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	03/29/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 5 residents (R6) reviewed who required staff assistance with personal care. R6's face sheet identified R6 admitted on [DATE] with diagnoses of type 2 diabetes, obesity, dementia, unspecified psychosis. R6's current care plan identified an alteration in behavior and interventions included to go into room with two staff when completing care. On 3/27/24 at 10:22 a.m., nursing assistant (NA)-D came into room to change roommate d/t a strong urine odor in room. Curtain was drawn between roommates. NA-D yelled from the R6's side of the room [LPN-A] he keeps throwing his fists up at me, his sheet is wet. NA-D came over to R3's side of the room angrily with a garbage bag and stated, He just keeps laughing now, it isn't funny. NA-D then left the room. LPN-A stated when a resident was not cooperative staff should let the nurse know and reapproach in 10 minutes. LPN-A stated she would talk to NA-D about the incident. During an interview on 3/28/24 at 10:53 a.m., NA-D conceded to being upset with R3. NA-D explained LPN-A advised her to reapproach R6 after she was upset. NA-D stated awareness R3 had been care planned for assistance of two staff with cares due to his behaviors. NA-D reported she walks away when residents become behavioral. During an interview on 3/28/24 at 11:50 A.M., director of nursing (DON) stated administration had educated NA-D and a staff meeting on 3/27/24 that encompassed customer service and dignity. A document titled Staff Meeting 3/27/24 identified attendance for the meeting. NA-D did not attend the meeting. During an interview on 3/29/24 at 12:25 P.M., DON and Administrator verified NA-D had not attended the staff meeting. DON stated LPN-A educated NA-D on 3/27/24. No paperwork that verified education provided.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to initiate, comprehensively assess, monitor, and treat skin conditions for 4 of 4 residents (R2, R3, R4, and R5) reviewed for impaired skin integrity. R2's face sheet undated identified an admitted ,d+[DATE]. Diagnoses morbid obesity (obesity categorized by a body mass index greater than 40), type 2 diabetes, urinary incontinence, and erythema intertrigo (inflammatory skin condition caused by skin-to-skin friction (rubbing) that is intensified by heat and moisture). R2's Minimum Data Set (MDS) dated [DATE], identified R2 needed maximum assistance with movement and complete dependence with toileting. R2 used a motorized wheelchair. R2's current care plan identified an alteration in skin integrity with a goal to remain free of skin breakdown. Interventions included: followed by wound care, monitor skin integrity daily during cares, weekly skin inspection by nurse, treatment to open areas per order, turn and reposition or reminders to offload every 2-3 hours and as needed, pressure redistribution cushion to wheelchair and chair, weekly measurements and assessment of wound, monitor for skin breakdown for signs/symptoms of infection and report to doctor, document on skin condition and keep doctor informed of changes. R2's December orders identified skin care of buttocks and posterior thighs to gently cleanse skin with warm washcloth and soap if resident will allow and pat dry. Apply a thin layer of triad hydrophilic wound paste twice daily and as needed alternating with calmoseptine twice daily and as needed two times daily for skin care from 11/30/23-12/13/23 and from 12/14/23-12/20/23. Additionally, and as needed (PRN) order to apply a Mepilex (soft, silicone foam dressing for wounds) to right inner thigh for multiple raw skin irritations every three days, replace PRN. Discontinue when healed began 10/30/23 and discontinued 12/22/23. R2's treatment administration record (TAR) identified the aforementioned treatments were not completed on 12/6/23, and 12/20/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Occupational Therapy (OT) notes from 12/4/23-1/2/24 identified wheelchair dependence and EZ stand for transfers (mechanical lift that assists caregivers to move a resident from sitting to standing and from one place to another with the resident not using 100% of their body strength). Baseline objectives on 12/4/24 identified that between the scooter and recliner R2 can only sit one hour, extremely uncomfortable, putting pressure on wound without noticing it. Relies on pain level to get out of scooter. R2 does not understand why sitting in scooter hurts so much, does not want to recline self when in recliner, and a poor overall awareness of positioning needs and pressure relief for healing of wounds. R2's reason for referral identified that R2 had a new blister/wound in right (r) crease of buttock, sliding in the scooter and inability to reposition self without shearing due to (d/t) decrease in upper body strength, and a recommendation for a pressure reduction device for the recliner as R2 only sleeps in a recliner. Current recliner 28 wide, 28 depth; current scooter 18 depth, can be 21 if reclined seat, 24 wide. Current scooter does not fit R2's body size, especially depth. OT goal is R2 can sit in scooter without pain. Discharge short term goals on 1/2/24 identified R2 is now able to sit several hours a day in scooter, changes position while sitting from hip to the other, denied pain, and is aware of pressure put on wounds and with new padding and pressure relief, met this goal. Long term goal met 1/2/24 identified that R2 can request to be transferred into recliner, staff is able to position R2 more in back of the seat for better positioning, R2 is aware of wounds and able to request staff to reposition and not put pressure directly on wound. R2's current orders included Triad hydrophilic wound dress external paste to apply to right posterior thigh topically one time a day every Monday, Wednesday, and Friday for wound care beginning 12/29/23. Additionally, for skin care of posterior right thigh: gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry; apply a THIN layer of Triad hydrophilic wound paste over affected skin followed by a large border foam dressing; change every three days and PRN one time a day. R2's TAR identified the aforementioned treatment was not completed on 12/21/23, 12/30/23, 1/2/24, 2/7/24, 2/10,24, 2/16/24, 2/25/24, and 3/5/24. R2's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -12/12/23 right (R) thigh red and open, small amount of bleeding noted. -12/19/23 open area on R) inner thigh improving, R2 reports decreased pain. -12/26/23 R) thigh dressing intact. -1/2/24 no changes. -1/9/24 wound on R) thigh unchanged. -1/16/24 no documentation of R) thigh wound. -1/23/24-refused shower, no skin assessment completed. -1/30/24 no new skin condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/6/24 wound on R) thigh, posteriors. Unchanged. -2/20/24 no changes to skin. -3/5/24 red on R) posterior thigh. 3/12/24 thighs just below buttocks are tender and Mepilex applied. Put on the list for wound nurse. 3/19/24 no documentation of R) posterior thigh. No weekly skin assessments completed by licensed nursing staff on 2/13/24, 2/27/24, and 3/26/24. R2's progress note (PN) dated 10/3/23 indicated R2 came to the desk in tears stating she had a sore area to her bottom and thighs. Noted two pinpoint reddened areas to inner R) buttocks, and five pinpoint open areas scattered to area of inner R) thigh. A Mepilex was placed to inner R) thigh. R2's PN dated 10/21/23 indicated to place Mepilex to R) inner thigh for multiple raw skin irritations every three days, replace PRN. Discontinue when healed. Replaced dressing for comfort. Not open. R2's PN dated 11/20/23 indicated mepilex to R) inner thigh replaced effectively. R2's PN dated 11/24/23 an open area to R) crease of buttocks and a mepilex applied to both sides. Put in provider book and report given to oncoming nurse. R2's Skin and Wound Evaluation V7.0 dated 12/13/23, identified location R) medial thigh, middle with wound measurements of area 10 cm2, length 4.8cm and width 2.6cm. In red lettering it stated Note: wound is not open per CNP notes on 12/13/23. Measurements are incorrect. Resolved. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Extended Care Visit Note dated 12/13/23, identified at last visit resident reporting that her posterior right thigh is very painful. Reports she has been sitting in her recliner more because after 10 minutes or so in her wheelchair she wants to pass out from the pain in her thigh. The degree of breakdown in her skin is difficult to assess today due to the thick layer of paste over the area. Area is tender and would require the paste to be softened up by soaking the area. Resident reports that she could not take a shower yesterday because sitting on the shower chair hurts too much. Today, reports that pain is slightly less but she continues to notice some blood on pad in the morning that covers her recliner. She is concerned about getting an infection in that area. The area of concern is located on the right leg (posterior R) thigh). The last clinic visit was 1 week ago. The patient is currently experiencing symptoms which include pain. The patient describes the pain as tenderness. Exacerbating factors include chronic friction, chronic trauma, and chronic moisture. Current treatment includes daily skin care. Due to having an electric wheelchair does not have a pressure reduction cushion in wheelchair. Posterior R) thigh looks improved without signs/symptoms (s/s) of bleeding. No evidence of open or draining skin. Area continues to be tender per resident report. Follow up in 1 week. Orders for skin care of (B) buttocks and posterior thighs: gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry. Apply a THIN layer of triad hydrophilic wound paste twice daily and PRN alternating with Calmoseptine twice daily and PRN. Recommendations that in order for residents' skin of buttocks and thighs to heal, resident needs to get the pressure off of them. This is difficult given that she does not want to lay down in a bed and is constantly sitting on them in addition to friction/shearing forces that happen when she slides in chair or tries to reposition self and does not completely lift skin off the surface she is sitting on due to her body habitus and poor upper extremity strength. Also, brought up that the electric wheelchair appears to be getting too small for her and could be the cause of some of her skin problems if the seat is not deep enough. Resident frequently has to push her weight back for repositioning when she starts to feel to forward. Resident disagrees and feels that her wheelchair is large enough. R2's PN dated 12/18/23 indicated nutrition follow-up related to (r/t) wound. Resident has a friction injury on R) posterior thigh. Resident refused protein supplements, staff continue to encourage protein intake at meals. R2's Extended Care Visit note dated 12/19/23, identified posterior R) thigh looks to have partial thickness skin loss near the medial edge of the friction injury. Area continues to be tender per resident report. Orders changed to skin care of posterior R) thigh-d/c all previous wound care orders! Gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry. Apply a THIN layer of Triad Hydrophilic Wound Paste over affected skin followed by a large border foam dressing. Change every 3 days and as needed. New recommendations that resident does not want a wheelchair evaluation for evaluation for a larger wheelchair. Current wheelchair appears to be getting too small for her and could be the cause of some of her skin problems if the seat is not deep enough. Resident frequently has to push her weight back for repositioning when she starts to feel too forward. Resident disagrees and feels that her wheelchair is large enough. Turn and reposition/offload at least every 2 hours or as indicated on Tissue Tolerance Evaluation if interval is more frequent. Resident will need assistance with major repositioning changes since she is unable to do this on her own. Follow up in one week to re-evaluate per facility request. No measurements done. R2's PN dated 12/31/23 indicated R2 complained of upper thigh pain under buttocks. Skin is dry and irritated. Skin cleansed and barrier cream applied. Pillow offered to help offload from bottom, patient refused. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's PN dated 1/22/24 indicated nutrition follow-up r/t wound. Resident has an ongoing friction injury on R) posterior thigh. R2's PN dated 2/22/24, indicated skin care of posterior R) thigh cleaned and treated as ordered. Area of skin is rough and sore in it. R2's Skin and Wound Evaluation V7.0 dated 3/28/24, identified R) medial thigh, new wound-minutes old, in-house acquired friction. Area 0.24cm2, length 1.4cm and width 0.47cm. Granulation (small red granules of new capillaries on a wound surface) 100%, surrounding tissue with erythema (superficial reddening of the skin as a result of injury or irritation causing dilatation of the blood capillaries). Treatment included normal saline, triad with no secondary dressing. Additional care included cushion, incontinence management, moisture barrier and turning/repositioning program, added to weekly wound rounds for next week. Notified dietician, practitioner, and resident/responsible party. On 3/26/24 at 12:28 p.m., R2 was laying in her recliner. I have a little wound on the side of my right thigh, but they are taking care of it., I prefer to sleep in my recliner, it makes a beautiful bed, I sleep in it perfectly. R2 demonstrated how to raise and lower the recliner. No bed in room. No pressure reduction cushions in recliner or electric wheelchair. During an interview on 3/26/24 at 2:34 p.m., nursing assistant (NA)-A and NA-B indicated that there were usually two staff working on R2's hall and that there were 23 rooms on that hall. They get the information to care for the residents from the care plan and toileting and care sheets. NA-A indicated that it did make it harder to get cares done if there was only one staff member working the hall. On 3/27/24 from 7:32 A.M. to 10:35 A.M., observed wound care rounds with CNP and LPNMC. Wound care and observation were not performed on R2. On 3/28/24 at 10:41 A.M, CNC verified there were no measurements included in the 12/27/24 skin and wound assessment and that skin assessments had not been completed weekly. On 3/28/24 at 11:06 A.M., R2 was using the commode with NA-D in room. R2 stated I've had the wound on my inner R) thigh for a long, long time. If they put a bandage on it, its ok. R2 stated last night it hurt so bad they came in and put stuff on it. R2 continued It's been a long time since I've seen [CNP]. NA-D stated that R2 had this wound for a while and they try so many creams, mepilex and it seems to get a little better and then it gets worse, it is worse now. There was no pressure reduction cushion in the wheelchair or the recliner. DON came in and observed the wound and verified that there was no pressure reduction cushion in the wheelchair or the recliner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 2:42 P.M., R2 was observed for wound care. DON took barrier cream out of R2's drawer. NA-C and R2 verified that was the cream that has been applied to R) posterior thigh, not the triad paste. DON educated R2 and NA-C the barrier cream was not what the order says to use and that they were to be using triad paste. DON left room. R2 was on the commode with a washcloth placed on the R) side front of the commode. NA-C stated it was per R2's request so it did not hurt so much. No pressure reduction cushion in the recliner or wheelchair, a chux pad (for urinary incontinence) was on the wheelchair. NA-C stated that the pressure reduction cushion for R2 was over by the nurse's station drying because they just got it and I used the purple wipes on it. DON returned with a tube of triad paste. DON did not date the triad upon opening it. NA-C stood R2 with the EZ-stand and DON used a piece of gauze and wiped the R) posterior thigh with sterile water. R2 stated my left side is starting to get one. DON stated that there were two little areas of red, superficial, no slough, no drainage, and no redness around it. R2 stated It bleeds at night and the chux has blood in it. DON applied triad paste, no foam dressing over. R2 stated I'm starting to get one on the other side [DON], it [NAME] over there. DON did not assess or acknowledge R2's comments. During a phone interview on 3/27/24 at 1:23 P.M., Family member (FM)-A stated family had not been notified about R2's R) posterior thigh wound and they were also not aware of the wheelchair being too small. FM-A stated they put a new seat cushion on R2's power wheelchair with a seat cushion. During a phone interview on 3/29/24 at 9:43 A.M., CNP stated that R2's assessment from 12/27/23 indicated that the R) posterior thigh had a skin loss and to follow up in one week. CNP unsure what happened that R2 dropped off the schedule when she was supposed to continue to be seen. CNP stated that facility staff were to keep her informed if a wound reopens so that the treatment can be changed. If something was open and not healing in 2-4 weeks, the treatment should be changed. R3's face sheet undated identified R3 admitted on [DATE]. Diagnoses included adult failure to thrive, dementia (loss of memory), type 2 diabetes, stage 1 pressure ulcer of right upper back, pressure ulcer of other site, pressure ulcer of other site unstageable, Alzheimer's (brain disorder that causes problems with memory, thinking and behavior). R3's care plan identified an alteration in skin integrity with current pressure ulcers left (L) lateral knee. Interventions included to put pillows between knees when in bed, resident to wear heel lift boots at all times, monitor skin integrity daily during cares and weekly skin inspection by nurse. Treatment to open areas per order, pressure redistribution cushion to wheelchair and chair, low air loss air bed, weekly measurements, and assessment of wound. R3's admitted collection form dated 1/31/24, identified no amputations and pedal pulses present in both feet. Wounds included the L) scapula 3cm x 2.5cm, right knee front 1cm x 0.5cm, right ankle outer 1.5cm x 0.5cm, left ankle outer 0.7cm. Skin comments identified small scabs on ankles, sores in the process of healing, both knees still open a small size. Back has a healing older red mark. Mepilex applied as directed. R3's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -2/7/24 R3 had several foam mepilex to bilateral lower extremities (BLE) that were just changed this morning. Foams left in place and remain intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/14/24 wound care dressings in place from wound nurse today. -3/6/24 skin breakdown on left lateral knee, right ankle, and front of right knee. All already noted by wound care and addressed. -3/13/24 mepilex on knees bilaterally and ankle did not need changing. Stayed clean and dry during bathing. R3's weekly Skin and Wound Evaluation V7.0 with sections available to mark the description of wound, location, where acquired, how long the wound has been present, staging, measurements, description of the wound bed, other issues including bleeding, bone, fibrin, gangrene, hematoma, hypergranulated, intact blister, islands of epithelium, pink/red, ruptured blister, scab, other, amount of exudate, odor, periwound, induration, edema, periwound temperature, wound pain, goal of care; treatment which included dressing appearance, cleansing solution, debridement, primary dressing, secondary dressing, modalities, additional care; progress, infection, notes, education, and notifications. These assessments were completed on and included the following information: -2/7/24 unknown location of pressure measured 1cm x 0.6cm. Physician note dated 2/7/24, identified R) ankle unstageable ulcer measured 0.97cm x 0.62cm x 0.1cm and had minimal drainage and 100% devitalized tissue. L) lateral knee unstageable ulcer measured 0.91cm x 0. 81cm x 0.1cm and had 100% devitalized tissue. The surrounding tissue was noted to have erythema but no increased warmth. Wound care ordered to L) lateral knee: cleanse wound bed with wound cleanser. Treat periwound with skin barrier prep. Apply medihoney to the wound bed. Cover with mepilex, ok to reinforce with tape as needed, recommend to use cast padding and coban with no compression in attempt to keep dressing in place, change every 3 days, sooner if greater that 50% saturated. R) lateral knee: cleanse wound bed with wound cleanser, treat periwound with skin barrier prep, apply medihoney to the wound bed, cover with mepilex and okay to reinforce with tape as needed-recommend use of cast padding and coban with no compression in attempt to keep dressing in place. change every 3 days, sooner if greater than 50% saturated. Recommendations included heel lift boots on in bed, turn and reposition at least every 2 hours, air overlay or other specialty mattress if available due to high risk for pressure sore development, cushion in wheelchair at all times, follow up in one week. Resolved scapula wound. -2/14/24 R) lateral malleolus measured 1cm x 0.7cm. -2/20/24 R) lateral malleolus measured 0.8cm x 0.5cm, front R) knee stage 2 pressure injury no measurement-resolved. -2/28/24 R) lateral malleolus measured 0.8cm x 0.5cm-see Certified Nurse Practitioner (CNP) note from 2/28/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician note dated 2/28/24, idenitifed R) ankle measured 0.52cm x 0.82cm. the wound had decreased in size and noted to be dry, brown scab. Dry and 100% devitalized tissue. L) lateral knee measured 0.47 x 0.43 x 0.1cm with 100% granular tissue and a decrease in size. R) lateral knee measured 0.85 x 1.24 x 0.1cm depth and noted to be 100% granular tissue. The surrounding tissue noted to have erythema. Wound orders to knees were to cleanse wound and surrounding skin with normal saline or wound cleanser and pat dry, apply skin prep to periwound skin and allow to dry, apply a dab of iodosorb gel to wound beds, cover with border foam dressing and change every other day and as needed. R) lateral ankle cleanse wound and surrounding skin with normal saline or wound cleanser and pat dry, paint with betadine and allow to dry, cover with border foam dressing and change every other day and as needed. -3/6/24 R) lateral malleolus measured 1.5cm x 0.8cm-see CNP note. Front R) knee 1.4cm x 0.9cm status resolved. -3/13/24 R) lateral malleolus measured 1.3cm x 0.6cm-see CNP note, L) above knee amputation site measured 1.4cm x 1cm-see CNP note. Physician note dated 3/13/24, identified R) ankle measured 1.32cm x 0.56cm, the wound had decreased in size, noted to have red discoloration and dry. L) proximal lateral knee ulcer measured 0.98cm x 1.37cm x 0.1cm with moderate drainage and 100% devitalized tissue. L) distal lateral knee ulcer measured 1.39cm x 0.79 cm x 0.1cm and had moderate drainage and 50% granular and 50% devitalized tissue. Ordered for L) lateral knee to cleanse with wound cleanser, apply skin prep to periwound skin, apply cut to fit calcium alginate to wound bed, cover with border foam dressing and change every other day and PRN. R) lateral ankle-no changes, R) lateral knee cleanse wound and surrounding skin and pat dry, cover with border foam dressing for protection, change every 3 days and PRN. -3/18/24 R) lateral malleolus measured 1.7cm x 1.1cm status marked resolved, L) above knee amputation site 1.3cm x 0.8cm, L) shin medial measured 0.8cm x 0.6cm status marked stable. Physician note dated 3/18/24, identified R) ankle unstageable ulcer measured 1.72cm x 1.07cm. cleansed with saline. The wound has increased in size and had red discoloration and was dry. L) proximal lateral knee unstageable ulcer measured 0.81cm x 0.59cm. minimal amount of drainage and had 100% devitalized tissue with intact margins. L) distal knee unstageable ulcer measured 1.33cm x 0.77cm and noted to be 50% granular and 50% devitalized tissue. The surrounding skin was noted to have induration. Continue dressing leg wounds as ordered. -3/22/24 front L) knee lateral measured 3.2cm x 0.9cm status resolved. -3/27/24 description of wound is pressure. Location is left above knee amputation site. Wound measured 0.6cm x 0.4cm. Granulation tissue in wound bed 100%. Progress was improving-see CNP note. Physician note dated 3/27/24, identified R) ankle measured 0.8cm x 2cm and had red discoloration and was dry. L) proximal lateral knee measured approximately 0.2cm x 0.2cm x <0.1cm. The wound had decreased in size. Scant drainage after removal of devitalized tissue wound was 100% granular. L) distal knee resolved. Wound order to L) lateral knee to cleanse open wound and surrounding skin with cleanser, paint with betadine and allow to dry, cover with bordered foam and change every other day and PRN. R) lateral ankle cleanse wound and surrounding skin, cover with border foam for protection, change every 3 days and PRN. (continued on next page)

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	03/29/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 3:46 P.M., R3 was not in room. Bed was unmade. TAR wound care was not signed out. On 3/27/24 at 10:22 A.M., R3 was laying in bed with a second mattress on the floor next to the bed. Air mattress was on the bed. Fall mat was tucked into the wall side of the bed. Body pillow was against the wall. Two pillows were tucked under the fitted sheet of the mattress on the outside of the bed. R3 is not wearing heel lift boots and there are no pillows between the legs. LPN-A stated it's a body pillow, I know they aren't supposed to be under the sheet. I'll make sure to re-educate the aides. CNP stated R3's sheet is wet and smelled of urine. CNP, LPNMC, and LPN-A removed the four corners of the fitted sheet to aid in repositioning R3 and for the aides to change the sheet. CNP kept the heel protectors off since R3 needed a clothing change but stated I worry how long he'll be without his boots? CNP turned call light on, and they left the room. On 3/27/24 at 10:35 A.M., NA-E stated the front pillow is so R3 doesn't crawl out of bed. R3 was lying in a fetal position on his right side. NA-E and NA-D applied the four corners of the bed sheet back to the mattress. NA-E and NA-D changed R3's brief and pants. NA-E and NA-D did not apply heel protectors or place a pillow between his knees. On 3/27/24 at 11:14 A.M., NA-E and NA-D assisted R3 to his wheelchair. At 11:19 A.M., R3 was in the hallway with heel protectors. On 3/27/24 at 1:01 P.M., R3 was lying in bed. Heel boots off, secondary mattress on floor, no pillow between his knees. During an interview on 3/27/24at 1:15 P.M., LPN-A verified R3 did not have heel protectors on, a pillow was not between his knees. LPN-A stated, I'm sorry, it's disheartening, he is supposed to have the heel boots on at all times and the pillow between his legs. LPN-A verified that care sheets are located in the closet door, so staff know what cares need to be done. R4's face sheet identified an admitted ,d+[DATE]. Diagnoses included cellulitis (bacterial infection of the skin), peripheral vascular disease (blood circulation disorder), non-pressure chronic ulcer of lower leg, L) leg above knee amputation, methicillin resistant staphylococcus aureus (infection caused by specific bacteria that are resistant to commonly used antibiotics). R4's care plan identified alteration in skin integrity with interventions to monitor skin daily during cares and weekly inspection by nurse, turn and reposition with offloading every 2-3 hours and PRN, pressure redistribution mattress to bed, pressure redistribution cushion to wheelchair and chair, monitor for skin breakdown and document on skin condition and report to doctor. R4's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -12/24/23 R) leg was wrapped and covered for shower, unable to see wounds. (continued on next page)

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	245507	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's weekly Skin and Wound Evaluation V7.0 with sections available to mark the description of wound, location, where acquired, how long the wound has been present, staging, measurements, description of the wound bed, other issues including bleeding, bone, fibrin, gangrene, hematoma, hypergranulated, intact blister, islands of epithelium, pink/red, ruptured blister, scab, other, amount of exudate, odor, periwound, induration, edema, periwound temperature, wound pain, goal of care; treatment which included dressing appearance, cleansing solution, debridement, primary dressing, secondary dressing, modalities, additional care; progress, infection, notes, education, and notifications. These assessments were completed on and included the following information: -1/16/24 front right lateral lower leg 4.1cm x 3cm progress marked stable. See Certified Nurse Practitioner (CNP) notes. No CNP note for 1/16/24. -1/24/24 front right lateral lower leg 2.8cm x 1.8cm progress marked improving. -1/31/24 front right lateral lower leg 2.5cm x 1.3cm. See orders from CNP. Physician note dated 1/31/24, identified R) lower extremity mid-tibial wound had decreased in size, had moderate drainage, 10% granular and 90% devitalized tissue with margins intact. Distal to wound was skin loss due to moisture. R) dorsal foot wound resolved. Medial distal R) foot dorsal surface resolved. -2/7/24 front right lateral lower leg 2cm x 1.4cm Progress improving. See CNP dictation. Physician note dated 2/7/24, identified R) lower extremity mid-tibial wound had moderate drainage, and was 20% granular and 80% devitalized tissue. -2/14/24 front right lateral lower leg 1.5cm x 0.9cm granulation marked 100% of wound filled. Moderate amount of drainage. No odor. Attached edges. Surrounding skin dry and flaky. No swelling, edema, or induration. Periwound normal. Progress improving. See CNP note. Physician note dated 2/14/24, identified R) lower extremity mid-tibial wound decreased in size, moderate drainage and 100% granular. -2/23/24 front right lateral lower leg 1/1cm x 0.8cm progress marked improving. See CNP notes. No notes from physician visit. -2/28/24 front right lateral lower leg 1.3cm x 1.2cm progress marked improving. See CNP notes. Physician note dated 2/28/24, identified R) lower extremity mid-tibial wound appeared smaller, had serosanguineous drainage and was 100% granular with blistering skin surrounding wound. -3/6/24 front right lateral lower leg 0.7cm x 0.6cm, progress marked improving. See CNP notes. R4's Physician note dated 3/6/2 identified a new ulceration on R) lower extremity partially circumferential and distal to primary wound. Wound measured 5.98cm x 3.09cm x 0.1cm. Margins were intact, 100% granulation tissue and minimal amount of drainage. R) lower extremity mid-tibial wound had minimal drainage and 100% granular with blistering surrounding wound. -3/13/24 front right lateral lower leg not measured-see CNP note. Physician note dated 3/13/24, identified R) lower extremity mid-tibial wound resolved. R) lower extremity blistering ulceration approximated measurement 5.66cm x 2.48cm x 0.1cm and had decreased in size, had minimal drainage and 100% granular with intact margins. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Physician note dated 3/20/24 identified the wound was almost completely healed at this time. No assessment or measurements included in note. R4's TAR for March 2024 identified acetic acid, collagenase ointment, xerofoam with hydrofera blue, R) lower extremity dressings, rooke vascular boots, and tubigrips on leg treatments not completed on 3/12/24. On 3/27/24 at 8:07 A.M., CNP and LPNMC assessed R4's wound. R4 had an open, undated package of xeroform dressing in container of wound supplies. LPNMC stated it is common practice at the facility to reuse opened dressings. LPNMC threw away the opened dressing. CNP stated wound is a venous/mixed arterial ulcer on the front of R) shin that appeared as an upside-down rainbow in shape. R5's face sheet identified admitted ,d+[DATE]. Diagnoses anemia (deficiency of red blood cells), peripheral vascular disease (slow and progressive disorder of blood vessels), hemiparesis (one sided muscle weakness), occlusion of R) artery with stenosis (narrow or blockage of artery), tobacco use, R) knee prepatellar bursitis (inflammation of the bursa located within the kneecap). -2/13/24 admission assessment: right knee surgical incision, no measurements, skin tear o.4 x o.1 cm left forearm, skin tear 0.2 cm x 0.1 cm left forearm R5's admission assessment dated [DATE], identified Resident's skin is without blemish. Right knee was operated upon to clean out pus that pooled in a hole in his knee following an accidental fall. Resident is alert and oriented x3. Has both upper and lower dentures. He is assist of 1 with pivot for transfers. Sustained an unwitnessed skin tear to lateral left forearm shortly after admission. Site of Mantoux administration bled out shortly after administration. These new areas were cleansed and covered up with island dressings. Resident did not want dressing covering knee wound to be taken off so - not yet assessed. Nurse at [NAME] north western reports that no dressing changes necessary for right knee until resident's follow up appointment with ortho. R5's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -2/15/24 Skin is clear, dry and intact with the exception of skin tears on left forearm and surgical incision on right knee. -2/22/24 Skin shows minor small bruising on his arms. Wounds on his right knee. Treated. -3/6/24 Right knee surgical incision covered with wound vac dressing and also wrapped before shower. Other skin appears clean, dry and intact. Generalized bruising on bilateral upper extremities. -3/13/24 R knee surgical site not visualized, covered with wound vac. Otherwise rest of the skin is clean, dry and intact. -3/27/24 refused shower dressing intact Weekly skin assessments not completed on skin tears to L) forearm. R5's readmission from hospital on 3/21/24, identi[TRUNCATED]