

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  Hilltop Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  410 Luella Street Watkins, MN 55389	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645</b></p> <p>Based on interview and document review, the facility failed to notify the Ombudsman for Long Term Care (LTC) of resident transfers to the hospital for 2 of 2 residents (R19, R32), reviewed for hospitalization . This had the potential to affect all residents transferred to hospital.</p> <p>Findings include:</p> <p>R19's significant change Minimum Data Set (MDS) dated [DATE], indicated R19's diagnoses included chronic obstructive pulmonary disease (COPD) and heart failure, and R19 was cognitively intact.</p> <p>R19's progress notes indicated R19 was hospitalized from 6/3/23 through 6/8/23.</p> <p>R19's medical record lacked evidence the Ombudsman for LTC was notified of R19's transfer to the hospital.</p> <p>R32's face sheet, undated, indicated the following diagnoses hemiplegia and hemiparesis of the right side (weakness and paralysis on the right side), osteoarthritis, right femur fracture, and cerebral vascular infarction (CVA-stroke).</p> <p>Progress notes indicated R32 was hospitalized from 9/10/23 until 9/20/23 and 10/22/23 until 10/24/23.</p> <p>R32's medical record lacked evidence a written notification of transfer was sent to the Ombudsman for long term care.</p> <p>The facility's Admission/Discharge To/From Report for 6/1/23 to 6/30/23, listed resident names, dates, and location for seven residents discharged to home or other facilities from 6/1/23 through 6/30/23. However, the report did not include the names and dates of residents transferred to the hospital.</p> <p>On 3/21/24 at 1:03 p.m., social services director (SSD) stated the ombudsman of LTC was not notified of transfers to the hospital and was only notified of discharges to home or other facilities. SSD acknowledged the ombudsman should have been notified of all discharges, including residents transferred to the hospital.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/21/24 at 1:11 p.m., administrator acknowledged the ombudsman of LTC had not been notified of resident transfers to hospital. Administrator stated the ombudsman of LTC should have been notified of all resident hospital transfers.</p> <p>The facility's Transfer or Discharge, Emergency policy, last approved 3/2024, indicated the procedures that would be implemented for emergency transfer or discharge to a hospital. However, the policy lacked information regarding notification to the ombudsman of LTC.</p> <p>49657</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40938</p> <p>Based on interview and document review, the facility failed to notify the physician and/or nurse practitioner (NP) for 1 of 3 residents (R34) reviewed for change of condition.</p> <p>Findings include:</p> <p>R34's quarterly minimum data set (MDS) dated [DATE], identified R34 had severe cognitive impairment and diagnoses which included dementia, Alzheimers, chronic kidney disease, edema and constipation.</p> <p>A review of R34's medical record revealed on 3/16/2024, at 4:41 a.m. a nursing progress note indicated Resident had small blood clots in her incontinent product. Further progress note on 3/16/2024 2:22 p.m. indicated resident had an emesis during lunch. After lunch, resident also had blood clots in her stool noted.</p> <p>Progress note on 3/18/2024, at 2:26 a.m. indicated R34 had a large blood clot and blood coming from her rectum that filled her incontinent pad.</p> <p>Further review of R34's medical record revealed the medical record lacked evidence R34's physician and/or NP had been notified.</p> <p>During interview on 3/21/24, at 11:07 a.m. registered nurse (RN)-B stated R34 had not had blood clots coming from the rectum prior to this and was not sure if the physician and/or NP were notified.</p> <p>On 3/21/24, at 11:13 a.m. RN-C stated it was not ordinary for R34 to have blood clots or blood coming from the rectum. RN-C stated the provider would be informed of a change in condition if there was a concern with R34's comfort or if there was something out of the ordinary.</p> <p>On 3/21/24, at 12:15 p.m. director of nursing (DON) reviewed the medical record and verified the record lacked evidence the provider had been notified of clots and blood coming from the rectum. The DON stated the provider should have been updated blood and clots from the rectum are definitely not ordinary.</p> <p>Facility policy Change in a Resident's Condition or Status dated 1/2024 identified our facility shall promptly notify the resident, his or her attending Physician, and representative of changes in the resident's medical/mental condition and /or status.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49657</p> <p>Based on observation, interview and document review the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 46 residents residing in the facility and visitors who may have wished to view this information.</p> <p>Findings include:</p> <p>On 3/18/24 until 3/21/24 the staff posting was posted at the door. However, upon review of the weekend postings the facility only indicated licensed staff in the facility but did not differentiate between registered nurses (RN) and licensed practical nurses (LPN).</p> <p>The Staff Posting Report [NAME] dated 2/17/24, listed out 3 licensed staff working a total of 24 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 2/18/24, listed out 3 licensed staff working a total of 24 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 2/24/24, listed out 2 licensed staff working a total of 16 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 2/25/24, listed out 2 licensed staff working a total of 16 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 3/2/24, listed out 3 licensed staff working a total of 24 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 3/3/24, listed out 3 licensed staff working a total of 24 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 3/9/24, listed out 2 licensed staff working a total of 16 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 3/10/24, listed out 2 licensed staff working a total of 16 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 3/16/24, listed out 3 licensed staff working a total of 24 hours but no designation of their license being RN or LPN.</p> <p>The Staff Posting Report [NAME] dated 3/17/24, listed out 3 licensed staff working a total of 24 hours but no designation of their license being RN or LPN.</p> <p>On 3/21/24 at 9:00 a.m., the business office manager (BOM) stated the staff posting was auto populated by a computer program, printed daily and was not broken down to indicate RN or LPN and only listed them as licensed staff. The BOM confirmed the staff posing lacked information on the weekends. It was important to include so anyone who wanted to know the staffing, could view the information.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>On 3/21/24 at 2:00 p.m., the director of nursing (DON) confirmed on the weekends the RN's and LPNs were only listed out as licensed staff with no designation between RN and LPN. The DON stated it was important to include the information to show how many RNs were in the building and they have enough staffing coverage.</p> <p>The facility policy Posting of Nursing Hours-Long term care last approved 12/2022, indicated the total number of actual hours worked by the following categories of hours worked was to be listed on the posting: RNs, LPNs, certified nurse aides, and resident census.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49657</p> <p>Based on observation, interview and document the review the facility failed to ensure the dishwashing machine temperatures reached adequate washing temperatures to clean and sanitize dishes. This deficient practice had the potential to affect all 46 residents who received meals from the facility's kitchen.</p> <p>Findings include:</p> <p>On 3/20/24 at 8:22 a.m., while observing the dishwasher, the wash cycle was observed 4 times and the temperatures were as follows:</p> <p>Wash cycle #1 at 8:22 a.m. =147 degrees Fahrenheit ( F)</p> <p>Wash cycle #1 at 8:23 a.m. =148 F</p> <p>Wash cycle #1 at 8:25 a.m. =149 F</p> <p>Wash cycle #1 at 8:27 a.m. =152 F</p> <p>On 3/20/24 at 8:27 a.m., the dietary dishwasher (DD)-A stated it was a common occurrence for the dishwasher wash cycle to not reach the required temperature of 150 F, since date of hire (November 2023). The log for the dishwasher temperatures was reviewed and indicated wash cycle temperatures greater than 150 F. DD-A stated the machine had to run a few times before it got to the required temperature that morning. However, DD-A stated when/if the wash cycle did not reach the required temperature the dishes were put out for use and not rewashed.</p> <p>On 3/20/24 at 9:23 a.m., the dietary manager (DM)-A stated they had not been notified the dishwasher was not meeting required wash cycle temperature. DM-A confirmed the dishwasher used high heat and chemical to sanitize and the required temperatures were 150 F for wash cycle and 180 F for rinse cycle. The DM-A expected staff to rewash dishes if the dishwasher did not get to the required washing temperature and report occurrence to DM-A.</p> <p>On 3/21/24 at 4:15 p.m., the maintenance staff (MA)-A confirmed the required temperatures for the dishwasher was a wash cycle at 150 F or higher, and sanitize cycle at 180 F. Additionally, MA-A confirmed issues in the past with dishwasher temperatures had been addressed.</p> <p>On 3/21/24 at 4:22 p.m., the Ecolab technician who maintained the machine for the facility confirmed the wash cycle needed to reach 150 F and the rinse cycle 180 F. If the temperature did not reach 150 F, staff should have run a test strip to ensure the machine reached the required temperatures. Prior to washing dishes, approximately 20-30 cycles could be necessary to reach the required 150 F.</p> <p>The facility policy Operation of the Dish Machine dated 03/2024, indicated the required ranges was &gt;150 F for the wash cycle and &gt;180 F for rinse cycle.</p>