DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 11, 2023

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

RE: CCN: 245507
Cycle Start Date: April 6, 2023

Dear Administrator:

On May 8, 2023, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

May 11, 2023

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

Re: Reinspection Results
Event ID: 30X712

Dear Administrator:

On May 8, 2023 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 April 6, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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April 19, 2023

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

RE: CCN: 245507
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 6, 2023, 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 July 6, 2023 (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 October 6, 2023 (six months after 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 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
	00031	A. BUILDING: _____ B. WING _____	C 04/06/2023

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 4/5/23 and 4/6/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H55079915C (MN00092239) with a licensing order issued at 1665. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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.	2 000		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to replace a ceiling tile in 1 of 3 shower rooms observed for environment. Additionally, based on observation, interview, and document review the facility failed to secure 2 of 2 rooms that contained chemicals on a locked memory care unit. Finding include: During an observation on 4/5/23, at 3:45 p.m. the shower room on the 200 wing had a missing ceiling tile in the left hand corner. There was a fully exposed sprinkler in the area of the missing tile. During an interview on 4/6/23, at 9:35 a.m. maintenance assistant (M-A) stated the tile was removed due to the roof leaking which was repaired, he thought, last week, and would be replacing that tile today.	21665	Corrected	4/28/23

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21665	Continued From page 3 During a phone conversation on 4/6/23 at 10:39 a.m. fire marshal (FM-A), stated that it was important the tiles were to be in place so that the fire and smoke detection systems worked properly. FM-A stated that the tile should be replaced today. During an interview on 4/6/23 at 10:57 a.m. the maintenance manager (M-B), indicated the tile was removed on 3/16/23 when they noticed the problem with the roof leaking. After a leak was identified and repaired, the facility waited for it to rain again to make sure there were no other leaks after the repair was completed, before they usually replace the tile. unlocked doors: R4's quarterly Minimum Data Set (MDS) dated 2/17/23, included diagnoses of Alzheimer's Disease, and dementia with behavioral disturbances. R4 was cognitively impaired and did not wander. R4's Care Plan dated 12/9/22, indicated R4 spends much of her time wheeling up and down the hallway. Interventions initiated 2/21/23, indicated target mood/behaviors included wandering and grabbing objects around her. During an observation on 4/5/23, at approximately 4:25 p.m. of the secured memory care unit, a door labeled, Clean Linen was unlocked and contained clean linen, but also wound cleanser, personal care products and skin creams. In addition, a door labeled, Utility Room was unlocked. The room had a cart inside the door with open and accessible chemicals in bottles labeled, Abolish (odor eliminator), Sanix	21665		

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21665	Continued From page 4 (detergent/disinfectant). Additionally, there was a wet jet with cleanser bottle attached accessible on the floor. During the observation, R4 was wheeling independently up and down the hallways in a wheelchair repeatedly passing the unlocked rooms containing the chemicals. Abolish material safety data sheet (MSDS) last updated 6/1/2006, included store out of the reach of children. Health hazard listed was serious eye damage, eye irritation, and nausea. Sanix MSDS issued on 5/1/2021, included the potential health hazards were toxic if swallowed, with skin contact, or inhaled and may cause serious burns, damage to eyes, and damage to organs. Prevention of these potential serious health affects was to keep out of reach of children and store locked up. During an interview on 4/5/23, at 4:30 p.m., nursing assistant (NA)-A verified both doors were unlocked and stated that the doors should be locked. NA-A walked away without locking the doors. During an interview on 4/5/23, at 4:33 p.m., NA-B stated their were current residents that wander the hallways, that both doors were unlocked, and then stated, "the doors should be locked because there were chemical in the rooms". Further stated, "sometimes they don't get locked because someone will push a button on the back of the door, so they don't lock". NA-B did lock both doors. During an interview on 4/5/23, at 4:37 p.m., the regional nurse consultant (CM-B) stated it was her expectation that the doors be locked because chemicals were stored in there. The director of	21665		

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21665	Continued From page 5 nursing (DON) was present and agreed the doors should be locked. No policy received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days.	21665		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 30X711

Dear Administrator:

The above facility was surveyed on April 5, 2023 through April 6, 2023 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 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 04/06/2023

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

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F 000	INITIAL COMMENTS On 4/5/23 to 4/6/23, 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. The following complaint were reviewed. H55079915C (MN00092239) with a deficiencies issued at F609 and F921. 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. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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 serious bodily injury, or not later than 24 hours if	F 609		4/28/23

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

Electronically Signed | 04/21/2023

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	Continued From page 1 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. §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: Based on interview and document review the facility failed to ensure an incident of serious bodily injury was reported to the state agency (SA) immediately, but no later than 2 hours, as required for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's admission Minimum Data Set (MDS) dated 11/30/22, included diagnoses of non-traumatic subdural hemorrhage (brain bleed), age related cognitive decline, unspecified tremor, history of falling, and abnormalities of gait and mobility. MDS also indicated R1 had moderate cognitive impairment without behaviors. R1 required extensive assist of one staff with bed mobility, transfers, walking in room. Limited assist of 1 with locomotion off of unit and supervision with locomotion on the unit.	F 609	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. How corrective action will be taken for those affected by the alleged deficient practice: -R1 is no longer a resident at the facility. How will the facility identify other residents having the potential to be affected by the same deficient practice? -All residents have the potential to be affected by the alleged deficiency. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not	

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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 609	Continued From page 2 R1's self care deficit care plan dated 11/23/22 directed staff R1 required one assist with activities of daily living. R1's mobility care plan dated 11/23/23, identified R1 had an alteration in mobility related to history of falls, general weakness, and imbalance. Corresponding interventions included transfer with assist of one and ambulate with front wheeled walker with assist of one staff. R1's care plan for cognition indicated R1 had diagnoses of subdural hematoma and compression of the brain. Corresponding interventions directed staff to provide cues, reorientation, and supervision as needed. R1's care plan for mood and behavior dated 11/23/22, directed staff to be alert to mood and behavior changes. R1's fall care plan dated 11/23/23, identified R1 was at risk for falls; corresponding interventions directed staff to follow physical and occupational instructions for mobility function. R1's progress note dated 2/8/23, indicated R1 had been somewhat restlessness and having delusions he was at home. R1 had put on his call light to use the bathroom and reported he had seen his friend in the corner of the room (delusion-noone was there). R1 then did not want to sit in his recliner again because his room was out in the hallway; redirection were "mildly successful". Staff were able to have him sit on the edge of the bed. R1 was found 5 minutes later at 3:50 a.m. in the hallway on the floor. R1 was not responsive to verbal stimuli at first and complained of head and neck pain. R1 was bleeding from the back of the head and had fixed pupils. 911 was called and resident was transferred to the hospital by ambulance at 4:25 a.m. Subsequent progress note on 2/8/23, indicated R1 had been admitted for brain bleed	F 609	occur: -Administrator1 was educated on the facility's reporting policy. Staff were educated on the Abuse Prohibition/Vulnerable Adult Plan policy. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: -Administrator or designee will audit grievances daily x 2 weeks to determine if any incidents are reportable. Administrator or designee will audit residents to ensure they feel safe and secure 5x per week x 2 weeks.	

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 04/06/2023

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F 609	Continued From page 3 and required surgery for cervical fracture; unable to determine extent of spinal cord damage. It was not evident in R1's record a comprehensive assessment was completed of R1's delusions and restlessness for the need of further treatment and/or interventions. R1's care plan did not indicate and/or identify that R1 had a history of delusions, had history of restlessness, had rejection of care behaviors, or history of self-transfers. R1's Minnesota Documentation of Death identified R1 died on 2/20/23. Further identified manner of death was accident. Immediate cause of death identified as complications of cervical spine injuries, due to or as a consequence of fall. Review of facility reported incidents between 1/1/23 and 4/5/23, it was not evident the facility reported R1's fall that resulted in serious injury. During an Interview on 4/6/23, at 1:35 p.m. with NM-B, DON and Administrator both stated that they did not have to report the incident as they were following R1's falls care plan. During the interview, NM-B, DON, or administrator did not address or articulate the care plan interventions that directed staff that R1 required extensive assistance from one staff assistance for ambulation and transfers and provide supervision as needed for alteration in cognition. Facility Abuse Prohibition/Vulnerable Adult Plan dated 2/2023, is not consistent with reporting guideline as identified in State Operations manual for Long Term Care Facilities included Suspected abuse shall be reported to OHFC (Office of Health Facility Complaints) online	F 609		

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F 609	Continued From page 4 reporting process not later than 2 hours after forming the suspicion of abuse. 2) Suspicion of neglect, exploitation, or misappropriation of resident property must be reported to the OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury Facilities policy Fall Prevention and Management dated 2/2021 included the following: - The facility interdisciplinary team or designee will determine the need for reporting to the state survey agency. Avoidable fall with serious injury shall be reported to the SA through online reporting process immediately but not later than 2 hours after identifying the injury. Definitions: - Serious bodily injury means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse. -Avoidable Accident means that an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident; including the need for supervision and/or assistive device and/or evaluate/analyze the hazards or risk and eliminate them, if possible or if not possible, identify and implement measures to reduce the hazards/risks as much as possible and or Implement interventions including adequate supervision and assistive devices, consistent with the residents needs, goals, and care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident and/or montor for	F 609		

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F 609	Continued From page 5 effectiveness of the interventions and modify the care plan as necessary.	F 609		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to replace a ceiling tile in 1 of 3 shower rooms observed for environment. Additionally, based on observation, interview, and document review the facility failed to secure 2 of 2 rooms that contained chemicals on a locked memory care unit. Finding include: During an observation on 4/5/23, at 3:45 p.m. the shower room on the 200 wing had a missing ceiling tile in the left hand corner. There was a fully exposed sprinkler in the area of the missing tile. During an interview on 4/6/23, at 9:35 a.m. maintenance assistant (M-A) stated the tile was removed due to the roof leaking which was repaired, he thought, last week, and would be replacing that tile today. During a phone conversation on 4/6/23 at 10:39 a.m. fire marshal (FM-A), stated that it was important the tiles were to be in place so that the fire and smoke detection systems worked properly. FM-A stated that the tile should be	F 921	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. How corrective action will be taken for those affected by the alleged deficient practice: -No residents were directly impacted by the alleged deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? -No residents were directly impacted by the alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: -Education has been completed with the maintenance team on the importance of replacing ceiling tiles timely and checking doors with chemicals behind them. Staff	4/28/23

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F 921	Continued From page 6 replaced today. During an interview on 4/6/23 at 10:57 a.m. the maintenance manager (M-B), indicated the tile was removed on 3/16/23 when they noticed the problem with the roof leaking. After a leak was identified and repaired, the facility waited for it to rain again to make sure there were no other leaks after the repair was completed, before they usually replace the tile. unlocked doors: R4's quarterly Minimum Data Set (MDS) dated 2/17/23, included diagnoses of Alzheimer's Disease, and dementia with behavioral disturbances. R4 was cognitively impaired and did not wander. R4's Care Plan dated 12/9/22, indicated R4 spends much of her time wheeling up and down the hallway. Interventions initiated 2/21/23, indicated target mood/behaviors included wandering and grabbing objects around her. During an observation on 4/5/23, at approximately 4:25 p.m. of the secured memory care unit, a door labeled, Clean Linen was unlocked and contained clean linen, but also wound cleanser, personal care products and skin creams. In addition, a door labeled, Utility Room was unlocked. The room had a cart inside the door with open and accessible chemicals in bottles labeled, Abolish (odor eliminator), Sanix (detergent/disinfectant). Additionally, there was a wet jet with cleanser bottle attached accessible on the floor. During the observation, R4 was wheeling independently up and down the hallways in a wheelchair repeatedly passing the unlocked	F 921	were educated on the importance of locking the doors with chemicals behind them on all wings to create and ensure a safe, clean, functional, and homelike environment. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: -Administrator or designee will audit shower room tiles for placement 1x per week x 4 weeks to determine if there are any missing tiles or concerns. Administrator or designee will audit rooms with chemicals to ensure doors are locked 4x per week x 4 weeks.	

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F 921	Continued From page 7 rooms containing the chemicals. Abolish material safety data sheet (MSDS) last updated 6/1/2006, included store out of the reach of children. Health hazard listed was serious eye damage, eye irritation, and nausea. Sanix MSDS issued on 5/1/2021, included the potential health hazards were toxic if swallowed, with skin contact, or inhaled and may cause serious burns, damage to eyes, and damage to organs. Prevention of these potential serious health affects was to keep out of reach of children and store locked up. During an interview on 4/5/23, at 4:30 p.m., nursing assistant (NA)-A verified both doors were unlocked and stated that the doors should be locked. NA-A walked away without locking the doors. During an interview on 4/5/23, at 4:33 p.m., NA-B stated their were current residents that wander the hallways, that both doors were unlocked, and then stated, "the doors should be locked because there were chemical in the rooms". Further stated, "sometimes they don't get locked because someone will push a button on the back of the door, so they don't lock". NA-B did lock both doors. During an interview on 4/5/23, at 4:37 p.m., the regional nurse consultant (CM-B) stated it was her expectation that the doors be locked because chemicals were stored in there. The director of nursing (DON) was present and agreed the doors should be locked. No policy received.	F 921		

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