

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a wheelchair in a clean and sanitary manner for 1 of 1 resident (R32) and ensure fans in resident rooms were kept clean for 3 of 3 residents (R2, R52 and R21) reviewed for safe, clean, comfortable, and home-like environment. Findings include:R32's face sheet received on 8/13/25, included diagnosis of Parkinson's disease (a movement disorder of the central nervous system). R32's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition. R32 had unclear speech, was usually understood and could understand. R32 required substantial assistance or was dependent upon staff for activities of daily living (ADLs) and did not walk. R32's care plan did not include use of a wheelchair. During an observation on 8/11/25 at 7:18 p.m., while seated in her wheelchair at a table in the great room, observed a heavy grayish/white film over the blue brackets under and alongside R32's wheelchair. The film was hardened onto the brackets and was not able to be wiped off with a finger. During an interview on 8/12/25 at 2:08 p.m., the director of nursing (DON) stated there was not a wheelchair cleaning schedule, that staff cleaned them on a resident's bath day, and the cleaning was not documented. During an interview on 8/12/25 at 2:13 p.m., nursing assistant (NA)-E stated wheelchairs were cleaned on a resident's bath day with disposable wipes. NA-E did not know if wheelchair cleaning was documented. During an interview on 8/13/25 at 7:31 a.m., NA-C stated wheelchairs were cleaned when staff had time, or the night shift did it. NA-C was asked to look at R32's chair under the light in the hallway and stated the heavy whitish/grayish film on the surfaces of the bars alongside and under the wheelchair was from R32's food. During an interview on 8/13/25 at 7:36 a.m., licensed practical nurse (LPN)-C, who was also the care coordinator approached while speaking to NA-C. LPN-C stated R32's wheelchair was hers from her home. LPN-C stated R32 was a new resident and that was the condition of her wheelchair at the time she was admitted to the facility. R32 was admitted three months prior, on 5/13/25. During an interview on 8/14/25, at 11:05 a.m., R32 stated she was unaware her wheelchair had a film on it. The film was described to her, and she indicated she didn't know what it was from. During an interview on 8/14/25, at 11:30 a.m., the DON stated she would expect staff to notice dirty wheelchairs and clean them. Facility wheelchair cleaning policy was requested. In an email dated 8/13/25, at 5:12 p.m., the administrator indicated wheelchair cleaning would follow the residents bill of rights. DIRTY FANSR2's face sheet received on 8/13/25, included diagnosis of dementia. R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R2 was cognitively intact, clear speech, was able to understand and be understood.R52's face sheet received on 8/13/25, included diagnosis of dementia.R52's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, was able to understand and be understood. R21's face sheet received on 8/13/25, included diagnoses of recurrent c. diff (clostridioides difficile - inflammation of the colon caused by bacteria), cancer of the rectum and receiving chemotherapy.R21's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, was able to understand and be understood. R21 was ambulatory per self.R21's care plan dated 7/10/25, indicated isolation precautions related to recurrent C-diff infection.During an observation and interview on 8/11/25 at 3:18 p.m., in R2's room observed a black standing fan in operation in the corner of R2's room directed at R2's recliner where he had been sitting and where he also slept. Observed a significant amount of whitish/gray fuzzy material hanging off the front and back grates of the fan. R2 stated he had not noticed, didn't know if it had ever been cleaned and stated it should probably be cleaned, but staff were busy. During an observation and interview on 8/11/25 at 6:37 p.m. , in R52's room observed a white standing fan in operation about two - three feet in front of R52's recliner where she had been sitting and where she also slept. Observed a significant amount of fuzzy whitish/gray material on the back grate of the fan and heavy dark material on edges of the fan blades. R52 stated she did not think it had ever been cleaned.During an observation on 8/12/25 at 8:40 a.m., in R21's room observed a standing white fan in operation about three feet from R21's bed as he sat on the side of the bed. The fan had a buildup of fuzzy grayish material on the front and back grates and dark material on the edges of the fan blades. R21 stated he hadn't noticed and that he thinks he brought the fan from home.During an interview and observation on 8/12/25 at 12:11 p.m., along with housekeeping manager-in-training (HM)-B and housekeeping regional supervisor (HS)-C looked at the fan in R52's room. HS-C stated housekeeping was responsible for cleaning fans, adding it was not done on a routine basis, just when housekeeping noticed them needing to be cleaned. HS-C stated they were behind on some routine work due to staffing but would</p>		