



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 7, 2024

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

RE: CCN: 245507
Cycle Start Date: August 28, 2024

Dear Administrator:

On October 2, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered

October 7, 2024

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

Re: Reinspection Results
Event ID: QJ9U12

Dear Administrator:

On October 2, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 28, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 9, 2024

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

RE: CCN: 245507
Cycle Start Date: August 28, 2024

Dear Administrator:

On August 28, 2024, a survey was completed at your facility by the Minnesota Department 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 28, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 28, 2025 (six months after

Hillcrest Care & Rehabilitation Center

September 9, 2024

Page 3

the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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Electronically delivered
September 9, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: QJ9U11

Dear Administrator:

The above facility was surveyed on August 27, 2024 through August 28, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 only a suggestion 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 10/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2024
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NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 8/27/24, and 8/28/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed H55077465C (MN00106115) and H55077802C (MN00106106) with deficiencies cited at F609 and F656.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 609 SS=D	<p>Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in</p>	F 609		9/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/18/2024
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	<p>Continued From page 1</p> <p>serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure an allegation of staff to resident sexual abuse was reported to the State Agency (SA) within two hours for 1 of 1 resident (R1) who reported a male staff member inappropriately touched her.</p> <p>Findings include:</p> <p>R1's face sheet dated 8/28/24, identified R1 had diagnoses of depression, major depressive disorder, social phobia, and anxiety disorder.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 8/9/24, identified R1 did not have cognitive impairment. R1 required two-person physical assist with dressing and grooming, and required a total mechanical lift and two assist to transfer from one location to another.</p>	F 609	<p>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -Education of the Abuse policy, which includes reporting, will be completed. The allegation was investigated further including notifying law enforcement.</p> <p>How the facility will identify other residents having the potential to be affected by the</p>	

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F 609	<p>Continued From page 2</p> <p>R1's Vulnerable Adult Maltreatment Report submitted to the State Agency on 8/26/24, identified notification of R1's accusation of sexual assault by a staff member that occurred on 8/25/24. R1 had been at the emergency room earlier in the day for a dislodged catheter after the sexual assault occurred. Facility was instructed to have two people for all cares, call police, and report incident.</p> <p>R1's clinic visit note dated 8/27/24, identified R1 had an incident on 8/25/24 in which staff inappropriately touched her. R1 had a history of sexual abuse from her father that R1 continued to have trauma from, and current incident was making it hard to sleep at night.</p> <p>During an interview on 8/27/24 at 10:17 a.m., R1 stated on 8/25/24, a male aide came up behind her and pulled her brief down while she was using the mechanical lift and ran his fingers across her "butt-cheeks". He said he was sorry, and she told him to leave. "Since I came to the facility, I told them about being molested and that I don't want men around me in that position."</p> <p>During an interview on 8/27/24 at 3:49 p.m., licensed practical nurse (LPN)-A stated she went to R1's room on 8/25/24 at approximately 9:00 a.m. to change R1's catheter. Upon entering the room R1 was visibly shaking and crying. R1 reported to LPN-A a male aide pulled her brief from behind her and ripped it out then put his fingers on that area and caressed her peri area. LPN-A immediately notified the LPN-B supervisor and was in R1's room while R1 gave the same statement to the LPN supervisor. LPN-A stated LPN-B took over the investigation and determined which male aide R1 had been talking about.</p>	F 609	<p>same deficient practice:</p> <p>-All residents have the potential to be affected.</p> <p>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:</p> <p>-Staff will be educated on the Abuse policy, which includes reportable events. R1's care plan was updated after further discussion with her to include no males for peri cares or showers per her preference. This in turn also updated her kardex.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</p> <p>-The Administrator or designee will audit phone calls received from the facility and facility staff, and the progress note report to ensure no reportable incidents occurred 5x/week x 1 month. Audits will be reported to the QA committee for further review and recommendations.</p>	

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

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F 609	<p>Continued From page 3</p> <p>LPN-A indicated while all that was going on R1 was sent to the emergency room for problems with her urinary catheter. LPN-B had left her a note on her computer to call R1's power of attorney and the physician. LPN-A explained the POA had already been to the facility and was made aware by R1, LPN-A called the nurse practitioner (NP) who told her to call the police and offer emergency room for further evaluation. LPN-A notified LPN-B of NP's orders to which LPN-B directed her not to call the police and not to tell the emergency department of the allegation until after she talked to the administrator. LPN-A stated she did not call the police as directed and was not aware if the police had been notified.</p> <p>LPN-B was called on 8/28/24 at 11:54 a.m., however the call was not answered, a message was left with no return phone call.</p> <p>During a phone interview on 8/27/24 at 11:20 a.m., NP-A stated LPN-A called approximately 3:15 p.m., on 8/25/24, LPN-A reported R1 had been sexually abused by a male staff who yanked her brief off forcibly and rubbed his fingers on her behind. NP-A told LPN-A to call and notify the police and offer R1 emergency department services. NP-A indicated later that evening she had followed-up with the police, the police informed her that a report had not been filed so she informed the police of R1's allegations.</p> <p>During an interview on 8/27/24 at 2:28 p.m. Administrator, DON, and Administrator in Training (AT)-A had been notified via phone by the LPN-B of the allegation however LPN-B had reported R1 did not report the incident as abuse or assault in nature. Administrator stated R1 was questioned and stated, "he ran his finger across her bottom</p>	F 609		

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F 609	Continued From page 4 during repositioning." Administrator felt the incident was customer service related and not reportable to the SA. During an interview on 8/27/24 at 3:21 p.m., medical director (MD)-A stated she would expect the facility to follow the protocol for reporting an incident and all incidents reported would need an investigation attached. The facility Abuse Prohibition/ Vulnerable Adult Policy revised 3/2024, identified the purpose was to protect residents against abuse by anyone, including, but not limited to, facility staff ..., to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Suspected abuse shall be reported to Office of Health Facility Complaints (OHFC) online but not later than two hours after forming the suspicion of abuse.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		9/26/24

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F 656	<p>Continued From page 5</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to develop a person centered comprehensive care plan was developed for 1 of 3 residents (R1) who requested no male caregivers provide care.</p> <p>Findings include:</p>	F 656	<p>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/28/2024
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F 656	<p>Continued From page 6</p> <p>R1's face sheet dated 8/28/24, identified R1 had an admission date in July 2024 with diagnoses of depression, major depressive disorder, social phobia, and anxiety disorder.</p> <p>R1's admission Minimum Data Set (MDS) dated 8/9/24, identified R1 did not have cognitive impairment. R1 required two-person physical assist with dressing and grooming, and required a total mechanical lift and two assist to transfer from one location to another.</p> <p>During an interview on 8/27/24 at 1:52 p.m., registered nurse (RN)-A stated he completed R1's admission assessments. During that process R1 had brought up the history of sexual abuse; RN-A immediately initiated no male caregivers to provide cares. RN-A explained he did not add the history and R1's preferences to the care plan, did not document in a progress note, and did not complete the trauma assessment. RN-A stated he only reported the information during shift to shift report.</p> <p>During an interview on 8/27/24 at 10:17 a.m., R1 stated "Since I came to the facility, I told them [staff] about being molested and that I did not want male caregivers."</p> <p>During an interview on 8/28/24 at 9:46 a.m., family member (FM)-A stated R1 was always upfront with facilities and told them about the sexual trauma in her past.</p> <p>During an interview on 8/27/24 at 10:09 a.m., nursing assistant (NA)-A indicated R1 made it known that she did not want male care givers providing personal care since she was admitted to the facility. NA-A stated R1 had told her she</p>	F 656	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-R1's person centered comprehensive care plan was updated to reflect no male caregivers for peri cares and bathing, per her preference.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>-All residents have the potential to be affected.</p> <p>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:</p> <p>-The facility will update a resident's care plan, therefore also updating their kardex, upon learning preference of caregivers' gender, should the resident have any. This finding will also be discussed during the next clinical IDT meeting for additional communication. New admissions will complete a trauma questionnaire with Social Services upon admission, which will lead to the discussion of caregivers should a resident have specific preferences. Nursing leadership and Social Services completed education on revising care plans. Floor staff were educated on the updates to R1's care plan/kardex.</p>	

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F 656	<p>Continued From page 7</p> <p>had been sexually molested as a child shortly after she was admitted to the facility.</p> <p>During a phone interview on 8/27/24 at 12:07 p.m., NA-D stated since R1 was admitted to the facility she was only to have females for personal cares. NA-D stated R1 had been fine with a males helping transfer as long as her peri area was covered. NA-D stated R1's preferences not to have male care givers was passed down during shift to shift report.</p> <p>During an interview on 8/28/24 at 8:23 a.m., NA-B indicated since R1 was admitted she only could have females complete personal cares because she was sexual abused.</p> <p>During an interview on 8/28/24 at 9:01 a.m., RN-B stated R1 did not like male caregivers and does not want them to perform cares on her.</p> <p>R1's clinic visit note dated 8/27/24, identified R1 had an incident on 8/25/24 in which staff inappropriately touched her. R1 had a history of sexual abuse from her father that R1 continued to have trauma from, and current incident was making it hard to sleep at night.</p> <p>Although mulitple staff had awareness of R1's preferences, her care plan was not revised until 8/26/24, after R1 reported an allegation of a male nursing assistant inappropriately touched her on 8/25/24.</p> <p>R1's care plan dated 8/26/24, included R1 was at risk for alterations in behavior related to (r/t) trauma including self-reported history of being molested. Interventions included to speak clearly and explain steps to the cares being provided,</p>	F 656	<p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</p> <p>-Clinical IDT will complete a one-time audit to ensure known residents at this time with preference a preference of gender for cares have their care plan updated appropriately. The residents identified will be followed up with if it is a preference for all cares or only peri cares and showers, or any other preference in relation to gender of caregivers. Administrator or designee will audit one-time that the identified resident's care plan, and therefore kardex, have proper updates, if any were needed. Administrator or designee will complete random audits 5x/week x 1 month that staff know where to find resident individualized care plan (also known as kardex to CNAs). Audits will be reported to the QA committee for further review and recommendations.</p>	

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F 656	<p>Continued From page 8</p> <p>female staff only for peri-cares, two staff present during all cares, medication pass, and treatments, psychologist referral, staff will utilize trauma informed care when working with resident, encourage collaboration with therapeutic recreation and social services to improve social connections and minimize symptomology.</p> <p>During an interview on 8/28/24 at 12:06 p.m., administrator in training (AIT)-A stated nurses were expected to communicate with the nurse manager or adjust the care plan as needed and bring the discussion to the interdisciplinary meeting. AIT-A stated R1 did not report sexual trauma during the admission trauma questionnaire.</p> <p>The facility care planning policy revised 1/6/22, identified each resident will have a person-centered care plan developed by the interdisciplinary team (IDT) for the purpose of meeting the residents individual medical, physical, psychosocial, and functional needs. The baseline care plan will be developed within 48 hours of admission. The IDT, in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day after admission for the resident.</p> <p>The trauma informed care policy revised 2/24/23, identified staff will identify history of trauma when possible, residents with a history of trauma will have goals and interventions added to the care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident. Care plans will be updated as needed.</p>	F 656		