Electronically delivered
September 2, 2020

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: CCN: 245507
Cycle Start Date: August 12, 2020

Dear Administrator:

On August 12, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 17, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 17, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 17, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new

admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 17, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Hillcrest Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 17, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 February 12, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies

or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 8/11/20-8/12/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 8/11/20-8/12/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. Complaint #H5507043C was substantiated at F689, for past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. The following complaints were found to be substantiated with no deficiency due to actions implemented by the facility prior to survey. #H5507042C, #H5507044C, and #H5507045C. The following complaint was found to be unsubstantiated. #H5507046C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.	F 000		

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

Electronically Signed | 09/11/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the appropriate use of an air mattress for 1 of 3 (R2) residents identified at risk for falls. This deficient practice caused actual harm, a left hip fracture, when R2 fell out of bed due to the placement of an air mattress on top of the existing mattress on a bed. The facility had implemented corrective action on 4/26/20 therefore, the deficient practice is being issued at past non-compliance harm. Findings include: R2's admission Minimum Data Set (MDS) assessment dated 4/7/20, indicated the resident had severe cognitive impairment with diagnoses	F 689	Past noncompliance: no plan of correction required.	9/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

including Alzheimer's disease; was totally dependent on staff for all activities of daily living (ADLs), and was receiving hospice services.

An incident report submitted to the state agency (SA) on 4/17/20 at 6:48 a.m. identified a fall R2 sustained; Date and time of incident 4/16/20 at 22:20 (10:20 p.m.). Description of incident: At 10:20 p.m. on 04/16/20, resident was found on the floor in his room, laying on his left hip at bedside. Resident had been toileted 20 minutes prior at 10 p.m. and had voided at that time. Following toileting, resident had been left with his bed in low position, body pillow outlining outside edge of bed and call light within reach, per care plan. Resident appears to have rolled out of bed and onto the floor. All care plan interventions had been followed. Resident is on hospice for terminal diagnosis of Alzheimer's Disease, has severely impaired cognition and requires assist of 2 staff and Hoyer lift for transfers. Resident was immediately assessed for injury. Upon assessment, resident reported he "fell straight onto his buttock" and was noted to have complaints of left leg pain. Facility staff stayed with resident while on call hospice provider was updated at 10:35p.m. with orders to send to ER (emergency room) for evaluation. Gold Cross ambulance was called at 10:40 p.m. Administrator Designee was updated of incident at 10:50 p.m. Facility staff was notified by daughter at 3:50 a.m. that resident was being admitted [to hospital] for left hip fracture. Administrator Designee was updated of confirmed left hip fracture diagnosis at 3:55 a.m.

The investigative report submitted to the SA dated 4/21/20 at 20:18 (8:18 p.m.) included: During investigation it was discovered that an air

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

mattress had been applied over a standard facility mattress. This is not the standard procedure and the expectation is that air mattresses will be placed directly on the bed frame. Changes were not made to the policy and procedure as the procedure was not followed, but immediate re education was provided to staff involved in decision to place air mattress over a standard facility mattress...[registered nurse (RN)-C] completed causal factor investigation following fall and noted resident to have hospice air mattress on top of facility standard mattress. [Director of Nursing (DON)] spoke to [RN-D] with Moments Hospice and confirmed this resident's particular air mattress was not to be used as an air overlay mattress, and should've been placed directly on the bed frame. Interviewed [RN-E] Nurse Manager who reports being unaware an air mattress had been delivered for resident. Interviewed [Licensed Social Worker (LSW)] who reports being in resident's room while air mattress was being applied to resident's bed by [maintenance staff (MS)-B] on day of admission. Discussion occurred between LSW and [MS-B] with decision that mattress appeared to be an air overlay mattress, which was placed on top of facility standard mattress for this reason. Immediate re-education was provided to LSW and [MS-B] of standard procedure to place air mattresses directly on the bed frame and not on top of another mattress. Staff must consult with the air mattress provider or the manufacturer's directions for clarification on the proper placement of mattresses...Resident was assessed for injury and was sent to the ER for evaluation. Immediate re education was provided to staff involved in decision to place air mattress over a standard facility mattress, education was provided to staff involved in decision to place air

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

mattress over a standard facility mattress, education was provided to nursing and environmental services staff of appropriate placement, monitoring and care of resident beds and mattresses and immediately removed standard mattress from under air mattress so that only one mattress remained on the bed frame-this decreased the bed height by 6" (inches). Care plan updated to include fall precautions to be implemented upon resident's hospital return: low bed, body pillow to outline outside edge of bed, call light within reach, floor mat when in bed, room rearranged to increase resident supervision from doorway, position resident in center of the bed and away from the outside edge of the bed and top of the hour checks. House audit completed to ensure no other beds had a similar set up with no other concerns noted and education provided to nursing and environmental services staff of appropriate placement, monitoring and care of resident beds and mattresses.

When interviewed on 8/11/20 at 3:30 p.m., family member (FM)-C stated being very very upset with the negligence of the facility. FM-C stated R2 was admitted 3/31/20, had a fall the evening of 4/16/20, and died on 5/2/20. FM-C stated R2 fell while he was in bed. FM-C stated the maintenance person had not removed the original mattress when putting the air mattress, and further expressed being unaware whether the bed had been placed in the lowest position. FM-C stated, "I know when I visited with him [R2] through the window, it wasn't in the lowest position. The nurse that did the fall assessment didn't catch that he had 2 mattresses on the bed. The aides didn't catch it either. On Tuesday (4/28/20) they let me come into the facility as he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

was end of life. When I saw him on Tuesday he was in a Broda chair, had a catheter the hospital had put in and his leg looked terrible and was really swollen. He seemed comfortable when in his chair but anytime they repositioned him you could tell he was in terrible pain."

When interviewed on 8/12/20 at 9:03 a.m., the LSW confirmed she had helped get R2's room set up after admitting the resident. The LSW stated R2's daughter had brought his belongings in tubs and stated, "She told me when the mattress came in it was an air mattress. When [MS-B] looked at the mattress he thought it looked like an overlay and I did too. It didn't look any different than any of our other mattresses that are overlays. [MS-B] helped me fill it up then myself and a nursing assistant made the bed. When I made the bed I didn't have to stretch down over it to get the sheets on so I didn't notice that it was higher than any of the other air mattresses." The LSW confirmed she was educated on the protocol related to resident air mattresses, and stated setting up the resident's bed was something she wouldn't usually do but the resident was on hospice and the daughter was struggling with not being able to be in the room with the resident due to Covid 19 restrictions. The LSW stated the daughter was outside the facility by R2's window when they were setting up his room, directing where she wanted things. The LSW stated, "We knew prior to her [the daughter] coming, that she would be bringing equipment used at [R2's] prior assisted living placement." When asked, the LSW confirmed R2's daughter was not outside the room when the air mattress was being set up.

When interviewed on 8/12/20 at 9:46 a.m., MS-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

confirmed he had placed R2's air mattress on the bed when the resident was admitted to the facility. MS-B stated R2 had been admitted from an assisted living facility, was on hospice, and stated everyone told him it [the airmattress]was an overlay. "So I filled it up and put it on the bed and strapped it down. If I would have looked at the tag we might have been ok. He [R2] was tired from the ride and I wanted to get it done. Even our social services said it was an overlay. If they'd said it was a mattress I would have put it on as a mattress - but it didn't look that thick, and I haven't seen any other hospice ones that looked like that." When asked if the mattress was thicker than the other overlay mattresses he'd put on other resident beds MS-B stated, "yea, maybe". MS-B confirmed that following R2's incident, all resident air mattresses in the facility had been audited to ensure they were applied properly.

When interviewed on 8/12/20 at 10:31 a.m., the DON confirmed hospice had brought an air mattress for the resident to utilize. The DON acknowledged the LSW and maintenance staff both thought is was an air overlay and not an air mattress so had put it over the regular mattress. The DON stated normally hospice would have brought the mattress in and applied to the bed, but with covid they were not allowed to come into the facility to do that. The DON confirmed their post fall investigation of R2's fall revealed the causal factor of the fall to be the air mattress.

R2's hospital orthopedic surgery consult note dated 4/17/20, identified the resident sustained acute periprosthetic fracture of the proximal left femur extending from the greater trochanter through the intertrochanteric region. The consult

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 notes indicated R2's daughter consulted with the on-call surgeon and a decision was made to proceed with non-operative management with the goal being R2's comfort. The facility's 7/2018 policy, Falls Prevention and Management Protocol, included: Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The facility's corrective actions identified in the facility's post fall investigation, were verified as having been implemented as of 4/26/20 through interviews and record review.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		9/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 77 residents who resided at the facility. Findings include: During an interview on 8/11/20, at 9:55 a.m. housekeeping supervisor (HS)-A stated high touch surfaces were disinfected every other day with a product called Unicide 256, which was also used for floor cleaning and disinfection throughout the facility. A facility document titled: infection control program, scheduled maintenance checks, dated July 2020, had a column for each day of the month and a line for each item to check, including a line indicating: hi-touch zone. HS-A pointed to that line and stated the initials on that line were his and one other employee. Despite stating high touch surfaces were disinfected every other day, the log did not reflect that. HS-A admitted no disinfecting had been done on Saturdays and Sundays, and during one week of July it was done only twice, rather than three times. During an observation on 8/11/20, at 10:18 a.m.	F 880	F880 □ Infection Prevention and Control 1. High touch surfaces will be cleaned daily. All residents have the potential to be affected. All Environmental Services staff were educated on the expectation that high touch surfaces will be cleaned daily. A high touch surfaces cleaning log was created for staff to document daily upon completion. Environmental Services Director or designee will conduct random audits of completion to ensure cleaning of high touch surfaces has been completed and documentation is present. Audits will be completed weekly x4, monthly x2 and report to QA committee for further review and recommendations. 2. Musty odor on NE hallway was evaluated by Environmental Services Director, Administrator and Monarch Corporate Office Maintenance Consultant and determined to be related to high humidity. Added dehumidifier to draw excess moisture from the air and scent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 of the northeast resident hallway, noted a pungent musty odor upon walking a short distance into the hallway. Observed a ceiling tile by the nurses kiosk in this hallway with a large circular pattern of black material around a circular ceiling vent. Further down the hallway by room 515, observed another ceiling tile with the same black material around the circular ceiling vent. Also observed several ceiling tiles with yellowish colored stains. During an interview on 8/11/20, from 11:08 a.m. to 11:55 a.m. with registered nurse (RN)-A and director of nursing (DON), RN-A stated the expectation is for high touch surfaces such as railings in hallways, doorknobs and nursing kiosks were to be disinfected by night shift nurse aids. DON added that "maintenance and housekeeping tag team cleaning of high touch surfaces every day." The cleaning log titled: NE (northeast) nurse cleaning schedule, dated August 2020, had a column for each date and a line for various cleaning activities, including wiping down the treatment and med cart with a sanitizing wipe and wiping keyboards, telephones and counters with sanitizing wipes. These activities were to be done every shift, every day, however, the log indicated otherwise as the majority of days, it was done only once, or not at all. A log titled: infection control cleaning schedules nursing assistants, which RN-A stated had been started August 6, had a column for each day of the month and lines for various cleaning activities. A line titled: keep utility room clean, was to be completed every shift, every day, but had occurred only on the day shift, with the exception of one night shift. A line titled: clean all utility room cupboards every Sunday night, was blank. A line titled: wash and disinfect each lift,	F 880	machines to add pleasant fragrance. All residents on NE hall have the potential to be affected. All residents on NE hall were interviewed regarding having an odor free environment. All staff were educated on expectation for odor free environment and reporting of concerns via facility protocol. Environmental Services Director or designee will conduct random audits throughout facility to ensure facility is odor free. Audits will be completed weekly x4, monthly x2 and report to QA committee for further review and recommendations. 3. Black material around vents and yellow stained tiles on NE hallway were evaluated by Environmental Services Director, Administrator and Monarch Corporate Office Maintenance Consultant and determined to be related to condensation from air exchange system. Vents were cleaned and stained tiles were replaced. All residents on NE hall have the potential to be affected. Facility audit of all vents and ceiling tiles was completed. All Environmental Services staff were educated on expectation that evidence of moisture concerns are to be addressed immediately. All vents will be inspected and cleaned if necessary, each quarter. Ceiling tiles will be replaced as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 every evening, had only been done twice since August 6. A line titled: disinfect high touch areas (kiosk, rails and doorknobs) every night: had only been done twice since August 6. During interview with RN-A and DON could not verify if cleaning and disinfecting was being done as expected. During an observation on 8/11/20, at 1:25 p.m., entered the soiled utility room on the southwest hallway. As soon as a staff member opened the door, a pungent odor was noted. The room was small, measuring approximately eight feet by eight feet. On the left side were receptacles for soiled linen. On the right side was a countertop with sink and wooden cupboards below. The faucets on the stainless steel sink were corroded and rusty. Adjacent to the counter was a hopper (a large standalone sink-type receptacle with a sprayer hose for cleaning and flushing organic debris into the septic system). The hopper was elevated on a square platform covered in tile. Several pieces of the three inch by three inch brown tile were missing, exposing cement. There were several areas on walls that appeared to have been previously patched that were missing paint, exposing gray plaster or cement. On a wall above the hopper, near the ceiling was a jagged cement hole with pipe coming out. At least one ceiling tile was ajar; not fully seated. A small rectangular ceiling vent was covered with thick gray-colored debris. The brown tile floor was dull and dirty. The facility cleaner/disinfectant for high touch surfaces and floors, Brulin brand Unicide 256, was not found on the environmental protection agency (EPA) List N for disinfectants for use against SARS-CoV-2, the virus that causes Covid-19. During an interview on 8/11/20, at 2:30	F 880	Environmental Services Director or designee will conduct random audits throughout facility to ensure vents are clean and there is no evidence of leaks or condensation. Audits will be completed weekly x4, monthly x2 and report to QA committee for further review and recommendations. 4. Nurse and nursing assistant cleaning logs were updated to include appropriate cleaning schedules for high touch surfaces and utility rooms. All residents have the potential to be affected. All nursing department staff were educated on updated logs and cleaning schedules for high touch surfaces and utility rooms with the expectation that these duties will be completed every shift. Director of Nursing or designee will conduct random audits to ensure nurse and nursing assistant cleaning logs have been completed and documentation is present. Audits will be completed weekly x4, monthly x2 and report to QA committee for further review and recommendations. 5. SW dirty utility room was evaluated by Environmental Services Director, Administrator and Monarch Corporate Office Maintenance Consultant. Repair plan was drafted including replacement of faucet, sink and countertop, repair of tiles and wall behind hopper, ceiling tile	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 p.m., RN-A, HS-A and maintenance director (MD)-A stated they were not able to provide documentation that this cleaner/disinfectant killed SARS-CoV-2. RN-A stated to MD-A "remember when I asked you about that?" During an interview on 8/11/20, at 2:58 p.m. on the northeast hallway, (RN)-B stated it smelled musty in the hallway; "I noticed these resident rooms have poor ventilation compared to other parts of the facility." During an interview and observation on 8/11/20, at 3:20 p.m. with the administrator, HS-A, and MD-A in the northeast hallway, when asked if they noticed a smell, MD-A immediately acknowledged a musty odor, stating "this hallway always smells off." MD-A went on to say there was a crawl space under the entire length of the hallway and noticed when there was a heavy rain, the smell is prominent. HS-A stated he thought the hallway smelled like wet carpet and that the carpets had recently been cleaned. The administrator acknowledged the musty odor. The ceiling tiles with black material around the ceiling vents were discussed and the team did not know what caused it. The administrator stated she would contact a facility consultant to investigate the smell and the cause of the black material coming from the ceiling tiles. During an interview on 8/11/20, at 4:20 p.m. the administrator stated MD-A placed an order for a new cleaner/disinfectant that killed SARS-CoV-2 and again confirmed the facility was not able to provide documentation that the product they were using, Unicide 256, killed SARS-CoV-2. In addition, administrator confirmed it was her expectation that housekeeping staff perform high	F 880	adjustment, vent and utility room deep cleaning. All SW residents have the potential to be affected. Facility audit of remaining dirty utility rooms was completed to address similar concerns. All Environmental Services staff were educated on the expectation that the facility dirty utility rooms will be cleaned daily. A cleaning log was created for staff to document daily upon completion. Environmental Services Director or designee will conduct random audits throughout facility to ensure infection control and repair concerns are appropriately addressed. Random audits will be completed to ensure dirty utility room cleaning has been completed and documentation is present. Audits will be completed weekly x4, monthly x2 and report to QA committee for further review and recommendations. 6. High touch surface disinfectant was replaced with Virasept and Din-o-mite and were confirmed to be on the EPA List N for disinfectants for use against SARS-CoV-2. All residents have the potential to be affected. All Environmental Services staff were re educated on requirement for facility disinfectants to be on the EPA List N for use against SARS-CoV-2.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 level disinfection daily in common areas; nursing assistants disinfect high touch surfaces in resident hallways daily, and nurses disinfect keyboards, telephones and counters three times a day. Facility policy titled Coronavirus (Covid-19), updated on 7/23/20 indicated: Environmental Services: Cleaning and disinfecting resident rooms, equipment, and high touch areas such as hand rails, door knobs, tables, common areas, elevator buttons, door locks/key pads, etc, will be performed using products that have EPA-approved emerging vial pathogens claims that have demonstrated effectiveness against viruses similar to Covid-19 on hard non-porous surfaces. The facility assessment, revised 11/18/19, indicated physical environment and building/plant needs had a process to ensure adequate maintenance and replacement, with a program called preventative maintenance.	F 880	Environmental Services Director or designee will conduct random audits to ensure appropriate disinfectants remain in use. Audits will be completed weekly x4, monthly x2 and report to QA committee for further review and recommendations.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 2, 2020

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

Re: Event ID: 0W5K11

Dear Administrator:

The above facility survey was completed on August 12, 2020 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 6/15/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found in compliance with the MN State Licensure. Complaint #H5507043C was substantiated at F689, for past non-compliance.	2 000		

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

Electronically Signed | 09/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaints were found to be substantiated with no deficiency. #H5507042C, #H5507044C, and #H5507045C. The following complaint was found to be unsubstantiated. #H5507046C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		