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	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 Southbend Avenue Mankato, MN 56001

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to ensure an allegation of staff to resident sexual abuse was reported to the State Agency (SA) within two hours for 1 of 1 resident (R1) who reported a male staff member inappropriately touched her. Findings include: R1's face sheet dated 8/28/24, identified R1 had diagnoses of depression, major depressive disorder, social phobia, and anxiety disorder. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 did not have cognitive impairment. R1 required two-person physical assist with dressing and grooming, and required a total mechanical lift and two assist to transfer from one location to another. R1's Vulnerable Adult Maltreatment Report submitted to the State Agency on 8/26/24, identified notification of R1's accusation of sexual assault by a staff member that occurred on 8/25/24. R1 had been at the emergency room earlier in the day for a dislodged catheter after the sexual assault occurred. Facility was instructed to have two people for all cares, call police, and report incident. R1's clinic visit note dated 8/27/24, identified R1 had an incident on 8/25/24 in which staff inappropriately touched her. R1 had a history of sexual abuse from her father that R1 continued to have trauma from, and current incident was making it hard to sleep at night. During an interview on 8/27/24 at 10:17 a.m., R1 stated on 8/25/24, a male aide came up behind her and pulled her brief down while she was using the mechanical lift and ran his fingers across her butt-cheeks. He said he was sorry, and she told him to leave. Since I came to the facility, I told them about being molested and that I don't want men around me in that position. (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 3:49 p.m., licensed practical nurse (LPN)-A stated she went to R1's room on 8/25/24 at approximately 9:00 a.m. to change R1's catheter. Upon entering the room R1 was visibly shaking and crying. R1 reported to LPN-A a male aide pulled her brief from behind her and ripped it out then put his fingers on that area and caressed her peri area. LPN-A immediately notified the LPN-B supervisor and was in R1's room while R1 gave the same statement to the LPN supervisor. LPN-A stated LPN-B took over the investigation and determined which male aide R1 had been talking about. LPN-A indicated while all that was going on R1 was sent to the emergency room for problems with her urinary catheter. LPN-B had left her a note on her computer to call R1's power of attorney and the physician. LPN-A explained the POA had already been to the facility and was made aware by R1, LPN-A called the nurse practitioner (NP) who told her to call the police and offer emergency room for further evaluation. LPN-A notified LPN-B of NP's orders to which LPN-B directed her not to call the police and not to tell the emergency department of the allegation until after she talked to the administrator. LPN-A stated she did not call the police as directed and was not aware if the police had been notified. LPN-B was called on 8/28/24 at 11:54 a.m., however the call was not answered, a message was left with no return phone call. During a phone interview on 8/27/24 at 11:20 a.m., NP-A stated LPN-A called approximately 3:15 p.m., on 8/25/24, LPN-A reported R1 had been sexually abused by a male staff who yanked her brief off forcibly and rubbed his fingers on her behind. NP-A told LPN-A to call and notify the police and offer R1 emergency department services. NP-A indicated later that evening she had followed-up with the police, the police informed her that a report had not been filed so she informed the police of R1's allegations. During an interview on 8/27/24 at 2:28 p.m. Administrator, DON, and Administrator in Training (AT)-A had been notified via phone by the LPN-B of the allegation however LPN-B had reported R1 did not report the incident as abuse or assault in nature. Administrator stated R1 was questioned and stated, he ran his finger across her bottom during repositioning. Administrator felt the incident was customer service related and not reportable to the SA. During an interview on 8/27/24 at 3:21 p.m., medical director (MD)-A stated she would expect the facility to follow the protocol for reporting an incident and all incidents reported would need an investigation attached. The facility Abuse Prohibition/ Vulnerable Adult Policy revised 3/2024, identified the purpose was to protect residents against abuse by anyone, including, but not limited to, facility staff , to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Suspected abuse shall be reported to Office of Health Facility Complaints (OHFC) online but not later than two hours after forming the suspicion of abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to develop a person centered comprehensive care plan was developed for 1 of 3 residents (R1) who requested no male caregivers provide care. Findings include: R1's face sheet dated 8/28/24, identified R1 had an admitted in July 2024 with diagnoses of depression, major depressive disorder, social phobia, and anxiety disorder. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 did not have cognitive impairment. R1 required two-person physical assist with dressing and grooming, and required a total mechanical lift and two assist to transfer from one location to another. During an interview on 8/27/24 at 1:52 p.m., registered nurse (RN)-A stated he completed R1's admission assessments. During that process R1 had brought up the history of sexual abuse; RN-A immediately initiated no male caregivers to provide cares. RN-A explained he did not add the history and R1's preferences to the care plan, did not document in a progress note, and did not complete the trauma assessment. RN-A stated he only reported the information during shift to shift report. During an interview on 8/27/24 at 10:17 a.m., R1 stated Since I came to the facility, I told them [staff] about being molested and that I did not want male caregivers. During an interview on 8/28/24 at 9:46 a.m., family member (FM)-A stated R1 was always upfront with facilities and told them about the sexual trauma in her past. During an interview on 8/27/24 at 10:09 a.m., nursing assistant (NA)-A indicated R1 made it known that she did not want male care givers providing personal care since she was admitted to the facility. NA-A stated R1 had told her she had been sexually molested as a child shortly after she was admitted to the facility. During a phone interview on 8/27/24 at 12:07 p.m., NA-D stated since R1 was admitted to the facility she was only to have females for personal cares. NA-D stated R1 had been fine with a males helping transfer as long as her peri area was covered. NA-D stated R1's preferences not to have male care givers was passed down during shift to shift report. During an interview on 8/28/24 at 8:23 a.m., NA-B indicated since R1 was admitted she only could have females complete personal cares because she was sexual abused. During an interview on 8/28/24 at 9:01 a.m., RN-B stated R1 did not like male caregivers and does not want them to perform cares on her. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's clinic visit note dated 8/27/24, identified R1 had an incident on 8/25/24 in which staff inappropriately touched her. R1 had a history of sexual abuse from her father that R1 continued to have trauma from, and current incident was making it hard to sleep at night. Although mulitple staff had awareness of R1's preferences, her care plan was not revised until 8/26/24, after R1 reported an allegation of a male nursing assistant inappropriately touched her on 8/25/24. R1's care plan dated 8/26/24, included R1 was at risk for alterations in behavior related to (r/t) trauma including self-reported history of being molested. Interventions included to speak clearly and explain steps to the cares being provided, female staff only for peri-cares, two staff present during all cares, medication pass, and treatments, psychologist referral, staff will utilize trauma informed care when working with resident, encourage collaboration with therapeutic recreation and social services to improve social connections and minimize symptomology. During an interview on 8/28/24 at 12:06 p.m., administrator in training (AIT)-A stated nurses were expected to communicate with the nurse manager or adjust the care plan as needed and bring the discussion to the interdisciplinary meeting. AIT-A stated R1 did not report sexual trauma during the admission trauma questionnaire. The facility care planning policy revised 1/6/22, identified each resident will have a person-centered care plan developed by the interdisciplinary team (IDT) for the purpose of meeting the residents individual medical, physical, psychosocial, and functional needs. The baseline care plan will be developed within 48 hours of admission. The IDT, in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day after admission for the resident. The trauma informed care policy revised 2/24/23, identified staff will identify history of trauma when possible, residents with a history of trauma will have goals and interventions added to the care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident. Care plans will be updated as needed.