*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 23, 2024

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

RE: CCN:  245507
Cycle Start Date: October 17, 2024

Dear Administrator:

On October 17, 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 actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

## 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

## 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 $12,924; 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.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
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

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution**

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@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 10/17/2024 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>On 10/16/24, and 10/17/24, a standard abbreviated survey was conducted at your facility. Your facility was in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed H55079543C (MN00107469) with a deficiency cited at F689 at PAST NON-COMPLIANCE<br><br>Although the provider had implemented corrective action prior to survey, harm was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.<br><br>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. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to follow the care plan for safe transfers for a full body mechanical lift for 1 | F 689 | Past noncompliance: no plan of correction required. | |

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

Electronically Signed | 10/23/2024

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 689 | Continued From page 1<br>of 3 residents (R1) who required lifts for transfers. The facility's failures resulted in harm when R1 fell out of the lift and sustained subgaleal hematoma (bleeding between the skull and the scalp) and head laceration that required three staples. The facility implemented immediate corrective actions prior to survey and is issued at past non-compliance.<br><br>Findings include:<br><br>R1's face sheet dated 10/16/24, identified R1 had diagnoses that included traumatic brain injury (head injury causing damage to the brain by external force or mechanism), dementia (deterioration of memory, language, and other thinking abilities), bipolar disorder (serious mental illness characterized by extreme mood swings), and presence of cerebrospinal fluid drainage device (used when the normal flow of cerebrospinal fluid in the brain is obstructed).<br><br>R1's quarterly (MDS) dated 9/2/24, identified R1 did not have cognitive impairment. R1 was dependent for transfers, required maximum assist with cares, and R1 did not have behaviors.<br><br>R1's care plan dated 7/22/22, identified R1 required the full body mechanical lift with assistance from two staff for transfers. R1's care plan dated 11/16/18, identified R1 had issues with mood and behavior that included name calling, yelling, calling out, using profanities, and refusing to allow staff to complete tasks. Interventions included encouraging resident to call family, monitoring target behaviors, putting on favorite radio station, word searches, reading car/tractor magazines, offered a warm blanket, being alert to mood, and behavior changes, using a kind, and | F 689 | | |

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| F 689 | Continued From page 2 | F 689 | | |

firm approach, approach in a calm voice making eye contact and using therapeutic touch, validate feelings, provide emotional support.

R1's progress note dated 10/13/24 at 8:30 p.m., identified R1 was on the floor and bumped his head. R1 had a 1-centimeter (cm) x 2.0 cm "gash like" area. Nurse applied dressing to site and R1 was resistive to cares. The note did not identify why R1 was on the floor.

R1's emergency department after visit summary dated 10/14/24, identified the reason for the visit was fall, and laceration to head. R1 had a computed tomography (CT) completed on his head. The results identified a "posterior vertex scalp [area between mid-scalp and crow] and subgaleal hematoma" that required three staples to the site.

R1's progress note dated 10/14/24 at 9:26 a.m., identified R1 returned from the emergency department with three staples to the back of his head.

R1's Incident Review and Analysis report dated 10/14/24, identified the causal factor for the fall was R1 was agitated and moving around when nursing assistant (NA)-A attempted to transfer R1 off the commode (portable toilet). Interventions included all staff education related to lifts and safe transfers. The incident report identified R1 was transferred with one assist and R1 was to have two assist for all transfers.

During an observation and interview on 10/16/24 at 10:36 a.m., R1 was sitting in his wheelchair looking out the window. R1 had 3 staples in the back of his head with dried red substance

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| F 689 | Continued From page 3<br>surrounding staples. R1 stated that transfer was "poor operation, it was just one person and I damn near got killed in this room." R1 stated NA-A put the sling around him and transferred him without help. R1 stated this was the only time he was ever transferred with only one staff member. R1 could not recollect how far into the transfer they were when the fall occurred or what had happened that caused him to fall out of the sling.<br><br>During a phone interview on 10/16/24 at 2:59 p.m., NA-A explained she was a contracted staff member and could not recall what date her first shift was, but that it was recent. On her first shift, NA-C had showed her around one of the units, how residents transferred on that unit, and where supplies were kept. NA-A indicated the orientation at this facility did not include compentency for lifts, however has used that brand of lifts at other facilities. On 10/13/24 she had been covering NA-B's hallway while she was on break but NA-B had not told her how resident's transferred on that hallway. NA-A stated when NA-B was on break R1 turned on his call light and went to answer it. When NA-A entered R1's room he was sitting on the commode yelling his back hurt and wanted to get off the commode. NA-A asked R1 if he could wait but he continued to yell that he wanted to go to his bed. Because R1 was yelling she decided she would transfer him. NA-A placed the full body mechanical lift sling underneath R1, attached the sling to the lift, and began lifting R1 even though R1 continued to display behaviors. While R1 was suspended in the air, R1 continued to yell and move his body around while in the sling. NA-A asked R1 to calm down, to stop yelling, and stop moving around but R1 did not listen. He slipped out of the sling and fell to the floor. NA-A stated | F 689 | | |

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| F 689 | Continued From page 4<br>she was unaware that R1 required two people to transfer and thought R1 was assist of one because NA-B said R1 could go to bed prior to going on her break. NA-A did not ask the nurse or other staff for help with the transfer.<br><br>During an interview on 10/16/24 at 4:01 p.m., NA-C stated she worked with NA-A on her first day at facility but could not recall the date. NA-C explained she had been in a hurry that evening because she was leaving early so she only orientated NA-A to the building and where to find supplies. NA-C showed NA-A how to use a full body mechanical lift because she had never used one before at the facility and thought she had told NA-A she had to always use two staff to transfer residents with those lifts. NA-C stated most of the residents down the hall they were working on the evening of NA-A's first day required full body mechanical lifts however, NA-A had not assisted with a lot of those transfers. NA-A assisted the residents who only required one assist.<br><br>During a phone interview on 10/16/24 at 1:30 p.m., NA-B stated NA-A came from a different hall to relieve her while she took her break on 10/13/24. R1 had his fall while she was on her break. There were two other NA's working on the other halls that were supposed to be called for transfers and/or licensed practical nurse (LPN)-A who was passing medications.<br><br>During a phone interview on 10/16/24 at 1:14 p.m., LPN-A stated the evening of 10/13/24, NA-A asked her to go to R1's room. R1 was on the floor and the mechanical lift sling was attached to the machine, not on R1. NA-A told LPN-A R1 was wiggling and yelling and fell to the floor. LPN-A stated it took a long time to get R1 off the floor | F 689 | | |

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| F 689 | Continued From page 5<br>because he continued to yell and make demands "do this, do that, give me this". LPN-A told NA-A that two people were required for full body mechanical lift transfers. NA-A had told LPN-A she was unaware of that. LPN-A stated it was very well known that full body mechanical lifts always required two staff to transfer.<br><br>During a record review on 10/16/24 at 12:16 p.m., administrator sent an email identifying that the facility was unable to locate NA-A's orientation packet. Administrator provided a blank copy of what the orientation packet was, which included a competency for mechanical lifts. In a follow-up email dated 10/22/24, NA-A's first day of work at the facility on the floor was 9/29/24.<br><br>During an interview on 10/17/24 at 9:16 a.m., director of nursing (DON) stated she had reviewed NA-A's completed orientation packet but was not aware of the date she had reviewed, and was not sure where the completed packet was. DON explained R1 had not had behaviors while utilizing the mechanical lift prior to the incident on 10/13/24. DON questioned if R1's diagnosis of pneumonia contributed to the behavior exhibited on 10/13/24.<br><br>During an interview on 10/17/24 at 11:48 a.m., with administrator and DON, DON indicated NA-A should have called for assistance and waited for assistance prior to transferring R1 by herself on 10/13/24. The staff were expected to use two staff with full body mechanical lifts transfers. DON expected all orientation packets to be completed prior to working on the floor independently. Administrator and DON indicated the following had been implemented as a result of R1's fall prior to the survey: | F 689 | | |

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| F 689 | Continued From page 6<br>-NA-A was suspended pending investigation on 10/13/24,<br>-Facility-wide education with competencies on mechanical lifts began 10/14/24.<br>-Machine used for the transfer was locked out on 10/13/24 and inspected by facility maintenance department between 10/14/24-10/15/24, along with manufacturer inspection of all mechanical lifts at the facility the week of 10/20/24.<br>-Identification of the system breakdown for orientation of new hires and agency staff on 10/14/24 with an ad hoc meeting attended by DON, Administrator, and nurse scheduler.<br>-R1's care plan was updated to reflect trauma/risk of trauma from the fall from the lift.<br>-R1's orders were updated to include treatment to head wound, monitoring of site for infection, monitoring for signs and symptoms of emotional distress, skin assessment, cognition, depression screening, and trauma questionnaires completed on 10/14/24, and on-going as needed.<br>-Social services followed-up with R1 daily 10/14-10/16/24.<br><br>EZ-Way Smart Lift Operators Instructions included:<br>-For safe operation of the EZ Way Smart Lift, operators should watch the training video, read through this manual, complete competency checklist, and practice on fellow staff members before use with patients.<br>-The EZ Way Smart Lift was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patients condition, two caregivers maybe necessary.<br><br>The food and drug administration (FDA) patient lifts safety guide identifies the use of a lift should | F 689 | | |

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| F 689 | Continued From page 7<br>be avoided if a patient is agitated, resistive, or combative, determine how many caregivers are required to safely lift the patient. Ensure patient is able to understand and follow directions.<br><br>The facility Safe Resident Handling Program dated 3/20, identified training will be provided to direct care staff to demonstrate proper application and use of available safe patient handling equipment. Training records will be maintained and include dates of training, name and title of person conducting the training, name, and job title of employee. The records will be maintained in the employee's file.<br><br>The facility Care Planning policy dated 1/6/22, identified the care plan will identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. | F 689 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 23, 2024

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

Re:  Event ID:  P0EP11

Dear Administrator:

The above facility survey was completed on October 17, 2024, 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 contact me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN  55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On On 10/16/24, and 10/17/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.<br>The following complaints were reviewed:<br>H55079543C (MN00107469). NO licensing | 2 000 | | |

| 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 10/17/2024 |

| 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<br>orders were issued.<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |