STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the appropriate use of an air mattress for 1 of 3 (R2) residents identified at risk for falls. This deficient practice caused actual harm, a left [MEDICAL CONDITION], when R2 fell out of bed due to the placement of an air mattress on top of the existing mattress on a bed. The facility had implemented corrective action on [DATE] therefore, the deficient practice is being issued at past non-compliance harm. Findings include: R2's admission Minimum Data Set (MDS) assessment dated [DATE], indicated the resident had severe cognitive impairment with [DIAGNOSES REDACTED]. An incident report submitted to the state agency (SA) on [DATE] at 6:48 a.m. identified a fall R2 sustained; Date and time of incident [DATE] at 22:20 (10:20 p.m.). Description of incident: At 10:20 p.m. on [DATE], resident was found on the floor in his room, laying on his left hip at bedside. Resident had been toileted 20 minutes prior at 10 p.m. and had voided at that time. Following toileting, resident had been left with his bed in low position, body pillow outlining outside edge of bed and call light within reach, per care plan. Resident appears to have rolled out of bed and onto the floor. All care plan interventions had been followed. Resident is on hospice for terminal [DIAGNOSES REDACTED]. Resident was immediately assessed for injury. Upon assessment, resident reported he fell straight onto his buttock and was noted to have complaints of left leg pain. Facility staff stayed with resident while on call hospice provider was updated at 10:35p.m. with orders to send to ER (emergency room) for evaluation. Gold Cross ambulance was called at 10:40 p.m. Administrator Designee was updated of incident at 10:50 p.m. Facility staff was notified by daughter at 3:50 a.m. that resident was being admitted (to hospital) for left [MEDICAL CONDITION]. Administrator Designee was updated of confirmed left [MEDICAL CONDITION] [DIAGNOSES REDACTED]. This is not the standard procedure and the expectation is that air mattresses will be placed directly on the bed frame. Changes were not made to the policy and procedure as the procedure was not followed, but immediate re education was provided to staff involved in decision to place air mattress over a standard facility mattress .(registered nurse (RN)-C) completed causal factor investigation following fall and noted resident to have hospice air mattress on top of facility standard mattress. (Director of Nursing (DON)) spoke to (RN-D) with Moments Hospice and confirmed this resident's particular air mattress was not to be used as an air overlay mattress, and should've been placed directly on the bed frame. Interviewed (RN-E) Nurse Manager who reports being unaware an air mattress had been delivered for resident. Interviewed (Licensed Social Worker (LSW)) who reports being in resident's room while air mattress was being applied to resident's bed by (maintenance staff (MS)-B) on day of admission. Discussion occurred between LSW and (MS-B) with decision that mattress appeared to be an air overlay mattress, which was placed on top of facility standard mattress for this reason. Immediate re-education was provided to LSW and (MS-B) of standard procedure to place air mattresses directly on the bed frame and not on top of another mattress. Staff must consult with the air mattress provider or the manufacturer's directions for clarification on the proper placement of mattresses .Resident was assessed for injury and was sent to the ER for evaluation. Immediate re education was provided to staff involved in decision to place air mattress over a standard facility mattress, education was provided to staff involved in decision to place air mattress over a standard facility mattress, education was provided to nursing and environmental services staff of appropriate placement, monitoring and care of resident beds and mattresses and immediately removed standard mattress from under air mattress so that only one mattress remained on the bed frame-this decreased the bed height by 6 (inches). Care plan updated to include fall precautions to be implemented upon resident's hospital return: low bed, body pillow to outline outside edge of bed, call light within reach, floor mat when in bed, room rearranged to increase resident supervision from doorway, position resident in center of the bed and away from the outside edge of the bed and top of the hour checks. House audit completed to ensure no other beds had a similar set up with no other concerns noted and education provided to nursing and environmental services staff of appropriate placement, monitoring and care of resident beds and mattresses. When interviewed on [DATE] at 3:30 p.m., family member (FM)-C stated being very very upset with the negligence of the facility. FM-C stated R2 was admitted [DATE], had a fall the evening of [DATE], and died on [DATE]. FM-C stated R2 fell while he was in bed. FM-C stated the maintenance person had not removed the original mattress when putting the air mattress, and further expressed being unaware whether the bed had been placed in the lowest position. FM-C stated, I know when I visited with him (R2) through the window, it wasn't in the lowest position. The nurse that did the fall assessment didn't catch that he had 2 mattresses on the bed. The aides didn't catch it either. On Tuesday ([DATE]) they let me come into the facility as he was end of life. When I saw him on Tuesday he was in a Broda chair, had a catheter the hospital had put in and his leg looked terrible and was really swollen. He seemed comfortable when in his chair but anytime they repositioned him you could tell he was in terrible pain. When interviewed on [DATE] at 9:03 a.m., the LSW confirmed she had helped get R2's room set up after admitting the resident. The LSW stated R2's daughter had brought his belongings in tubs and stated, She told me when the mattress came in it was an air mattress. When (MS-B) looked at the mattress he thought it looked like an overlay and I did too. It didn't look any different than any of our other mattresses that are overlays. (MS-B) helped me fill it up then myself and a nursing assistant made the bed. When I made the bed I didn't have to stretch down over it to get the sheets on so I didn't notice that it was higher than any of the other air mattresses. The LSW confirmed she was educated on the protocol related to resident air mattresses, and stated setting up the resident's bed was something she wouldn't usually do but the resident was on hospice and the daughter was struggling with not being able to be in the room with the resident due to Covid 19 restrictions. The LSW stated the daughter was outside the facility by R2's window when they were setting up his room, directing where she wanted things. The LSW stated, We knew prior to her (the daughter) coming, that she would be bringing equipment used at (R2's) prior assisted living placement. When asked, the LSW confirmed R2's daughter was not outside the room when the air mattress was being set up. When interviewed on [DATE] at 9:46 a.m., MS-B confirmed he had placed R2's air mattress on the bed when the resident was admitted to the facility. MS-B stated R2 had been admitted from an assisted living facility, was on hospice, and stated everyone told him it (the airmattress)was an overlay. So I filled it up and put it on the bed and strapped it down. If I would have looked at the tag we might have been ok. He (R2) was tired from the ride and I wanted to get it done. Even our social services said it was an overlay. If they'd said it was a mattress I would have put it on as a mattress - but it didn't look that thick, and I haven't seen any other hospice ones that looked like that. When asked if the mattress was thicker than the other overlay mattresses he'd put on other resident beds MS-B stated, yea, maybe. MS-B confirmed that following R2's incident, all resident air mattresses in the facility had been audited to ensure they were applied properly. When interviewed on [DATE] at 10:31 a.m., the DON confirmed hospice had brought an air mattress for the resident to utilize. The DON acknowledged the LSW and maintenance staff both thought is was an air overlay and not an air mattress so had put it over the regular mattress. The DON stated normally hospice would have brought the mattress in and applied to the

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

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 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) bed, but with covid they were not allowed to come into the facility to do that. The DON confirmed their post fall investigation of R2's fall revealed the causal factor of the fall to be the air mattress. R2's hospital orthopedic surgery consult note dated [DATE], identified the resident sustained [REDACTED]. The consult notes indicated R2's daughter consulted with the on-call surgeon and a decision was made to proceed with non-operative management with the goal being R2's comfort. The facility's ,[DATE] policy, Falls Prevention and Management Protocol, included: Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The facility's corrective actions identified in the facility's post fall investigation, were verified as having been implemented as of [DATE] through interviews and record review.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 77 residents who resided at the facility. Findings include: During an interview on 8/11/20, at 9:55 a.m. housekeeping supervisor (HS)-A stated high touch surfaces were disinfected every other day with a product called Unicide 256, which was also used for floor cleaning and disinfection throughout the facility. A facility document titled: infection control program, scheduled maintenance checks, dated July 2020, had a column for each day of the month and a line for each item to check, including a line indicating: hi-touch zone. HS-A pointed to that line and stated the initials on that line were his and one other employee. Despite stating high touch surfaces were disinfected every other day, the log did not reflect that. HS-A admitted no disinfecting had been done on Saturdays and Sundays, and during one week of July it was done only twice, rather than three times. During an observation on 8/11/20, at 10:18 a.m. of the northeast resident hallway, noted a pungent musty odor upon walking a short distance into the hallway. Observed a ceiling tile by the nurses kiosk in this hallway with a large circular pattern of black material around a circular ceiling vent. Further down the hallway by room [ROOM NUMBER], observed another ceiling tile with the same black material around the circular ceiling vent. Also observed several ceiling tiles with yellowish colored stains. During an interview on 8/11/20, from 11:08 a.m. to 11:55 a.m. with registered nurse (RN)-A and director of nursing (DON), RN-A stated the expectation is for high touch surfaces such as railings in hallways, doorknobs and nursing kiosks were to be disinfected by night shift nurse aids. DON added that maintenance and housekeeping tag team cleaning of high touch surfaces every day. The cleaning log titled: NE (northeast) nurse cleaning schedule, dated August 2020, had a column for each date and a line for various cleaning activities, including wiping down the treatment and med cart with a sanitizing wipe and wiping keyboards, telephones and counters with sanitizing wipes. These activities were to be done every shift, every day, however, the log indicated otherwise as the majority of days, it was done only once, or not at all. A log titled: infection control cleaning schedules nursing assistants, which RN-A stated had been started August 6, had a column for each day of the month and lines for various cleaning activities. A line titled: keep utility room clean, was to be completed every shift, every day, but had occurred only on the day shift, with the exception of one night shift. A line titled: clean all utility room cupboards every Sunday night, was blank. A line titled: wash and disinfect each lift, every evening, had only been done twice since August 6. A line titled: disinfect high touch areas (kiosk, rails and doorknobs) every night: had only been done twice since August 6. During interview with RN-A and DON could not verify if cleaning and disinfecting was being done as expected. During an observation on 8/11/20, at 1:25 p.m., entered the soiled utility room on the southwest hallway. As soon as a staff member opened the door, a pungent odor was noted. The room was small, measuring approximately eight feet by eight feet. On the left side were receptacles for soiled linen. On the right side was a countertop with sink and wooden cupboards below. The faucets on the stainless steel sink were corroded and rusty. Adjacent to the counter was a hopper (a large standalone sink-type receptacle with a sprayer hose for cleaning and flushing organic debris into the septic system). The hopper was elevated on a square platform covered in tile. Several pieces of the three inch by three inch brown tile were missing, exposing cement. There were several areas on walls that appeared to have been previously patched that were missing paint, exposing gray plaster or cement. On a wall above the hopper, near the ceiling was a jagged cement hole with pipe coming out. At least one ceiling tile was ajar; not fully seated. A small rectangular ceiling vent was covered with thick gray-colored debris. The brown tile floor was dull and dirty. The facility cleaner/disinfectant for high touch surfaces and floors, Brulin brand Unicide 256, was not found on the environmental protection agency (EPA) List N for disinfectants for use against [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes Covid-19. During an interview on 8/11/20, at 2:30 p.m., RN-A, HS-A and maintenance director (MD)-A stated they were not able to provide documentation that this cleaner/disinfectant killed [DIAGNOSES REDACTED]-CoV-2. RN-A stated to MD-A remember when I asked you about that? During an interview on 8/11/20, at 2:58 p.m. on the northeast hallway, (RN)-B stated it smelled musty in the hallway; I noticed these resident rooms have poor ventilation compared to other parts of the facility. During an interview and observation on 8/11/20, at 3:20 p.m. with the administrator, HS-A, and MD-A in the northeast hallway, when asked if they noticed a smell, MD-A immediately acknowledged a musty odor, stating this hallway always smells off. MD-A went on to say there was a crawl space under the entire length of the hallway and noticed when there was a heavy rain, the smell is prominent. HS-A stated he thought the hallway smelled like wet carpet and that the carpets had recently been cleaned. The administrator acknowledged the musty odor. The ceiling tiles with black material around the ceiling vents were discussed and the team did not know what caused it. The administrator stated she would contact a facility consultant to investigate the smell and the cause of the black material coming from the ceiling tiles. During an interview on 8/11/20, at 4:20 p.m. the administrator stated MD-A placed an order for [REDACTED]. Facility policy titled Coronavirus (Covid-19), updated on 7/23/20 indicated: Environmental Services: Cleaning and disinfecting resident rooms, equipment, and high touch areas such as hand rails, door knobs, tables, common areas, elevator buttons, door locks/key pads, etc, will be performed using products that have EPA- approved emerging vial pathogens claims that have demonstrated effectiveness [MEDICAL CONDITION] similar to Covid-19 on hard non-porous surfaces. The facility assessment, revised 11/18/19, indicated physical environment and building/plant needs had a process to ensure adequate maintenance and replacement, with a program called preventative maintenance.