU's were first identified e physician was not notified verified the physician should sooner.		RIDK		
	DON or designee of policies and proced notified of changes accurately. The D all appropriate staff procedures. The D monitoring systems compliance.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp: 1 Adequate and re; General	2 830			10/28/10
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs	general. A resident must re and treatment, personal and supervision based on of preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a	Ŀ			

STATE FORM

ZN4M11

If continuation sheet 6 of 21

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00798	B. WING		09/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HILLTOF	CARE CENTER		LA STREET 6, MN 55389			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
		he attending physician that the ain in bed or the resident n bed.		0		
	by: Based on observat review the facility fa significant bruising R60) reviewed for r problems and failed implement timely in	ent is not met as evidenced ion, interview and document ailed to assess and monitor for 3 of 3 residents (R15, R41, non- pressure related skin d to assess, revise and nterventions to promote healing R24) reviewed who had a	- C	Corrected.		
	7/12/16, for R15 ind pulmonary disease hypertension, demo fibrillation. The Min	isted on the care plan dated cluded chronic obstructive (COPD), hypothyroid, entia, obesity and atrial imum Data Set (MDS) 8/10/16, indicated R15's Brief				
	Interview of Mental indicating no cognit On 9/19/16, at 3:53 have large bruises knees. R15 had ar indicated she has a elbow. It was noted of the wound. Whe explained, "those a just roll you over, th observation of R15	Status (BIMS) score was 15,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:			
		00798	B. WING		09/2	22/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET S, MN 55389			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 7	2 830			
	was wrapped with a bruising which apper purple in color. This circumference of the extending to the are inches. The backsid had a rectangle sha 3.5 x 5 inches. Brui both hands, coverin arm had bruising w hand, circumference extended to above The outer forearm wound, measuring appeared to be oper a weepy base was The surrounding tis was peeling. Review of the current identified R15 at rist decreased mobility present to right fore skin tear to the left R15 bruises easily, (blood thinner), only protective sleeve day Documentation in the hospitalized from 9 sepsis and pneumon dated 9/16/16, iden bruising to the body	at the left elbow area, which a soft gauze. The arm had eared dark maroon to dark s bruising extended around the earm from the fingers ea above the elbow, 4.5 de (posterior) of the upper arm aped bruise which measures sing was noted on the tops of ng the entire surface. The right hich started at the top of the ees the arm at the wrist and the elbow approx. 2 inches. revealed an uncovered open 1.5 x 2 inches. The wound bed en and a ½ inch opening with evident through the dermis. sue was very dry and the skin ent care plan dated 7/12/16, sk for skin breakdown due to and incontinence; ulcer earm from a hematoma and elbow. Interventions indicated had been on Coumadin y on aspirin now and to apply a aily. he record revealed R15 was /6/16-9/16/16 for treatment of onia. The hospital transfer form tified that R15 had large dark y; involving the arms, hands, asts and abdomen.		sh		
	Documentation ind Coumadin and asp was discharged on	icated R15 had been on irin prior to hospitalization but aspirin only.				
	Review of the admi	ssion assessment dated				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00798	B. WING		09/	22/2016
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • • •	
			LLA STREET			
ILLIOP	CARE CENTER	WATKIN	S, MN 55389			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	ige 8	2 830			
2 830	9/16/16, also identi bruising to both upp knee, bruising to do tear to the left elboy measuring 7 centin length. Steri-strips were applied. When interviewed of registered nurse (F the hospital stay wi upper extremities, f knee and bruising t She confirmed doc to review related to and/or status of the R41 R41 had diagnoses	fied that R15 had extensive ber extremities, faded to right orsal hands and a large skin w which was L shaped, neters and 3 centimeters in and a secondary dressing on 9/22/16, at 12:03 p.m. N)-A stated R15 returned from th bruising to bilateral (both) fading bruises on the right o dorsal (posterior) hands. umentation was not available any ongoing assessment e extensive bruising.		RIDR		
	Lewy body disease multiple falls. R41 r 9/16/16 with bruisin lower extremities; b	(2/8/16) and history of returned from the hospital on ng noted to bilateral upper and bruising faded to right knee, ands, purplish color from shins				
	have bruises on bo arms, both wrists a	8 a.m. R41 was observed to th elbows, top of both lower nd both hands. These bruises to maroon in color and varied				
	in size. Interview w he was unsure of w bruises. The identif both arms, wrists a	ith R41 at this time indicated then or how he obtained these ied bruises varied in size on nd hands. The top of the right				
	second and third fir right hand there wa top of the wrist had	bruise 1.5 inches between the nger. On the top surface of the is another 2 inch bruise. The a 3 inch bruise, (involving the The forearm had 3 more	•			

Minneso	ta Department of He	ealth			FORMAPPRO	JVEL
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET S, MN 55389			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE COMP HE APPROPRIATE DA	PLETE
2 830	Continued From pa	age 9	2 830			
	Located above the purple bruise. On t inch bruises and th measuring 3.5 x 4	es, 1 x 1 inch and 2 x 3 inches elbow was a 3 x 4 inch dark top of the left hand were two 1 e left forearm had 2 bruises inches. ent care plan 9/4/16, identified		S		
	R41 had experience months. The care p spouse brought in wear to reduce the The care plan also sleeves have been	ed 12 falls in the last 3 blan intervention identified the long sleeve shirts for R41 to risk of skin tears with falls. revealed that arm protector attempted but R41 kept they were discontinued.		SPID.		
	RN-B indicated she on the arms, wrists indicated R41 alwa on his arms and co been monitored on any other format. F	on 9/22/16, at 12:23 p.m. e was aware of R41's bruises and hands. RN-B further ys has some kind of bruising onfirmed these bruises had not the treatment sheets nor in RN-B confirmed she had never g for bruises while working at				
	confirmed R41 free and hands from fal staff have attempte protectors, but R41 confirmed staff had	D on 9/21/16, at 12:27 p.m. quently has bruises on his arms ls. She further indicated that ed in the past to don sleeve removed them. RN-D a not had a system for R41's bruises for healing and/or				
	R60 had significant hands and arms ha bruises. The top of 1.5 inch bruises. Th	9/19/16, at 11:49 a.m. that t bruising on his arms. R60's ad dark purple to maroon color his right hand revealed two he forearm had 4 x 4 inch				
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Minnesota	a Department of He	ealth			FORM APPROVI
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00798	B. WING		09/22/2016
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
HILLTOP (CARE CENTER		LLA STREET S, MN 55389		
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLET HE APPROPRIATE DATE
2 830	Continued From pa	age 10	2 830		
	arm. Located above bruise. The left arr and the forearm hat two 1.5 inch bruise purple to maroon in the time indicated h them but shared he bruising. The quart indicated R60 had Status (BIMS) scor impairment. Review of the R60 7/14/16, identified h skin alteration due of life and decrease revealed diagnosis fibrillation, malignal anemia due to che disease. Review of observations for Ju 2016 identified the related to the signif arms. During an interview RN-B stated that up a bruise and/or a si the nursing assista alert is electronical which subsequently treatment and/or m confirmed that mor deterioration and/o idea.	ved the circumference of the ve the elbow was a 3 x 4 inch n revealed two 1 inch bruises id one 3 x 4 inch bruises and s. The bruises were all dark n color. Interview with R60 at he was unsure of how he got e has a history of easily erly assessment dated 7/7/16, a Brief Interview of Mental e of 15, indicating no cognitive current care plan dated him as having a potential for to the dying process and end ed mobility. The care plan which included: atrial nt neoplasm of the lung, motherapy and chronic kidney, the bath audit skin ly, August, and September re was no documentation icant bruising evident on R60's on 9/22/16, at 10:17 a.m. bon discovery of a new wound, kin tear, an alert is created by nt in the software system. The ly sent to the charge nurse y triggers an assessment, ionitoring program. RN-B hitoring bruising to identify r healing would be a good		R	
:	significant bruising	is no system to monitor the on the arms of R60. RN-D			
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	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00798	B. WING		09/	22/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET			
			S, MN 55389			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	stated that R60 has admission on 3/16/	s experienced bruising since 16.				
	director of Nursing a system implement DON stated that if it condition of a wour the progress notes process for daily/we confirmed there is a	on 9/22/16, at 12:12 p.m. the (DON) confirmed there is not need to monitor skin bruising. there was a change in nd it would be documented in but there was no current eekly skin monitoring. She no policy to address monitoring ated wounds or bruises.		RIDR		
	9/22/16, at 1:00 p.r picture of a monitor facility software and implement this syst	nt interview with the DON on n. the DON presented a ring system to be set up in the d indicated she would tem for monitoring and bruises after staff were				
	5/2011, indicates sl treatments institute oversees each resi with the comprehen The facility staff rec and standard proto	ty skin care policy dated kin problems are identified and id promptly. A registered nurse dents skin care in accordance nsive assessment/care plan. ceive education on skin care col to assure accurate I timely interventions for skin				
	Review of R24's ac 7/28/16, identified t cm open area to ca Scant weeping drai approximately 1 cm dressings were pla	Imission assessment dated hat R24 had a 0.2 cm by 0.2 allused area on left bunion; inage and bilateral bunion with n pinkness was present. Foam ced on both bunion for ne of admission, (7/28/16).				
		S assessment dated 8/4/16,				
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 830	Continued From pa	age 12	2 830			
	(BIMS) score of 14 assistance of two s at risk for PU and t foot. The CAA date pressure ulcers, a s bunion and the care	terview of Mental Status (intact cognition), extensive taff with bed mobility/transfers he presence of a lesion on the ed 8/4/16, included: no scab to hammer toe and e plan indicated a chedule every 2 hours and		pr		
	R24 were as noted (1) 8/1/16-small are (2) 8/5/16- open lef (3) 8/12/16-bunion (4) 8/19/16-open le The nurse progress included: open area with foam dressing edges; no pressure infection symptoms with skin prep to we visit" physician not identify the presend area. A fax sent to the ph p.m. identified: sma despite adding foar 0.5 cm by 0.5 cm.; The fax was noted, faxed back to the fa The 8/19/16, wound open area as: mea moist area with 100	ea to left bunion, t bunion, pink, sore to left bunion and ft bunion. s notes dated 8/19/16, a to left bunion despite padding ; red round with well-defined e noted from shoes; no s; and foam dressing replaced bund edges. A "get acquainted e dated 8/10/16, did not be of a bunion nor any open hysician dated 8/19/16, at 4:38 all open area to left bunion m padding to area; measured and continue foam dressing. signed by the physician and acility on 8/22/16, at 1:52 p.m. d observation tool identified the asurement-0.5 cm by 0.5 cm 0% granulation tissue. The bontinue adhesive foam		5		
		note dated 8/25/16, identified: replaced to left bunion; an				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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HILLTOP	PCARE CENTER		LLA STREET			
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2 830	Continued From pa	age 13	2 830			
	total of two open ar measurements wer observation tool da worsening, measur moist with 100% gr A nurses note date an appointment scl 8/31/16, but the ap rescheduled for 9/8 well. The wound of identified the area a granulation tissue a measuring 0.8 cm treatment plan was changes 2 times pe identified worsened was noted to worse documentation date revisions and/or rea ensure healing occ During interview on stated the bunion w more she had thera She stated, "you ar time and it hurt." Fu until 9/9/16. Docur indicate the plan of the offloading of the R24's regular shoe Review of a podiatu identified a full thick foot bunion, approx- ulceration was deb	d 8/31/16, indicated R24 had heduled with the podiatrist on pointment was canceled and 8/16 due to R24 not feeling bservation tool dated 9/1/16, as worsening with 50% and 50% slough tissue and by 1.3 cm. The current is to continue foam dressing er week. The evaluation d sore. Although the wound en according to the ed 8/25/16 and 9/1/16, no assessments occurred to surred. n 9/21/16, at 8:03 a.m. R24 vas not sore initially but the apy the more it started to hurt. re working your shoe all the 8/24 received physical therapy mentation was lacking to care was revised to address e foot to remove pressure from		R		

ID PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURV COMPLETED	
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	00798	B. WING		09/22/20	16
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
LLTOP CARE CENTER		LLA STREET S, MN 55389			
REFIX (EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM HE APPROPRIATE	(X5) MPLET DATE
2 830 Continued From page	14	2 830			
A physician visit note d ulceration on the bunio 0.6 cm and pink around observation tool dated unchanged, 10 % gran	/9/16, identified: 75 % % slough tissue, by 1.2 cm and treatment of kerlex daily change. ated 9/14/16, identified the n as measuring 0.6 cm by d the edge. The wound 9/16/16, identified: area ulation tissue and 90 % surements-0.9 cm by 0.9 Current treatment	,	RIDR		
p.m. identified the area being red, warm to tour macerated/non-blanch pain to area with palpa noted dated 9/17/16, a increased drainage not site. The dressing was with soaked through F identified at red and wa drainage.	-able with R24 expressing tion. Nursing progress t 9:50 a.m. identified ted to left foot at bunion saturated with drainage R24's socks. The site was arm to touch with purulent				
that R24 was receiving Cipro for a possible uri culture was pending, b day). A fax from the ph indicated to continue C					
dated 9/21/16, identifie	I's wound evaluation tool d: area worsening, 100 % by 0.8 cm by 0.9 cm depth, d purulent drainage				

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IILLTOP	CARE CENTER		LLA STREET S, MN 55389			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	and kerlex, started twice daily on 9/16/ 9/17/16 and culture During interview on registered nurse (F R24 had an open a and the physician v by fax on 8/19/16. the fax on 8/22/16 v physician should ha area when identifie "we just covered it shoes didn't seem pressure or anythin SUGGESTED MET The director of nurs educate all licensed non-pressure skin of skin conditions pre- admission to the fa	THOD OF CORRECTION: sing, or designee, could d staff on the need to monitor conditions and/or non-pressure sent on residents upon ucility. The director of nursing udit to monitor staff		RIDR		
2 900	(21) days. MN Rule 4658.052	R CORRECTION: Twenty One 5 Subp. 3 Rehab - Pressure	2 900			10/28/10
	comprehensive res of nursing services	sores. Based on the sident assessment, the director must coordinate the nursing care plan which				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET			
			S, MN 55389			1
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 16	2 900			
	pressure sores unle condition demonstr authenticates, that B. a resident w receives necessar	ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores y treatment and services to revent infection, and prevent veloping.		R		
	by: Based on observat interview the facility appropriate treatme deterioration of pre	ent is not met as evidenced ion, document review and y failed to provide the ent to prevent further ssure ulcers for 1 of 1 (R18) with facility acquired pressure		Corrected.		
	R18's annual Minin assessment dated Interview for Menta indicating severe co assistance of 2 sta and does not walk. (CAA) dated 7/25/1 risk for pressure ul	num Data Set (MDS) 7/23/16, identified a Brief al Status (BIMS) score of 4 ognitive impairment, extensive ff with transfers/bed mobility The Care Area Assessment 6, identified R18 as being at cers, no pressure ulcer (PU) a minimum of every 6 hours per assessment.				
	skin/problem areas and were described and measured 1.5 middle area open r and (#3) bottom are	ed 8/16/16, identified 3 b located on the spine of R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 area was cleansed and left				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	CARE CENTER	410 LUE	LLA STREET			
	CARE CENTER	WATKIN	S, MN 55389			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 17	2 900			
	identified adhesive lower spine. Three identified with skin has pinkness that is wound has 0.2 cm the lower wound ha Wounds occurred w	rogress noted dated 8/22/16, foam dressing applied to e bony prominence's were breakdown: (#1) upper wound s resolving, (#2) middle x 0.2 cm yellow scab and (#3) as 0.5 cm x 0.8 cm scab. with longer period of sitting on ths; Sitz baths were 16.				
	was lying supine (o R18 was resting in had a pillow positio wedge under legs.	on 9/20/16, at 2:07 p.m. R18 on back) in bed. At 2:37 p.m. bed facing the window. R18 oned behind her back and a At 3:31 p.m. she remained in but lying more on her back		5		
	bathroom seated o hooked up. R18's against the toilet se curved and kyphoti R18 was assisted f into the wheel chair lambs wool over th observed seated in registered nurse (F	a.m. R18 was observed in the n the toilet with EZ stand back was resting/pressing eat cover. R18's spine was c. At approximately 7:15 a.m. from the toilet and transferred r which had a thin piece of e back. At 9:30 a.m. R18 was a recliner. At 10:20 a.m. RN) A was observed doing a p R18's spine. The top wound				
	(#1) was reddened middle area (#2) ha bottom (#3) open a R18 had a rolled ba back. RN-A stated from her back and implemented. At 1 the toilet hooked up	and did not appear open, the ad an open area and the area was covered with slough. ath blanket behind her lower this was to relieve pressure had just (9/20/16) been :26 p.m. R18 was observed or o to EZ stand. R18's ain pressing up against the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HILLTOP	CARE CENTER		LLA STREET S, MN 55389				
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 18	2 900				
		ely 1:36 p.m. There was no between the resident and the					
	toilet, hooked up to appearing back/spi the toilet seat cover	3 p.m. R18 was seated on the EZ stand. R18's kyphotic ne remained pressed against r. R18 was taken off the toilet pproximately 12:55 p.m.		PR			
	described the probl as noted: upper we tissue injury (a purp discolored intact sk damage of underlyi and/or shear) and t an Unstageable PL which the base of the (yellow, tan, gray, g	ation tool dated 8/22/16, lem areas on the spine of R18 bund (#1) as a suspected deep ole or maroon localized area of in or blood-filled blister due to ing soft tissue from pressure he lower spine wound (#3) as J (full thickness tissue loss in he ulcer is covered by slough preen or brown) and/or eschar k) in the wound bed		\$			
	Review of the care R18 at risk for skin present to bony pro Interventions incluo treatment per nursi least every 6 hours repositioning at nig spine. No reassess	plan revised 8/26/16, identified breakdown and open areas ominence's to back. led: air mattress on bed, ng order, turn and reposition a when sitting and every 2 hour ht due to skin breakdown to ments were conducted and/or ed after noted skin breakdown.	t				
	9/6/16, identified 2 area of skin breakd identified as quite r during the night; ho	sing home rounds note dated closed areas and one open lown on R18's spine. R18 was esistant to being repositioned wever, nursing staff allow repositioning to aid in	\$				

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NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
HILLTOF	CARE CENTER		LLA STREET S, MN 55389				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLET DATE	
2 900	Continued From pa	age 19	2 900				
2 900	identified the spine area (#3) as being tissue loss. Subcut bone, tendon or mu may be present but tissue loss. May in tunneling). Docum physician was notif ulcers on 9/6/16.	ation tool for R18 dated 9/9/16, wound located on the lower a Stage III PU (Full thickness aneous fat may be visible but uscle are not exposed. Slough t does not obscure the depth o clude undermining and entation indicated the ied of the identified pressure		2108			
	identified the upper	ation tool dated 9/21/16, r wound on the spine (#1) as J and the lower spine (#3) III PU.	4)r			
	nursing assistant ([bony prominence] seat while seated o	n 9/22/16, at 12:43 p.m. NA) A verified R18's back does press against the toilet on the toilet. She stated she 10 minutes at a time in this					
	registered nurse (F sores started from longer periods of the She stated the sitz 8/15/16, but she co baths were started.	n 9/22/16, at 11:46 a.m. RN)- D stated she thought the R18 sitting on the toilet for me due to having sitz baths. baths were discontinued on build not identify when the sitz . She stated she thought they em maybe 2 weeks before they	,				
	discontinued them. areas were identified put a foam dressing the lambs wool place implemented this we blanket behind bac	She verified the pressure ed on 8/16/16, and stated she g on right away. She stated ced on the wheel chair was veek and the rolled bath k in recliner had been 19/16. RN-D further stated I					
nnesota D	didn't really think at	bout them being from pressure that all three areas on the					

Minnesc	ta Department of He	alth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00798	B. WING		09/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HILLTOP	CARE CENTER		LA STREET , MN 55389			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	spine were open ag (#1) was healed on re-opened. RN-D w to the open areas/b and resting against She verified R18 we back from the toilet had not been reass PU developed and would not be adequicare. SUGGESTED MET The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could cord delivery of care; to a services are implent pressure ulcer developed	gain. RN-D stated the top one Friday (9/16/16) but had verified R18 still had pressure ony prominence when toileted the seat due to her kyphosis. ould have pressure on her ing and sitting. She stated R18 essed for positioning since the repositioning every 6 hours late as defined in the plan of THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure he necessary to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 900			
Minnesota D	epartment of Health					

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
	MEDIC	ARE/MEDICAII	D CERTIFI	CATION A	N AND TRANSMITTAL ID: ZN4M			
	PART I -	TO BE COMPL	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00798		
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245358	R	3. NAME AND AD (L3) HILLTOP C				 TYPE OF ACTION: <u>7</u>(L8) Initial Recertification 		
2. STATE VENDOR OR MEDICAID N (L2) 764975000	0.	(L4) 410 LUELLA STREET (L5) WATKINS, MN		(L6) 55389	3. Termination4. CHOW5. Validation6. Complaint			
5. EFFECTIVE DATE CHANGE OF OV (L9) 05/01/2002	WNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
	/2016 (L34)	02 SNF/NF/Dual 06 PRTF 10 NF			14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):		Program Re Compliance			2. Technical Personnel			
		-			3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director		
12.Total Facility Beds	50 (L18)	1. A0	cceptable POC			· <u> </u>		
13.Total Certified Beds	50 (L17)	X B. Not in Com	pliance with Pro	gram	5. Life Safety Code	9. Beds/Room		
		Requirements	and/or Applied	Waivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOW					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
50	(1.20)	(T 42)	(1.42)					
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Connie Brady, HFE	ENE II	1	0/24/2016	(L19)	Kamala Fiske-Downing, Enforcement Specialist 10/27/2016 (L20)			
PAR	Г II - ТО BE	COMPLETED F	BY HCFA R	EGIONAI	OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILIT	Ϋ́		IPLIANCE WIT	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
 Facility is Eligible to Par 	ticipate	RIGH	ITS ACT:					
2. Facility is not Eligible	(7.2.1)							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	(L30)		
OF PARTICIPATION	BEGINNINC	DATE	ENDING DA	TE	<u>VOLUNTARY</u> 00	<u>0</u> <u>INVOLUNTARY</u>		
10/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · · · · · · · · · · · · · · · ·		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Plovidel Status Change		
(L27)	B Rescind Si	uspension Date:	(L44)			00-Active		
	Di Resenia si	opension Duter	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		00140						
	(L28)			(L31)				
	· ·							
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVA	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 7, 2016

Mr. Fred Struzyk, Administrator Hilltop Care Center 410 Luella Street Watkins, MN 55389

RE: Project Number S5358025

Dear Mr. Struzyk:

On September 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>Electronic 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 Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: <u>Kathryn.serie@state.mn.us</u> 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 November 1, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY
		245358	B. WING			09/	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HILLTOP	CARE CENTER				10 LUELLA STREET /ATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	000			
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.					
F 157 SS=D	revisit of your facilit validate that substa		F 1	157			10/28/16
	consult with the resknown, notify the resort an interested fan accident involving trinjury and has the printervention; a signiphysical, mental, or deterioration in heat status in either life trinical complication significantly (i.e., a existing form of treat consequences, or treatment); or a deet the resident from the §483.12(a).	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in					
	and, if known, the r or interested family change in room or	esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in					
	director's or provid	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 10/21/2016

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

PRINTED: 10/24/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED	
		245358	B. WING		09/	09/22/2016	
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		22/2010	
IILLTOF	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 157	regulations as spect this section. The facility must re the address and ph legal representative This REQUIREMED by: Based on observat review the facility fa physician of the opt bony prominence's (R18) reviewed who Findings include: R18's annual Minim assessment dated Interview for Menta indicating severe co assistance of 2 stat and does not walk. (CAA) dated 7/25/1 risk for pressure uld ulcer present. Progress notes dat skin/problem areas and were described and measured 1.5 middle area open n and (#3) bottom area	ge 1 er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced tion, interview and document illed to immediately notify the en wounds located on the of the spine 1 of 1 resident o developed pressure ulcers. NUT Data Set (MDS) 7/23/16, identified a Brief I Status (BIMS) score of 4 ognitive impairment, extensive f with transfers/bed mobility The Care Area Assessment 6, identified R18 as being at cers (PU) and no pressure ed 8/16/16, identified 3 located on the spine for R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 rea was cleansed and left	F 15	7 Resident 18's physician was 9/6/16 regarding pressure ulc Physician is updated on woun on rounds and if wound show progress in 2 weeks or if wou deteriorates. Staff was provic education on wounds and to r physician upon discovery of a DON or designee will audit re- pressure ulcers to ensure the notified upon discovery and a The DON will present to the C Assurance Committee the aud on physician notification and t Assurance Committee will def continuing periodic auditing.	ers. d progress s no nd led notify the wound. sidents with physician is s needed. Quality dit findings he Quality		

If continuation sheet Page 2 of 20

	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL	(X3) DATE SURVEY COMPLETED	
245358 B. WING 09/2	2/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP CARE CENTER 410 LUELLA STREET WATKINS, MN 55389		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX(EACH CORRECTIVE ACTION SHOULD BE TAGTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
 F 157 Continued From page 2 adhesive foam dressing was applied to the lower spine; three bony prominence's with skin breakdown were: (#1) upper wound on spine has pinkness that is resolving, (#2) middle wound located on the spine measured 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during sitz baths; Sitz baths were discontinued 8/15/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or marcon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician mas notified of the identified PU on 9/6/16 even though it was first identified on 8/16/16 and documentation dated 8/22/16, indicated the wound located on the upper part of the spine was due to deep tissue injury and the lower wound was documented as unstageable PU. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open area present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour 		

Facility ID: 00798

If continuation sheet Page 3 of 20

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/24/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245358	B. WING			09/22/2016		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HILLTOP	CARE CENTER		410 LUELLA STREET WATKINS, MN 55389					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 157	Continued From pa spine.	ge 3	F 1	57				
F 309 SS=D	9/6/16, identified 2 of area of skin breakd R18 was identified a repositioned during staff encouraged he in healing the spine During interview on registered nurse (R sores started as a r toilet for longer peri RN-D confirmed the on 8/15/16; howeve on 8/16/16, and the until 9/6/16. RN-D have been notified a 483.25 PROVIDE Of HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	9/22/16, at 11:46 a.m. N)-D stated she thought the esult of R18 sitting on the ods of time due to sitz baths. e sitz baths were discontinued er, the PU's were first identified physician was not notified verified the physician should sooner. CARE/SERVICES FOR	F 3	809			10/28/16	
	by: Based on observat review the facility fa significant bruising R60) reviewed for n	NT is not met as evidenced ion, interview and document iled to assess and monitor for 3 of 3 residents (R15, R41, ion- pressure related skin I to assess, revise and			Resident's 15 and 41 have daily monitoring of bruises documented in electronic medical record. Resident discharged. Resident 24 has daily monitoring of bunion wound in elect	t 60		

Facility ID: 00798

If continuation sheet Page 4 of 20

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
IND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPLETED	
		245358	B. WING	09/22/2016		
NAME OF F	PROVIDER OR SUPPLIER		S			
HILLTOP	CARE CENTER		2			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	
F 309	Continued From pa	age 4	F 309	,		
	for 1 of 1 resident (bunion wound. Findings include: R15 Current diagnosis li 7/12/16, for R15 ind pulmonary disease hypertension, deme fibrillation. The Min assessment dated Interview of Mental indicating no cognit On 9/19/16, at 3:53	p.m. R15 was observed to		medical record. Staff was provide education on daily monitoring of k and non-pressure related wounds when to notify physician. DON or designee will audit residents with and non-pressure related wounds to ensure that daily documentatio completed. The DON will presen Quality Assurance Committee the findings on bruise and non-press related wound documentation and Quality Assurance Committee will determine continuing periodic aud	bruises bruises weekly n is t to the audit ure d the	
	knees. R15 had ar indicated she has a elbow. It was noted of the wound. Whe explained, "those a just roll you over, th observation of R15 noted: The left arm a skin tear located was wrapped with a bruising which appe purple in color. This circumference of th extending to the ard inches. The backsin had a rectangle sha 3.5 x 5 inches. Brui	on both forearms, hands and im protectors donned and a skin tear located on the left I that a dressing covered a part in interviewed at this time, R15 ire all from the hospital, they ney don't care." During further 's arms, the following was in had a Vaseline dressing over at the left elbow area, which a soft gauze. The arm had eared dark maroon to dark is bruising extended around the ne arm from the fingers ea above the elbow, 4.5 de (posterior) of the upper arm aped bruise which measures ising was noted on the tops of ng the entire surface. The right				

If continuation sheet Page 5 of 20

		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED			
		245358	B. WING			09/22/2016			
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
HILLTOF	CARE CENTER		410 LUELLA STREET WATKINS, MN 55389						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 309	The outer forearm r wound, measuring appeared to be operative a weepy base was The surrounding tis was peeling. Review of the curre- identified R15 at ris decreased mobility present to right fore- skin tear to the left R15 bruises easily, (blood thinner), only protective sleeve da Documentation in th hospitalized from 9/ sepsis and pneumod dated 9/16/16, iden bruising to the body knees, sides of brea- Documentation indi Coumadin and aspi was discharged on Review of the admi 9/16/16, also identifi bruising to both upp knee, bruising to do tear to the left elbow measuring 7 centirr length. Steri-strips were applied. When interviewed or registered nurse (R the hospital stay with	revealed an uncovered open 1.5 x 2 inches. The wound bed en and a ½ inch opening with evident through the dermis. usue was very dry and the skin ent care plan dated 7/12/16, k for skin breakdown due to and incontinence; ulcer earm from a hematoma and elbow. Interventions indicated had been on Coumadin y on aspirin now and to apply a aily. he record revealed R15 was /6/16-9/16/16 for treatment of pnia. The hospital transfer form tified that R15 had large dark y; involving the arms, hands, asts and abdomen. icated R15 had been on irin prior to hospitalization but	F	309					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245358	B. WING	i		09/22/2016	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				I10 LUELLA STREET NATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	She confirmed doct to review related to and/or status of the R41 R41 had diagnoses dated 9/22/16, which Lewy body disease multiple falls. R41 r 9/16/16 with bruisin lower extremities; b bruising to dorsal hat to toes. On 9/20/16, at 10:4 have bruises on bot arms, both wrists at were dark purplish in size. Interview with he was unsure of w bruises. The identiff both arms, wrists at hand revealed one second and third fir right hand there wa top of the wrist had sides of the wrist). bruises: 2 x 3 inche Located above the purple bruise. On t inch bruises and the measuring 3.5 x 4 i Review of the curre R41 had experience months. The care p spouse brought in la	 o dorsal (posterior) hands. umentation was not available any ongoing assessment extensive bruising. according to the face sheet th included dementia with (2/8/16) and history of eturned from the hospital on g noted to bilateral upper and ruising faded to right knee, ands, purplish color from shins 8 a.m. R41 was observed to th elbows, top of both lower nd both hands. These bruises to maroon in color and varied th R41 at this time indicated then or how he obtained these ied bruises varied in size on nd hands. The top of the right bruise 1.5 inches between the nger. On the top surface of the s another 2 inch bruise. The a 3 inch bruise, (involving the The forearm had 3 more es, 1 x 1 inch and 2 x 3 inches. elbow was a 3 x 4 inch dark op of the left hand were two 1 e left forearm had 2 bruises 	F	309			

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245358	B. WING			09/22/2016			
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
HILLTOP	CARE CENTER		410 LUELLA STREET WATKINS, MN 55389						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 309	The care plan also sleeves have been removing them so t When interviewed of RN-B indicated she on the arms, wrists indicated R41 alway on his arms and co been monitored on any other format. R seen any monitoring the facility. Interview with RN-E confirmed R41 freq and hands from fall staff have attempte protectors, but R41 confirmed staff had monitoring any of R deterioration. R60 It was observed on R60 had significant hands and arms ha bruises. The top of 1.5 inch bruises. Th bruises which involu arm. Located abov bruise. The left arm and the forearm ha two 1.5 inch bruises purple to maroon in the time indicated h them but shared he bruising. The quarter	age 7 revealed that arm protector attempted but R41 kept they were discontinued. on 9/22/16, at 12:23 p.m. was aware of R41's bruises and hands. RN-B further ys has some kind of bruising nfirmed these bruises had not the treatment sheets nor in N-B confirmed she had never g for bruises while working at 0 on 9/21/16, at 12:27 p.m. uently has bruises on his arms s. She further indicated that d in the past to don sleeve removed them. RN-D not had a system for R41's bruises for healing and/or 9/19/16, at 11:49 a.m. that bruising on his arms. R60's d dark purple to maroon color his right hand revealed two he forearm had 4 x 4 inch ved the circumference of the re the elbow was a 3 x 4 inch n revealed two 1 inch bruises d one 3 x 4 inch bruise and s. The bruises were all dark n color. Interview with R60 at he was unsure of how he got thas a history of easily erly assessment dated 7/7/16, a Brief Interview of Mental	F	309					

Facility ID: 00798

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/24/2016 APPROVED 0938-0391			
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245358	B. WING		09/2	22/2016			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
HILLTOP	CARE CENTER		410 LUELLA STREET WATKINS, MN 55389						
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 309	Status (BIMS) scorr impairment. Review of the R60 7/14/16, identified h skin alteration due for of life and decrease revealed diagnosis fibrillation, malignar anemia due to cher disease. Review of observations for Ju 2016 identified the related to the signif arms. During an interview RN-B stated that up a bruise and/or a sh the nursing assistant alert is electronicall which subsequently treatment and/or m confirmed that mon deterioration and/or idea. During an interview confirmed there wa significant bruising stated that R60 has admission on 3/16/ When interviewed of director of Nursing a system implement DON stated that if to condition of a wour	current care plan dated him as having a potential for to the dying process and end ed mobility. The care plan which included: atrial nt neoplasm of the lung, motherapy and chronic kidney the bath audit skin ly, August, and September re was no documentation ficant bruising evident on R60's on 9/22/16, at 10:17 a.m. pon discovery of a new wound, kin tear, an alert is created by nt in the software system. The ly sent to the charge nurse y triggers an assessment, ionitoring program. RN-B hitoring bruising to identify r healing would be a good	F 309						

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245358	B. WING	i		09/:	22/2016
NAME OF I	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				110 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	confirmed there is r of non-pressure rel During a subseque 9/22/16, at 1:00 p.n picture of a monitor facility software and implement this syst assessing resident educated. Review of the facilit 5/2011, indicates sk treatments institute oversees each resi with the compreher The facility staff red and standard proto documentation and care or problems. R24 Review of R24's ad 7/28/16, identified t cm open area to ca Scant weeping drai approximately 1 cm dressings were plac protection at the tim The admission MD2 identified a Brief Int (BIMS) score of 14 assistance of two s at risk for PU and th foot. The CAA date pressure ulcers, a s bunion and the care	eekly skin monitoring. She no policy to address monitoring ated wounds or bruises. Int interview with the DON on h. the DON presented a ing system to be set up in the d indicated she would em for monitoring and bruises after staff were by skin care policy dated kin problems are identified and d promptly. A registered nurse dents skin care in accordance isive assessment/care plan. weive education on skin care col to assure accurate timely interventions for skin mission assessment dated hat R24 had a 0.2 cm by 0.2 illused area on left bunion; nage and bilateral bunion with pinkness was present. Foam ced on both bunion for ne of admission, (7/28/16). S assessment dated 8/4/16, erview of Mental Status (intact cognition), extensive taff with bed mobility/transfers, ne presence of a lesion on the ed 8/4/16, included: no scab to hammer toe and	F	309			

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391		
		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245358	B. WING _			09/22/2016			
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE				
HILLTOP CARE CENTER			410 LUELLA STREET WATKINS, MN 55389						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 309	Continued From pa monitor skin.	ge 10	F 30	09					
	R24 were as noted: (1) 8/1/16-small are (2) 8/5/16- open left (3) 8/12/16-bunion p (4) 8/19/16-open left The nurse progress included: open area with foam dressing; edges; no pressure infection symptoms with skin prep to wo visit" physician note identify the presence area. A fax sent to the ph p.m. identified: small	ea to left bunion, t bunion, pink, sore to left bunion and							
	0.5 cm by 0.5 cm.; a The fax was noted, faxed back to the fa The 8/19/16, wound open area as: mea moist area with 100	and continue foam dressing. signed by the physician and acility on 8/22/16, at 1:52 p.m. d observation tool identified the asurement-0.5 cm by 0.5 cm 0% granulation tissue. The pontinue adhesive foam							
	foam dressing was additional sore was total of two open ar measurements wer observation tool dat	note dated 8/25/16, identified: replaced to left bunion; an noted to the left bunion; and a eas were noted to bunion. No re documented. The wound ted 8/25/16, identified: area ed 0.5 cm by 0.5 cm, and anulation.							

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391			
		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245358	B. WING	í		09/22/2016				
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
HILLTOP CARE CENTER			410 LUELLA STREET WATKINS, MN 55389							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 309	A nurses note dated an appointment sch 8/31/16, but the app rescheduled for 9/8 well. The wound ob identified the area a granulation tissue a measuring 0.8 cm b treatment plan was changes 2 times per identified worsened was noted to worse documentation date revisions and/or rea ensure healing occu During interview on stated the bunion w more she had thera She stated, "you are time and it hurt." R until 9/9/16. Docum indicate the plan of the offloading of the R24's regular shoe. Review of a podiatr identified a full thick foot bunion, approx ulceration was debr surgical shoe utilize for Bacitracin ointm foot, surgical shoe utilize for Bacitracin ointm foot shoe utilize for Bacitracin ointm foot shoe utilize	d 8/31/16, indicated R24 had neduled with the podiatrist on pointment was canceled and /16 due to R24 not feeling bservation tool dated 9/1/16, as worsening with 50% and 50% slough tissue and by 1.3 cm. The current to continue foam dressing er week. The evaluation d sore. Although the wound en according to the ed 8/25/16 and 9/1/16, no assessments occurred to urred. 9/21/16, at 8:03 a.m. R24 vas not sore initially but the apy the more it started to hurt. e working your shoe all the 24 received physical therapy nentation was lacking to care was revised to address e foot to remove pressure from ry visit note dated 9/8/16, kness ulceration over the left timately 1 cm in diameter. The rided and a dressing and ed. New orders were written nent, gauze and kling wrap to (open toe shoe) to offload 4 weeks. The wound ed 9/9/16, identified: 75 %	F	309						

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245358	B. WING			09/22/2016				
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
HILLTOP	CARE CENTER		410 LUELLA STREET WATKINS, MN 55389							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 309	A physician visit not ulceration on the bu 0.6 cm and pink arc observation tool dat unchanged, 10 % g slough tissue and n cm and 0.1 cm dep identified as Bacitra A nursing progress p.m. identified the a being red, warm to macerated/non-blar pain to area with pa noted dated 9/17/16 increased drainage site. The dressing v with soaked throug identified at red and drainage. A nursing progress that R24 was receiv Cipro for a possible culture was pending day). A fax from the indicated to continu foot infection and a bunion was ordered Documentation on I dated 9/21/16, iden slough tissue, 0.7 c infection suspected present. Treatment and kerlex, started twice daily on 9/16/	te dated 9/14/16, identified the union as measuring 0.6 cm by bund the edge. The wound ted 9/16/16, identified: area granulation tissue and 90 % neasurements-0.9 cm by 0.9 th. Current treatment acin and gauze wrap daily. note dated 9/17/16, at 2:34 area on R24's left foot ulcer as touch , nch-able with R24 expressing alpation. Nursing progress 6, at 9:50 a.m. identified noted to left foot at bunion was saturated with drainage gh R24's socks. The site was d warm to touch with purulent note dated 9/19/16, identified ving the antibiotic medication e urinary tract infection (a urine g, but no growth after one e physician dated 9/19/16, ie Cipro which would cover the culture of the open area on	F 3	809						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.								
		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
		245358	B. WING			09/22/2016		
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HILLTOP CARE CENTER					10 LUELLA STREET /ATKINS, MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 309 F 314 SS=D	CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 During interview on 9/22/16, at 12:21 p.m. registered nurse (RN)-D verified the left bunion of R24 had an open area when admitted (7/28/16) and the physician was notified of the open area by fax on 8/19/16. The physician responded to the fax on 8/22/16 with "noted". RN-D verified the physician should have been notified of the open area when identified on admission. She stated "we just covered it with a foam dressing; [R24's] shoes didn't seem tight like they were adding pressure or anything." 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless tha they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to provide the appropriate treatment to prevent further deterioration of pressure ulcers for 1 of 1 (R18) resident reviewed with facility acquired pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS)			314	Resident 18 had reassessment of bos sitting and lying assessments. Reside 18 had OT evaluation to review positioning and make recommendatio Resident 18's plan of care was update Staff was provided education on press ulcers and facility policy on treatment pressure ulcers. DON or designee wi audit residents with pressure ulcers weekly to ensure that assessments ar	ent ons. ed. sure of ill re	10/28/16	
		7/23/16, identified a Brief			completed and facility policy is followe			

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		& MEDICAID SERVICES				. 0938-039		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED			
		B. WING _			09/22/2016			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODI	E			
HILLTOP CARE CENTER			410 LUELLA STREET WATKINS, MN 55389					
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 314	Interview for Menta indicating severe or assistance of 2 stat and does not walk. (CAA) dated 7/25/1 risk for pressure uld identified, is turned and tolerates this p Progress notes dat skin/problem areas and were described and measured 1.5 middle area open n and (#3) bottom are open to the air. A p identified adhesive lower spine. Three identified with skin has pinkness that is wound has 0.2 cm the lower wound has Wounds occurred w toilet during Sitz bas discontinued 8/15/1 During observation was lying supine (o R18 was resting in had a pillow positio wedge under legs. the same position b than side. On 9/21/16, at 7:00 bathroom seated o hooked up. R18's	I Status (BIMS) score of 4 ognitive impairment, extensive ff with transfers/bed mobility The Care Area Assessment 6, identified R18 as being at cers, no pressure ulcer (PU) a minimum of every 6 hours er assessment. ed 8/16/16, identified 3 a located on the spine of R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 area was cleansed and left rogress noted dated 8/22/16, foam dressing applied to a bony prominence's were breakdown: (#1) upper wound s resolving, (#2) middle x 0.2 cm yellow scab and (#3) as 0.5 cm x 0.8 cm scab. with longer period of sitting on ths; Sitz baths were	F 31	4 The DON will present to the Quantum Assurance Committee the audion pressure sores and the Quantum Assurance Committee will detect continuing periodic auditing.	it findings ality			

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245358	B. WING			09/22/2016				
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
HILLTOP CARE CENTER			410 LUELLA STREET WATKINS, MN 55389							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 314	curved and kyphotic R18 was assisted fr into the wheel chair lambs wool over the observed seated in registered nurse (R wound treatment to (#1) was reddened middle area (#2) ha bottom (#3) open al R18 had a rolled ba back. RN-A stated from her back and I implemented. At 1: the toilet hooked up back/spine was aga toilet seat cover unt bed at approximate padding/protection hard surface. On 9/22/16, at 12:4 toilet, hooked up to appearing back/spin the toilet seat cover and put to bed at ap The wound observa described the probl as noted: upper wo tissue injury (a purp discolored intact sk damage of underlyi and/or shear) and ti an Unstageable PU which the base of th (yellow, tan, gray, g	age 15 c. At approximately 7:15 a.m. rom the toilet and transferred which had a thin piece of e back. At 9:30 a.m. R18 was a recliner. At 10:20 a.m. N) A was observed doing a o R18's spine. The top wound and did not appear open, the ad an open area and the rea was covered with slough. Ath blanket behind her lower this was to relieve pressure had just (9/20/16) been :26 p.m. R18 was observed on to to EZ stand. R18's ain pressing up against the til she was assisted back to by 1:36 p.m. There was no between the resident and the A p.m. R18 was seated on the EZ stand. R18's kyphotic ne remained pressed against r. R18 was taken off the toilet oproximately 12:55 p.m. Ation tool dated 8/22/16, em areas on the spine of R18 bund (#1) as a suspected deep ole or maroon localized area of in or blood-filled blister due to ng soft tissue from pressure he lower spine wound (#3) as I (full thickness tissue loss in he ulcer is covered by slough preen or brown) and/or eschar s() in the wound bed.	F3	314						

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		AND HUMAN SERVICES			FORM	10/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245358	B. WING		09/	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Review of the care R18 at risk for skin present to bony pro Interventions includ treatment per nursin least every 6 hours repositioning at nigl spine. No reassess interventions revise A review of the nurs 9/6/16, identified 2 of area of skin breakd identified as quite re during the night; ho encouraged her to a healing the spine. The wound observa- identified the spine area (#3) as being tissue loss. Subcuta bone, tendon or mu may be present but tissue loss. May ine tunneling). Docume physician was notifi ulcers on 9/6/16. The wound observa- identified the upper being a Stage II PU wound as a Stage I During interview on nursing assistant (N [bony prominence] seat while seated o	plan revised 8/26/16, identified breakdown and open areas ominence's to back. led: air mattress on bed, ng order, turn and reposition at when sitting and every 2 hour ht due to skin breakdown to oments were conducted and/or ed after noted skin breakdown. sing home rounds note dated closed areas and one open lown on R18's spine. R18 was esistant to being repositioned owever, nursing staff allow repositioning to aid in ation tool for R18 dated 9/9/16, wound located on the lower a Stage III PU (Full thickness aneous fat may be visible but uscle are not exposed. Slough t does not obscure the depth of clude undermining and entation indicated the ied of the identified pressure	F 314	4		

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245358	B. WING	i		09/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa position.	ge 17	F	314	4		
F 329 SS=D	registered nurse (R sores started from I longer periods of tir She stated the sitz 8/15/16, but she co baths were started. had been doing the discontinued them. areas were identifie put a foam dressing the lambs wool place implemented this w blanket behind back implemented on 9/1 didn't really think at and also confirmed spine were open ag (#1) was healed on re-opened. RN-D w to the open areas/b and resting against She verified R18 we back from the toilet had not been reass PU developed and would not be adequ care. 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy);	9/22/16, at 11:46 a.m. N)- D stated she thought the R18 sitting on the toilet for ne due to having sitz baths. baths were discontinued on uld not identify when the sitz She stated she thought they m maybe 2 weeks before they She verified the pressure ed on 8/16/16, and stated she g on right away. She stated ced on the wheel chair was reek and the rolled bath k in recliner had been 19/16. RN-D further stated I bout them being from pressure that all three areas on the gain. RN-D stated the top one Friday (9/16/16) but had verified R18 still had pressure ony prominence when toileted the seat due to her kyphosis. ould have pressure on her ing and sitting. She stated R18 essed for positioning since the repositioning every 6 hours late as defined in the plan of EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate	F	329			10/28/16

Facility ID: 00798

If continuation sheet Page 18 of 20

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245358	B. WING _		09/2	22/2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HILLTOP	CARE CENTER			410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	se; or in the presence of nces which indicate the dose or discontinued; or any	F 32	29		
	by: Based on interview facility failed to ider monitoring of a cho (simvastatin) for 1 of for unnecessary me Findings include: According to the re- sheet, R34 was adr including: heart faile cholesterol level) an Review of the Phys 8/3/16, directed Sim	sident admission record face nitted with diagnoses ure, hyperlipidemia (high		This plan and response to this find written solely to maintain certification the Medicare and Medicaid progra These written responses do not co an admission of non-compliance n agreement with any findings. We le requested an Informal Dispute Res Resident 34 had laboratory values lipids dated 3/14/16 present in cha Review of the consultant pharmacion monthly drug review documentation dated 8/11/16 made no mention of recommendation to the physician regarding laboratory monitoring, lip cholesterol medication. The consu- pharmacist documentation on 9/15	on in ms. nstitute or any nave solution. for rt. st n form a wids, or ilting	

Facility ID: 00798

If continuation sheet Page 19 of 20

PRINTED: 10/24/2016 FORM APPROVED

		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245358	B. WING			09/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER				IO LUELLA STREET /ATKINS, MN 55389		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	annually. Review of most cur lipids (cholesterol/fa than 15 months). F pharmacist's month form did indicate a laboratory lipid tests ongoing use of sime During interview on director of nursing (unable to provide te completed in the las Record review reve consulting pharmac	d a order to check fasting lipids rent laboratory values for ats) was dated 3/15/15, (more Review of the consultant hly drug review documentation recommendation for annual s related to cholesterol and the vastatin. 9/22/16, at 12:42 p.m. the (DON) confirmed she was ests for cholesterol monitoring	F 3	29	present in resident's chart indicates last checked 3/16.	ipids	
	physician related to	Ide a recommendations to the laboratory monitoring with lowering medication or be completed.					

If continuation sheet Page 20 of 20

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HILLTOP CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PRETRY (BAUMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0 K 000 INITIAL COMMENTS 0 FIRE SAFETY (BACH ORRECTION COTOR COMPLATE DEFICIENCY) THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION, A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016, At the time of this survey, HILIPG Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety form Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: FEREVOCC			& MEDICAID SERVICES					0938-0391
NAME OF PROVIDER OR SUPPLER STREET ADDRESS. CITY. STATE. ZIP CODE HILLTOP CARE CENTER STREET ADDRESS. CITY. STATE. ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (K4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (K 000 INITIAL COMMENTS K 000 K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016. At the time of this survey, HILLOP Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y 7				
Interest of Deficiences intervent of Deficiencies of the providers plan of conrective action should be prefixed by full means that the preceded by full means that the preceded by full means that the preceded by full means the preceded by the minnesotal peartment of Public Safety Safety for the preceded by the minnesotal peartment of public Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION of Constant for the preceded by the minnesotal peartment of Public Safety			245358	B. WING	-		09/2	21/2016
HILLTOP CARE CENTER WATKINS, MN 55389 (X4)D PRETK TAG Summary statement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDENTIFY TAG PROVIDENTIFY REQULATORY OR LSC IDENTIFYING INFORMATION) D PRECEDENTIFY K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. K 000 UPON RECEIPT OF AN ACCEPTABLE POC, AN O'NSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A LIF Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016. At the time of this survey, Hillop Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Tire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101. Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: FEEDOCC	NAME OF F	PROVIDER OR SUPPLIER						
PPETX TAG (EACH ODERCIPTIC ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEFARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016. At the time of this survey, Hilliop Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid 442 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: FERSENCE CONCUCCENT	HILLTOP	CARE CENTER			I .			
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ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016. At the time of this survey, Hilltop Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:		FIRE SAFETY						
ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016. At the time of this survey, Hilltop Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: TOTOCOLONICAL		ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
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CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:		Minnesota Departn Fire Marshal Division At the time of this so found not in substar requirements for particular Medicare/Medicaid 483.70(a), Life Safe edition of National (NFPA) Standard 1	nent of Public Safety, State on, on September 21, 2016. survey, Hilltop Care Center was initial compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					
Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or		CORRECTION FC DEFICIENCIES (K Health Care Fire Ir State Fire Marshal 445 Minnesota Stru	R THE FIRE SAFETY -TAGS) TO: nspections Division eet, Suite 145			EPOC		

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.

		AND HUMAN SERVICES				FORM	10/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE	
		245358	B. WING			09/2	21/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	CARE CENTER			1	410 LUELLA STREET WATKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	ĸ	000			
э	By email to: Marian.Whitney@s Angela.Kappenma						
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or p	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.			18		
	one-story in height	r was constructed in 1978, is , has no basement, is fully fire l, and was determined to be of ruction.					
	detection in corrido corridors which is department notific	ire alarm system with smoke ors and spaces open to the monitored for automatic fire ation. The facility has a s and had a census of 48 at					
K 062	NOT MET as evid NFPA 101 LIFE SA	it 42 CFR Subpart 483.70(a) is enced by: AFETY CODE STANDARD		06	2		9/22/16
SS=D	Required automat continuously main condition and are	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,	1 1 1				

Facility ID: 00798

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES				FORMA	10/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DATE	
		245358	B. WING			09/2	1/2016
	CARE CENTER			410	EET ADDRESS, CITY, STATE, ZIP CODE LUELLA STREET TKINS, MN 55389		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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
K 062	FIRE SAFETY Based on observat facility failed to mai coverage in accord 9.7.5. This deficient resident in the even Finding include: On facility tour bett 11:30 am on 09/21 sprinkler head was tile in the Activity O 19.7.6.	s not met as evidenced by: ion and staff interview, the intain proper sprinkler lance 19.7.6, 4.6.12, NFPA 25, practice could affect 5	K		Service Technicians from Summit Companies lowered the sprinkler I beneath the ceiling tile on 9/22/20 Completion date: 09/22/2016 Location of Sprinklers was added punch list for remodeling. The Director of Maintenance is responsible to verify the punch list upon the completion of a remodeling project	nead 16. to our is done	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: ZN4M	21	Facil	lity ID: 00798 If conti	nuation she	et Page 3 of 3



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted October 7, 2016

Mr. Fred Struzyk, Administrator Hilltop Care Center 410 Luella Street Watkins, MN 55389

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5358025

Dear Mr. Struzyk:

The above facility was surveyed on September 19, 2016 through September 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the

Hilltop Care Center October 7, 2016 Page 2

Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00798	B. WING		09/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
HILLTOP	CARE CENTER		LA STREET , MN 55389			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 10/21/16

Electronically Signed

6899

If continuation sheet 1 of 23

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00798	B. WING		09/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
HILLTOF	CARE CENTER		LLA STREET 6, MN 55389			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 000		age 1 Ith orders being submitted to	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	Department's staff, the following correct Please indicate in y correction that you	22, 2016, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed.				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IC statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follo	bumber appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00798	B. WING		09/22/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HILLTOP	CARE CENTER		LLA STREET S, MN 55389				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ige 2	2 000				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			10/28/16	
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:					
		involving the resident which I has the potential for requiring on;					
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;					
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;					
	D. a decision t resident from the n	o transfer or discharge the ursing home; or					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
		00798	B. WING		09/22	/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HILLTOP	CARE CENTER		LA STREET , MN 55389			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 265	Continued From pa	age 3	2 265			
	E. expected ar	nd unexpected resident deaths.				
	by: Based on observat review the facility fa physician of the op bony prominence's	ent is not met as evidenced ion, interview and document ailed to immediately notify the en wounds located on the of the spine 1 of 1 residents o developed pressure ulcers.		Corrected.		
1	Findings include:					
	assessment dated Interview for Menta indicating severe co assistance of 2 stat and does not walk. (CAA) dated 7/25/1	num Data Set (MDS) 7/23/16, identified a Brief Il Status (BIMS) score of 4 ognitive impairment, extensive ff with transfers/bed mobility The Care Area Assessment 6, identified R18 as being at cers (PU) and no pressure				
	skin/problem areas and were described and measured 1.5 middle area open n and (#3) bottom are	ed 8/16/16, identified 3 located on the spine for R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 area was cleansed and left				
	adhesive foam dres spine; three bony p breakdown were: has pinkness that is wound located on t 0.2 cm yellow scab	dated 8/22/16, identified ssing was applied to the lower prominence's with skin (#1) upper wound on spine s resolving, (#2) middle he spine measured 0.2 cm x and (#3) the lower wound e has 0.5 cm x 0.8 cm scab.				

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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
HILLTOP	P CARE CENTER		LLA STREET 6, MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 265	Wounds occurred v toilet during sitz bai discontinued 8/15/1 indicated the daugh this time, no physic wound observation the problem areas upper wound-(#1) a (a purple or maroor intact skin or blood underlying soft tissis shear) and the lowe PU (full thickness ti the ulcer is covered green or brown) an black) in the wound Documentation inconotified of the ident though it was first is documentation date wound located on t due to deep tissue was documented a Review of the care R18 at risk for skin present to bony pro- Interventions includ treatment per nursi least every 6 hours repositioning at nig spine. A review of the nurs 9/6/16, identified 2 area of skin breako R18 was identified	with longer period of sitting on ths; Sitz baths were 6. Although documentation inter was updated on wounds at ian notice was evident. The tool dated 8/22/16, described on the spine of R18 as noted: a suspected deep tissue injury in localized area of discolored -filled blister due to damage of ue from pressure and/or er wound (#3) an Unstageable ssue loss in which the base of d by slough (yellow, tan, gray, d/or eschar (tan, brown or l bed. licated the physician was ified PU on 9/6/16 even dentified on 8/16/16 and ed 8/22/16, indicated the he upper part of the spine was injury and the lower wound s unstageable PU. plan revised 8/26/16, identified breakdown and open area	ł			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COM	PLETED
		00798	B. WING		09/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET 6, MN 55389			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From pa	ige 5	2 265			
	in healing the spine).				
	registered nurse (R sores started as a r toilet for longer peri RN-D confirmed the on 8/15/16; howeve on 8/16/16, and the	9/22/16, at 11:46 a.m. N)-D stated she thought the result of R18 sitting on the iods of time due to sitz baths. e sitz baths were discontinued er, the PU's were first identified e physician was not notified verified the physician should sooner.				
	DON or designee c policies and procec notified of changes accurately. The D all appropriate staff	THOD OF CORRECTION: The could develop and monitor dures to ensure practioners are in residents condition ON or designee could educate on these policies and ON or designee could develop s to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 830	MN Rule 4658.0520 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			10/28/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				

ZN4M11

If continuation sheet 6 of 23

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00798	B. WING		09/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			LA STREET			
HILLIOP	CARE CENTER	WATKINS	, MN 55389	-		
(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
2 830	Continued From pa	ge 6	2 830			
	This MN Requireme by: Based on observati review the facility fa significant bruising R60) reviewed for r problems and failed implement timely in for 1 of 1 resident (1 bunion wound. Findings include: R15 Current diagnosis li 7/12/16, for R15 inc pulmonary disease hypertension, deme fibrillation. The Mini assessment dated a Interview of Mental indicating no cognit	ent is not met as evidenced on, interview and document illed to assess and monitor for 3 of 3 residents (R15, R41, ion- pressure related skin I to assess, revise and terventions to promote healing R24) reviewed who had a sted on the care plan dated cluded chronic obstructive (COPD), hypothyroid, entia, obesity and atrial mum Data Set (MDS) B/10/16, indicated R15's Brief Status (BIMS) score was 15, ive impairment.		Corrected.		
	have large bruises knees. R15 had an indicated she has a	p.m. R15 was observed to on both forearms, hands and m protectors donned and skin tear located on the left				
		that a dressing covered a part n interviewed at this time, R15				
		re all from the hospital, they				
	just roll you over, th	ey don't care." During further				
	observation of R15	s arms, the following was				
		had a Vaseline dressing over				
		at the left elbow area, which				
		a soft gauze. The arm had				
		eared dark maroon to dark				
/Innesota D	epartment of Health					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00798	B. WING		09/	09/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
HILLTOF	P CARE CENTER		LLA STREET 6, MN 55389				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	purple in color. This circumference of th extending to the arrinches. The backsi had a rectangle sha 3.5 x 5 inches. Brui both hands, coverin arm had bruising w hand, circumference extended to above The outer forearm wound, measuring appeared to be ope a weepy base was The surrounding tis was peeling. Review of the curre- identified R15 at ris decreased mobility present to right fore skin tear to the left R15 bruises easily, (blood thinner), onl protective sleeve d Documentation in t hospitalized from 9 sepsis and pneumo	s bruising extended around the ne arm from the fingers ea above the elbow, 4.5 de (posterior) of the upper arm aped bruise which measures ising was noted on the tops of ng the entire surface. The right thich started at the top of the ces the arm at the wrist and the elbow approx. 2 inches. revealed an uncovered open 1.5×2 inches. The wound bece en and a $\frac{1}{2}$ inch opening with evident through the dermis. sue was very dry and the skin ent care plan dated $\frac{7}{12}{16}$, sk for skin breakdown due to and incontinence; ulcer earm from a hematoma and elbow. Interventions indicated had been on Coumadin y on aspirin now and to apply a					
	Documentation ind Coumadin and asp was discharged on Review of the admi 9/16/16, also identi bruising to both upp	asts and abdomen. icated R15 had been on irin prior to hospitalization but aspirin only. ission assessment dated fied that R15 had extensive per extremities, faded to right orsal hands and a large skin					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVEY COMPLETED - 09/22/2016	
		00798	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
HILLTOF	CARE CENTER		LLA STREET 6, MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	tear to the left elbow measuring 7 centim length. Steri-strips were applied. When interviewed of registered nurse (R the hospital stay wi upper extremities, f knee and bruising t She confirmed doc to review related to and/or status of the	nge 8 w which was L shaped, neters and 3 centimeters in and a secondary dressing on 9/22/16, at 12:03 p.m. N)-A stated R15 returned from th bruising to bilateral (both) fading bruises on the right o dorsal (posterior) hands. umentation was not available any ongoing assessment e extensive bruising.	2 830			
	dated 9/22/16, which Lewy body disease multiple falls. R41 r 9/16/16 with bruisin lower extremities; b	according to the face sheet ch included dementia with (2/8/16) and history of returned from the hospital on ng noted to bilateral upper and bruising faded to right knee, ands, purplish color from shins	5			
	have bruises on bo arms, both wrists a were dark purplish in size. Interview wi he was unsure of w bruises. The identif both arms, wrists a hand revealed one second and third fir right hand there wa top of the wrist had sides of the wrist). bruises: 2 x 3 inch Located above the	8 a.m. R41 was observed to th elbows, top of both lower nd both hands. These bruises to maroon in color and varied ith R41 at this time indicated when or how he obtained these ied bruises varied in size on nd hands. The top of the right bruise 1.5 inches between the nger. On the top surface of the s another 2 inch bruise. The a 3 inch bruise, (involving the The forearm had 3 more es, 1 x 1 inch and 2 x 3 inches elbow was a 3 x 4 inch dark op of the left hand were two 1				

	ota Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00798	B. WING		09/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HILLTOF	P CARE CENTER		LA STREET			
	I		, MN 55389			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	ige 9	2 830			
	inch bruises and the measuring 3.5 x 4 i	e left forearm had 2 bruises nches.				
	R41 had experience months. The care p spouse brought in I wear to reduce the The care plan also sleeves have been removing them so t	ent care plan 9/4/16, identified ed 12 falls in the last 3 blan intervention identified the ong sleeve shirts for R41 to risk of skin tears with falls. revealed that arm protector attempted but R41 kept they were discontinued.				
	RN-B indicated she on the arms, wrists indicated R41 alwa on his arms and co been monitored on any other format. R	on 9/22/16, at 12:23 p.m. e was aware of R41's bruises and hands. RN-B further ys has some kind of bruising nfirmed these bruises had not the treatment sheets nor in RN-B confirmed she had never g for bruises while working at				
	confirmed R41 freq and hands from fall staff have attempte protectors, but R41 confirmed staff had	D on 9/21/16, at 12:27 p.m. juently has bruises on his arms ls. She further indicated that ed in the past to don sleeve removed them. RN-D I not had a system for R41's bruises for healing and/or				
	R60 had significant hands and arms ha bruises. The top of 1.5 inch bruises. Th bruises which invol- arm. Located abov	9/19/16, at 11:49 a.m. that bruising on his arms. R60's d dark purple to maroon color his right hand revealed two he forearm had 4 x 4 inch ved the circumference of the re the elbow was a 3 x 4 inch m revealed two 1 inch bruises				

Minnesota Department of Health STATE FORM

6899

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00798	B. WING		09/	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HILLTO	P CARE CENTER		LA STREET 6, MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	and the forearm ha two 1.5 inch bruises purple to maroon in the time indicated h them but shared he bruising. The quarte indicated R60 had a Status (BIMS) score impairment. Review of the R60 7/14/16, identified h skin alteration due of life and decrease revealed diagnosis fibrillation, malignar anemia due to cher disease. Review of observations for Ju 2016 identified the related to the signif arms. During an interview RN-B stated that up a bruise and/or a sl the nursing assistant alert is electronicall which subsequently treatment and/or m confirmed that mon deterioration and/or idea.	d one 3 x 4 inch bruise and s. The bruises were all dark a color. Interview with R60 at he was unsure of how he got e has a history of easily erly assessment dated 7/7/16, a Brief Interview of Mental e of 15, indicating no cognitive current care plan dated nim as having a potential for to the dying process and end ed mobility. The care plan which included: atrial nt neoplasm of the lung, motherapy and chronic kidney the bath audit skin ly, August, and September re was no documentation icant bruising evident on R60's on 9/22/16, at 10:17 a.m. bon discovery of a new wound, kin tear, an alert is created by nt in the software system. The y sent to the charge nurse / triggers an assessment, onitoring program. RN-B itoring bruising to identify r healing would be a good	2 830			

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HILLTOF	CARE CENTER		LLA STREET 6, MN 55389			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	director of Nursing a system implement DON stated that if the condition of a wourd the progress notes process for daily/we confirmed there is a of non-pressure relevant During a subseque 9/22/16, at 1:00 p.m picture of a monitor facility software and implement this system	on 9/22/16, at 12:12 p.m. the (DON) confirmed there is not the to monitor skin bruising. there was a change in no it would be documented in but there was no current eekly skin monitoring. She no policy to address monitoring ated wounds or bruises. Int interview with the DON on n. the DON presented a ring system to be set up in the d indicated she would tem for monitoring and bruises after staff were	3			
	5/2011, indicates sl treatments institute oversees each resi with the comprehen The facility staff red and standard proto documentation and care or problems. R24 Review of R24's ac 7/28/16, identified t cm open area to ca Scant weeping drai approximately 1 cm dressings were play	ty skin care policy dated kin problems are identified and d promptly. A registered nurse dents skin care in accordance nsive assessment/care plan. ceive education on skin care col to assure accurate I timely interventions for skin mission assessment dated hat R24 had a 0.2 cm by 0.2 allused area on left bunion; inage and bilateral bunion with n pinkness was present. Foam ced on both bunion for ne of admission, (7/28/16).				
	identified a Brief Int (BIMS) score of 14	S assessment dated 8/4/16, terview of Mental Status (intact cognition), extensive taff with bed mobility/transfers				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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HILLTOP	CARE CENTER		LLA STREET S, MN 55389				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 12	2 830				
	foot. The CAA data pressure ulcers, a bunion and the car turn/repositioning s monitor skin. Review of the show R24 were as noted (1) 8/1/16-small are (2) 8/5/16- open lef (3) 8/12/16-bunion (4) 8/19/16-open lef The nurse progress included: open are with foam dressing edges; no pressure infection symptoms with skin prep to we visit" physician not	chedule every 2 hours and ver day worksheet audits for l: ea to left bunion, ft bunion, pink, sore to left bunion and	3				
	p.m. identified: sma despite adding foat 0.5 cm by 0.5 cm.; The fax was noted faxed back to the fa The 8/19/16, woun open area as: mea moist area with 100 treatment was to co dressing every 3 da A nurses progress foam dressing was	note dated 8/25/16, identified: replaced to left bunion; an					
	total of two open a	s noted to the left bunion; and a reas were noted to bunion. No re documented. The wound					

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2 830	Continued From pa	age 13	2 830				
		ted 8/25/16, identified: area red 0.5 cm by 0.5 cm, and ranulation.					
	an appointment sch 8/31/16, but the app rescheduled for 9/8 well. The wound of identified the area a granulation tissue a measuring 0.8 cm I treatment plan was changes 2 times pe identified worsened was noted to worse documentation date	ed 8/25/16 and 9/1/16, no assessments occurred to					
	stated the bunion w more she had thera She stated, "you ar time and it hurt." R until 9/9/16. Docur indicate the plan of	n 9/21/16, at 8:03 a.m. R24 vas not sore initially but the apy the more it started to hurt. re working your shoe all the 224 received physical therapy nentation was lacking to care was revised to address e foot to remove pressure from					
	identified a full thick foot bunion, approx ulceration was deb surgical shoe utilize for Bacitracin ointm foot, surgical shoe ulcer and return in evaluation tool date	ry visit note dated 9/8/16, kness ulceration over the left kimately 1 cm in diameter. The rided and a dressing and ed. New orders were written nent, gauze and kling wrap to (open toe shoe) to offload 4 weeks. The wound ed 9/9/16, identified: 75 % 25 % slough tissue,					

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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
HILLTOP	CARE CENTER		LLA STREET 6, MN 55389				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 14	2 830				
		cm by 1.2 cm and treatment of and kerlex daily change.					
	ulceration on the bi 0.6 cm and pink ar observation tool da unchanged, 10 % g slough tissue and r cm and 0.1 cm dep	te dated 9/14/16, identified the union as measuring 0.6 cm by ound the edge. The wound the 9/16/16, identified: area granulation tissue and 90 % measurements-0.9 cm by 0.9 oth. Current treatment acin and gauze wrap daily.					
	p.m. identified the a being red, warm to macerated/non-bla pain to area with pa noted dated 9/17/1 increased drainage site. The dressing with soaked throug	note dated 9/17/16, at 2:34 area on R24's left foot ulcer as touch , nch-able with R24 expressing alpation. Nursing progress 6, at 9:50 a.m. identified e noted to left foot at bunion was saturated with drainage gh R24's socks. The site was d warm to touch with purulent					
	that R24 was receir Cipro for a possible culture was pendin day). A fax from th indicated to continu	note dated 9/19/16, identified ving the antibiotic medication e urinary tract infection (a urine g, but no growth after one le physician dated 9/19/16, ue Cipro which would cover the a culture of the open area on d.					
	dated 9/21/16, iden slough tissue, 0.7 c infection suspected present. Treatmen and kerlex, started	R24's wound evaluation tool tified: area worsening, 100 % cm by 0.8 cm by 0.9 cm depth, d and purulent drainage it: Bacitracin, Adaptic, gauze on Cipro 500 mg (antibiotic) (16; bunion became inflamed					

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00798	B. WING		09/	09/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HILLTOF	CARE CENTER		LLA STREET S, MN 55389				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 15	2 830				
	9/17/16 and culture	e was obtained on 9/19/16.					
	registered nurse (F R24 had an open a and the physician v by fax on 8/19/16. the fax on 8/22/16 physician should ha area when identifie "we just covered it	n 9/22/16, at 12:21 p.m. RN)-D verified the left bunion of area when admitted (7/28/16) was notified of the open area The physician responded to with "noted". RN-D verified the ave been notified of the open d on admission. She stated with a foam dressing; [R24's] tight like they were adding ng."					
	The director of nur- educate all license non-pressure skin skin conditions pre admission to the fa	THOD OF CORRECTION: sing, or designee, could d staff on the need to monitor conditions and/or non-pressure sent on residents upon ucility. The director of nursing udit to monitor staff e policy.	9				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			10/28/16	
	comprehensive res of nursing services	sores. Based on the sident assessment, the director must coordinate the nursing care plan which					
	without pressure s pressure sores unl	to enters the nursing home cores does not develop ess the individual's clinical rates, and a physician					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00798	B. WING		09/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HILLTOP	CARE CENTER		LA STREET 6, MN 55389			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ige 16	2 900			
	authenticates, that	they were unavoidable; and				
	receives necessar	tho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	This MN Requirement is not met as a by: Based on observation, document revi interview the facility failed to provide t appropriate treatment to prevent furth deterioration of pressure ulcers for 1 resident reviewed with facility acquire ulcers.	ion, document review and / failed to provide the ent to prevent further ssure ulcers for 1 of 1 (R18)		Corrected.		
	Findings include:					
	assessment dated Interview for Menta indicating severe co assistance of 2 stat and does not walk. (CAA) dated 7/25/1 risk for pressure uk	num Data Set (MDS) 7/23/16, identified a Brief I Status (BIMS) score of 4 ognitive impairment, extensive ff with transfers/bed mobility The Care Area Assessment 6, identified R18 as being at cers, no pressure ulcer (PU) a minimum of every 6 hours er assessment.				
	skin/problem areas and were described and measured 1.5 middle area open n and (#3) bottom are cm by 1 cm. The a open to the air. A p	ed 8/16/16, identified 3 located on the spine of R18 d as noted: (#1) Top area red centimeter (cm) by 2 cm; (#2) neasured 0.8 cm by 0.7 cm ea scabbed and measured 1.5 irea was cleansed and left rogress noted dated 8/22/16, foam dressing applied to				

a Department of He FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00798		B. WING		09/	09/22/2016	
ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
CARE CENTER						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
identified with skin I has pinkness that is wound has 0.2 cm the lower wound ha Wounds occurred w toilet during Sitz ba discontinued 8/15/1 During observation was lying supine (o R18 was resting in had a pillow positio wedge under legs. the same position b than side. On 9/21/16, at 7:00 bathroom seated of hooked up. R18's I against the toilet se curved and kyphoti R18 was assisted f into the wheel chair lambs wool over the observed seated in registered nurse (R wound treatment to (#1) was reddened middle area (#2) ha bottom (#3) open a R18 had a rolled ba back. RN-A stated from her back and implemented. At 1 the toilet hooked up back/spine was aga toilet seat cover un	breakdown: (#1) upper wound s resolving, (#2) middle x 0.2 cm yellow scab and (#3) as 0.5 cm x 0.8 cm scab. with longer period of sitting on ths; Sitz baths were 6. on 9/20/16, at 2:07 p.m. R18 n back) in bed. At 2:37 p.m. bed facing the window. R18 ned behind her back and a At 3:31 p.m. she remained in out lying more on her back 0 a.m. R18 was observed in the n the toilet with EZ stand back was resting/pressing eat cover. R18's spine was c. At approximately 7:15 a.m. rom the toilet and transferred r which had a thin piece of e back. At 9:30 a.m. R18 was a recliner. At 10:20 a.m. RN) A was observed doing a o R18's spine. The top wound and did not appear open, the ad an open area and the rea was covered with slough. ath blanket behind her lower this was to relieve pressure had just (9/20/16) been :26 p.m. R18 was observed on o to EZ stand. R18's ain pressing up against the til she was assisted back to	2 900	DEFICIENC	()		
	ROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa identified with skin has pinkness that is wound has 0.2 cm the lower wound ha Wounds occurred v toilet during Sitz ba discontinued 8/15/1 During observation was lying supine (o R18 was resting in had a pillow positio wedge under legs. the same position k than side. On 9/21/16, at 7:00 bathroom seated o hooked up. R18's l against the toilet sec curved and kyphoti R18 was assisted f into the wheel chain lambs wool over the observed seated in registered nurse (F wound treatment to (#1) was reddened middle area (#2) has batk. RN-A stated from her back and implemented. At 1 the toilet hooked up back/spine was aga toilet seat cover un bed at approximate	OF CORRECTION IDENTIFICATION NUMBER: 00798 00798 STREET AU 410 LUEL WATKINS CARE CENTER STREET AU 410 LUEL WATKINS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 identified with skin breakdown: (#1) upper wound has pinkness that is resolving, (#2) middle wound has 0.2 cm x 0.2 cm y cllow scab and (#3) the lower wound has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during Sitz baths; Sitz baths were discontinued 8/15/16. During observation on 9/20/16, at 2:07 p.m. R18 was lying supine (on back) in bed. At 2:37 p.m. R18 was resting in bed facing the window. R18 had a pillow positioned behind her back and a wedge under legs. At 3:31 p.m. she remained in the same position but lying more on her back than side. On 9/21/16, at 7:00 a.m. R18 was observed in the bathroom seated on the toilet with EZ stand hooked up. R18's back was resting/pressing against the toilet seat cover. R18's spine was curved and kyphotic. At approximately 7:15 a.m. R18 was assisted from the toilet and transferred into the wheel chair which had a thin piece of lambs wool over the back. At 9:30 a.m. R18 was observed seated in a recliner. At 10:20 a.m. registered nurse (RN) A was observed doing a wound treatment to R18's spine. The top wound (#1) was reddened and did not appear open, the middle area (#2) had an open area and the bottom (#3) open area was covered with slough. R18 had a rolled bath blanket behind her lower back. RN-A stated this was t	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	DF CORRECTION IDENTIFICATION NUMBER: 00798 A. BUILDING: B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 LUELLA STREET WATKINS, MN 55389 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PROVIDER'S PLAN OF C (EACH OORRECT'NE ACT) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ORONIDER'S COLSPANE" Continued From page 17 2 900 DEFICIENCIES MILENT PREPTICE Continued State RT8 MIS back was resting/pressing against the toilet seat cover. R18's as to relieve pressure from the back an	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	

STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00798		00798	B. WING		09/	22/2016
VAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET 6, MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 18	2 900			
	toilet, hooked up to appearing back/spi the toilet seat cover and put to bed at ap The wound observa described the probl as noted: upper wo tissue injury (a purp discolored intact sk damage of underlyi and/or shear) and t an Unstageable PL which the base of th (yellow, tan, gray, g (tan, brown or black) Review of the care R18 at risk for skin present to bony pro- Interventions includo treatment per nursi least every 6 hours repositioning at nig spine. No reassess interventions revised A review of the nursi 9/6/16, identified 2 area of skin breakd identified as quite r during the night; ho	3 p.m. R18 was seated on the EZ stand. R18's kyphotic ne remained pressed against r. R18 was taken off the toilet oproximately 12:55 p.m. ation tool dated 8/22/16, em areas on the spine of R18 bund (#1) as a suspected deep ole or maroon localized area of in or blood-filled blister due to ng soft tissue from pressure he lower spine wound (#3) as I (full thickness tissue loss in he ulcer is covered by slough preen or brown) and/or eschar (in the wound bed. plan revised 8/26/16, identified breakdown and open areas minence's to back. led: air mattress on bed, ng order, turn and reposition a when sitting and every 2 hour ht due to skin breakdown to ments were conducted and/or ed after noted skin breakdown. sing home rounds note dated closed areas and one open lown on R18's spine. R18 was esistant to being repositioned wever, nursing staff allow repositioning to aid in				
	identified the spine	ation tool for R18 dated 9/9/16, wound located on the lower a Stage III PU (Full thickness				

		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00798	B. WING			09/22/2016
AME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	CARE CENTER		LA STREET , MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
	cone, tendon or mu may be present but tissue loss. May ind cunneling). Docume obysician was notifi ulcers on 9/6/16. The wound observa dentified the upper being a Stage II PU wound as a Stage I During interview on nursing assistant (N bony prominence] of seat while seated o routinely sits for 5-1 cosition. During interview on registered nurse (R sores started from I onger periods of tin She stated the sitz I 8/15/16, but she coi coaths were started. had been doing the discontinued them. areas were identifie out a foam dressing the lambs wool place mplemented on 9/1 didn't really think ab and also confirmed spine were open ag	aneous fat may be visible but uscle are not exposed. Slough does not obscure the depth of clude undermining and entation indicated the ed of the identified pressure ation tool dated 9/21/16, wound on the spine (#1) as and the lower spine (#3)	2 900			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _			E SURVEY PLETED
	00798		B. WING		09/	22/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
HILLTOF	CARE CENTER		LLA STREET 6, MN 55389			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 900	to the open areas/b and resting against She verified R18 we back from the toilet had not been reass PU developed and would not be adequ care. SUGGESTED MET The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. Th designee, could con delivery of care; to services are implen pressure ulcer developed	ony prominence when toileted the seat due to her kyphosis. build have pressure on her ing and sitting. She stated R18 essed for positioning since the repositioning every 6 hours tate as defined in the plan of THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure he necessary to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for	3			
21540	Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resident adversely affected,	5 Subp. 2 Unnecessary Drug g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the	21540			10/28/16

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00798	B. WING		09/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HILLTOP	CARE CENTER		LA STREET 5, MN 55389			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21540		-	21540			
	the medical directo physician does not the order and if the change the order, t review to the Qualit (QAA) committee r the attending phys the consulting phar directly to the QAA					
	by: Based on interview facility failed to ider monitoring of a cho	ent is not met as evidenced and document review the ntify the need for laboratory plesterol lowering medication of 5 residents (R34) reviewed edications.		Corrected.		
	Findings include:					
	sheet, R34 was ad including: heart fail cholesterol level) a					
	8/3/16, directed Sir be given at bedtime	sician Order Report dated nvastatin 40 mg (milligrams) e (used to lower cholesterol d a order to check fasting lipids				
	lipids (cholesterol/f. than 15 months). F pharmacist's month form did indicate a	rrent laboratory values for ats) was dated 3/15/15, (more Review of the consultant hly drug review documentation recommendation for annual s related to cholesterol and the wastatin.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00798						
			B. WING		09/22/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
HILLTOP	CARE CENTER		LLA STREET S, MN 55389			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 22	21540			
	director of nursing unable to provide to completed in the la Record review reve consulting pharmad documented lipid p The pharmacist ma physician related to use of a cholestero rationale why not to SUGGESTED MET administrator, direc consulting pharmad policies and proced medication usage. educated as neces proper monitoring of designee, along wit medication reviews compliance.	ealed that on 8/13/16, the cist confirmed the last anel was drawn on 3/15/15. ade a recommendations to the b laboratory monitoring with I lowering medication or	3			