Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopkins Health Services	725 Second Avenue South Hopkins, MN 55343

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** 43083 Based on interview and document review, the facility failed to ensure an allegation of physical staff to resident abuse was reported timely, within two hours, as required to the State Agency (SA) and to the administrator for 1 of 1 residents (R1) reviewed for abuse. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1's diagnoses included dementia and personality disorder. R1's cognition was not impaired. Review of facility report number 358043 submitted to the SA on 9/24/24 at 5:41 p.m., identified R1 had reported a nursing assistant (NA) while providing cares was angry and telling R1 not to use the call light and it made her angry. R1 reported NA pinched her in the left leg and grabbed her hair with water on her hands. R1 was able to identify the staff as NA-A. On 10/2/24 at 10:32 a.m., licensed practical nurse (LPN)-A stated staff were expected to report allegations of abuse to the nurse manager, director of nursing (DON) and administrator immediately. On 10/2/24 at 10:41 a.m., LPN-B stated the facility's abuse policy required staff to report allegations of abuse right away to their immediate supervisor and the allegation would need to be reported to the SA within two hours. Further, LPN-B stated they were notified by LPN-C at approximately 1:00 p.m. on 9/24/24, R1 had reported a NA had pinched her. LPN-B stated they notified DON and administrator. On 10/2/24 at 10:57 a.m., social services (SS)-A stated staff were expected to report allegations of abuse immediately and report to the administrator and DON who were then required to report to the SA within two hours. SS-A stated they were informed on 9/24/24 at approximately 2:00 p.m., by LPN-C who reported R1 made an allegation she was hit and pinched by NA-A. SS-A stated they notified the administrator and they both went to interview R1. Further, SS stated LPN-C was made aware of R1's allegation at approximately 11:30 a.m., and LPN-C had reported the allegation to LPN-B as required however, LPN-B directed LPN-C to report the allegation to the administrator and SS-A. SS-A stated she was unsure why LPN-C waited until 2:00 p.m., to report R1's allegation to SS-A however assumed due to medication administration and meal service LPN-C was busy. SS-A stated she was unsure if LPN-C had been re-educated regarding reporting requirements as the administrator would have addressed that. (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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NAME OF PROVIDER OR SUPPLIER: Hopkins Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE: 725 Second Avenue South, Hopkins, MN 55343	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 11:14 a.m., administrator stated staff were trained annually regarding the facility's abuse policy and staff were required to report an allegation of abuse immediately, but within two hours, to the administrator. Administrator stated he then had to investigate if the allegation of abuse was expected to be reported to the SA within two or 24 hours based on if there was actual harm or injury. Administrator stated he was notified by SS-A of R1's allegation at approximately 2:00 p.m. on 9/24/24. Further, administrator stated he educated LPN-C verbally regarding reporting immediately however did not have evidence of addressing reporting requirement. On 10/2/24 at 11:31 a.m., LPN-C stated staff were provided abuse training but could not recall how often. LPN-C stated staff were expected to report allegations of abuse to their supervisors immediately. Further, LPN-C stated at approximately 11:30 a.m. on 9/24/24, LPN-C was administering R1's medications when R1 reported staff had pinched and hit her. LPN-C stated she reported this allegation to LPN-B after exiting R1's room. LPN-C stated she was directed by LPN-B to report the allegation to SS-A however SS-A was in a care conference and it was a busy day so LPN-C was not able to connect with SS-A until after lunch. In addition, LPN-C stated she was aware allegations of abuse were to be reported right away. LPN-C confirmed the administrator had not re-educated her regarding reporting requirements and had not spoken to the administrator since 9/24/24. On 10/2/24 at 11:42 a.m. administrator confirmed he did not report R1's allegation to the SA until 5:41 p.m., due to there was a lot going on and by the time administrator interviewed NA-A it was close to the two-hour timeframe, I don't know. Review of facility policy titled Abuse, Neglect and Exploitation revised 7/15/22, indicated staff were expected to report all alleged violations to the administrator, SA and to all other required agencies within specified timeframes: immediately, but not later than two hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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	245293	A. Building B. Wing	10/02/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to immediately implement an intervention to protect 1 of 1 residents (R1) following an allegation of physical staff to resident abuse. This deficient practice had the potential to affect all other residents currently residing in the facility. Findings include: R1's significant changes Minimal Data Set (MDS) dated [DATE], indicated R1's diagnoses included dementia and personality disorder. R1's cognition was not impaired. Review of facility report number 358043 submitted to the SA on 9/24/24 at 5:41 p.m. R1 had reported a nursing assistant (NA) while providing cares was angry and telling R1 not to use the call light and it made her angry. R1 reported NA pinched her in the left leg and grabbed her hair with water on her hands. R1 was able to identify the staff as NA-A. Review of NA-A's timecard dated 10/2/24, indicated NA-A had clocked in for work at 5:31 a.m. and clocked out at 3:34 p.m., on the day of the alleged incident 9/24/24. On 10/2/24 at 10:41 a.m., licensed practical nurse (LPN)-B stated following an allegation of staff to resident abuse, the alleged perpetrator would need to be removed from direct care and building pending the investigation to protect the residents. On 10/2/24 at 10:57 a.m., social services (SS)-A stated she was made are of R1's allegation at approximately 2:00 p.m. on 9/24/24, and SS-A stated the investigation started NA-A had already left the building as her shift was completed. SS-A stated she interviewed R1 regarding the allegation and R1 had reported she now felt safe in the facility knowing NA-A was no longer in the building. On 10/2/24 at 11:14 a.m., administrator stated he was notified of R1's allegation at approximately 2:00 p.m. on 9/24/24. Administrator stated he interviewed R1 at approximately 2:05 p.m., and R1 had reported she did not feel safe in the facility because NA-A was still in the building. Administrator stated he had not interviewed NA-A yet however ensured R1 that NA-A was going to be suspended immediately which R1 then reported she felt safe. On 10/2/24 at 11:31 a.m., LPN-C stated at approximately 11:30 a.m. on 9/24/24, LPN-C was administering R1's medications when R1 reported staff had pinched and hit her. LPN-C stated NA-A was R1's caregiver that day assisting R1 as needed and requested. LPN-C stated she was not aware of any incidents between R1 and NA-A, and LPN-C stated NA-A appeared fine that day no unusual behaviors. On 10/2/24 at 11:46 a.m., NA-A stated R1 had reported to LPN-C while NA-A was assisting R1 with cares NA-A pinched her. NA-A confirmed she had assisted R1 with cares on the day of the allegation, and NA-A was suspended for three days while the facility completed an investigation, however NA-A could not recall when she left the building on 9/24/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Abuse, Neglect and Exploitation revised 7/15/22, indicated the facility would make efforts to ensure all residents were protected from physical and psychosocial harm during and after the investigation. Examples included but were not limited to responding immediately to protect the alleged victim and integrity of the investigation and room or staffing changes to protect the resident(s) from the alleged perpetrator.