STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 51577 Based on observation, interview, and document review, the facility failed to provide contact information for the Ombudsman (resident advocate) to 3 of 3 residents (R36, R30, R37) who attended the resident council group meeting. This had the potential to affect all 37 residents residing in the facility. Findings include: During the resident group meeting on 12/11/24 at 10:00 a.m., R36, R30, and R37 were in attendance. R36 and R37 stated they were not aware of the Ombudsman, their telephone number, nor the advocacy services they provided. R30 stated they researched the Internet and obtained the information from the website as it was not posted in the facility. During an observation on 12/10/24, at 9:30 a.m., the Ombudsman information was not visible in the facility. During an interview on 12/12/24, at 2:06 p.m., licensed practical nurse (LPN)-D stated the Ombudsman phone number was in the copier room, and the residents could not access the information. During an interview on 12/13/24, at 12:09 p.m., LPN-C stated the Ombudsman information was not posted in the facility. During an interview on 12/16/24, at 10:15 a.m., director of nursing (DON) stated the Ombudsman contact information was in administrator's office, and confirmed it was not posted in the facility in a place accessible to residents and families. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility policy on Resident Rights 9/2017, reviewed/revised 7/2022, stated the purpose was to ensure that resident rights are respected, protected, and promoted, and to inform residents of their rights and provide an environment in which they can be exercised. Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. Residents will be treated with respect and dignity and care for each resident will be given in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident ' s individuality. This facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident ' s stay. The information must be presented both orally and in writing in a language the resident understands. The resident has the right to receive a list of the names, addresses (mail and email) and telephone numbers of all pertinent state regulatory and informational agencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 51577 Based on observation, interview and document review, the facility failed to ensure the most recent State agency survey results were available to review. This had potential to affect all 37 residents who resided on the second floor who wished to review this information without having to ask. Findings include: During an observation on 12/10/24, at 12:30 p.m., the postings of the State Survey results were in a red three-ring binder attached to the wall near the main entrance on the 1st floor. During an observation on 12/12/24 at 2:06 p.m., the 2nd floor, where all residents resided, did not have State Survey results posted, nor any indication they existed and were available elsewhere in the building for review. During the resident group meeting held on 12/11/24 at 10:00 a.m., 3 out of 3 residents (R30, R36, R37) stated they did not know where the State Survey results were posted and were not aware they were allowed to see them. During an interview on 12/13/24 at 12:09 p.m., licensed practical nurse (LPN)-C stated the three-ring State Survey results binder was located on the 1st floor by the business office. They confirmed the State Survey results were not easily accessible to all residents. The policy for Availability of Survey Results dated 6/16/22, stated the purpose of the policy is to uphold a resident's right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. Definitions: is a place (such as a lobby or other area frequented by most residents, visitors, or other individuals) where individuals wishing to examine survey results do not have to ask to see them. The policy for Residents Rights dated 9/2017 reviewed/revised on 7/2022 stated the resident has the right to examine the results of the most recent Federal or State survey as well as this facility ' s plan of correction. These documents must be posted in an accessible location. The facility will make available for review, upon request, any surveys, certification, and complaint investigations made during the 3 preceding years as well as any plan of correction. Information that identifies residents or complainants well not be available for review. Based on observation, interview and document review, the facility failed to ensure the most recent State agency survey results were available to review. This had potential to affect 2nd floor residents, who wished to review this information without having to ask.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to ensure resident-specific resuscitation wishes were clear and evident throughout the electronic medical record (EMR) and physical paper chart for 1 of 1 resident (R22) reviewed for advance directives. Findings include: R22's admission Minimum Data Set (MDS) dated [DATE], indicated R22 had short- and long-term memory problems, severely impaired cognitive skills for daily decision making, and continuous inattention and disorganized thinking. R22's diagnoses included hypertension, renal failure, hip fracture, osteoporosis, depression, Alzheimer's disease, and dementia. During record review on [DATE] at 6:00 p.m., R22 did not have an order for code status. R22's banner in the EMR had a link to Advance Directives which was blank and did not have a POLST (a medical order indicating treatments a person would like to receive in case of serious illness and/or cardiac arrest) uploaded in the EMR. Progress notes and care conference summaries indicated R22's code status was reviewed but did not specify R22's wishes. R22's Physician Discharge Orders/Instructions dated [DATE], indicated R22's code status as DNAR/DNI (do not attempt resuscitation/do not intubate). R22's Statutory Short Form Power of Attorney document dated [DATE], indicated R22 agreed to be kept comfortable and allow natural death to occur under the section of Terminal Condition/Life-Prolonging Treatment section. When interviewed on [DATE] at 6:11 p.m., nursing assistant (NA)-G indicated they would notify a charge nurse if they found a resident unconscious. When interviewed on [DATE] at 6:12 p.m., licensed practical nurse (LPN)-I indicated they would activate a code to get help right away if they found a resident unresponsive and would check resident's paper chart first to review their code status. LPN-I stated they would assume resident as a full code and start CPR (cardiopulmonary resuscitation) if there were no POLST in the resident's chart. LPN-I reviewed R22's paper chart and face sheet and confirmed the face sheet did not indicate R22's code status and there was no POLST. R22's Statutory Short Form Power of Attorney document was in R22's physical, paper chart. LPN-I stated the director of nursing (DON), floor managers, and social worker (SW) assisted with admissions and verified residents' code status and related paperwork. LPN-I stated they would check with the floor manager. During subsequent interview, LPN-I reviewed R22's Medication Administration Record (MAR), and the MAR indicated DNR/DNI under the Special Instruction section of the banner. LPN-I stated most residents have a POLST, but staff looked in the MAR when a POLST was not in the resident chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE] at 6:23 p.m., LPN-B stated R22 was not capable of making their own decisions and had called R22's family member (FM)-A to confirm R22's code status when R22 first admitted . LPN-B stated they mailed R22's POLST to FM-A for them to sign and forgot to make a copy for R22's chart. LPN-B stated the physician would sign the POLST after the family signed the POLST. LPN-B reviewed R22's Care Conference Summary dated [DATE] and confirmed the summary indicated R22's code status was reviewed but did not specify what R22's code status was. LPN-B stated R22 came from the hospital with orders for code status, and staff used the hospital ordered code status until they confirmed code status with resident or family within 48 hours of admission. LPN-B stated they or the director of nursing entered in admission orders, which included code status, and verified R22 did not have a code status in the EMR's orders. When interviewed on [DATE] at 7:32 p.m., LPN-K stated they would check resident's code status in the paper chart or EMR prior to initiating CPR or not if they found a resident pulseless and not breathing. LPN-K stated the director of nursing or other managers reviewed and entered residents' orders and POLST during admissions. During additional interview on [DATE] at 7:40 p.m., LPN-B stated code status orders were part of ancillary orders when residents first admitted . Staff used the template to add in the code status and another nurse verified the admission orders. The code status showed up in the EMR banner when the orders were entered using the template. LPN-B stated the process was missed for R22, and the facility did not use an admission checklist. LPN-B reviewed R22's Statutory Short Form Power of Attorney document and reviewed the section which described to keep R22 comfortable and allow natural death to occur but stated the statement still was not a POLST. When interviewed on [DATE] at 7:49 p.m., LPN-J stated they checked resident's code status under the advance directives section in the EMR's miscellaneous section and the paper chart before initiating CPR on a resident who was pulseless and not breathing. LPN-J stated the health unit coordinator scanned in the POLSTs into the miscellaneous section of the EMR. LPN-J stated they would initiate CPR if a POLST or code status was not in place. When interviewed on [DATE] at 9:23 a.m., FM-A stated they verbally spoke with staff to confirm R22's code status as DNR and did not receive a POLST in the mail to sign. When interviewed on [DATE] at 9:26 a.m., LPN-D stated they would initiate CPR if they found a resident pulseless and not breathing and would call a second nurse to check the resident's code status. LPN-D stated residents' code status was listed in the banner of the MAR and in the front tab of residents' paper charts. When interviewed on [DATE] at 9:32 a.m., LPN-L stated they would call a second nurse to check if a resident was pulseless and not breathing and would verify the resident's code status in their paper chart or EMR on the face sheet or miscellaneous section where POLSTs were scanned. When interviewed on [DATE] at 9:45 a.m., registered nurse (RN)-C stated they would first check resident's code status if they were pulseless and not breathing. RN-C checked for resident code status in the paper chart or checked the EMR, such as the resident face sheet, if not in the paper chart. When further interviewed on [DATE] at 9:54 a.m., LPN-B stated they reviewed resident POLSTs when first admitted and at quarterly care conferences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE] at 10:05 a.m., SW stated they facilitated conversations about code status with nursing on admission, quarterly, annually, and with hospitalization s or other changes. SW updated code status in resident care plans if nursing had other tasks to complete. SW stated the facility did not have a medical records person right now, so SW helped with scanning POLSTs into EMRs or sent out POLSTs for family members to sign if they were out of state and then notified the provider to sign the POLST or have a conversation with the resident's family. SW stated R22 had a health care directive which indicated DNR/DNI. When interviewed on [DATE] at 1:20 p.m., DON expected staff to call for help if a resident was unresponsive and verify code status immediately and assess the resident. DON stated code status was indicated on POLST found in residents' paper charts or the EMR had a banner which reflected residents' code status. DON stated they had monthly code status drills, and code statuses were in the EMR if not in the paper chart. DON stated staff reviewed POLST and code status when residents first admitted and quarterly at care conferences. DON expected a code status to be entered into residents' orders immediately during the admission process and reviewed by or at the 48-hour admission care conference. DON or floor managers entered residents' orders in a que, and a second nurse checked and confirmed the orders into the EMR. DON stated they emailed or faxed POLSTs for family to sign. DON expected a chart to have a copy of a POLST with verbal confirmation until a signed POLST returned. DON expected the resident or guardian preferred provider to review and sign POLST within 72 hours. When interviewed on [DATE] at 1:59 p.m., the vice president of success stated the facility did not have a POLST policy and procedure and followed state guidance. The CPR policy dated [DATE], directed staff to provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious sings of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to notify providers about a resident's weight status while on a prescribed diuretic (water pill) for 1 of 1 residents reviewed for edema (swelling). Findings include: R5's significant change Minimum Data Set (MDS) dated [DATE], indicated she had severe cognitive impairment with diagnoses of heart failure, kidney failure, respiratory failure, anxiety, depression, and lymphedema (a chronic condition causing swelling from lymph or protein-rich fluid in the body's tissues). The MDS further indicated R5 received hospice care. R5's Care Area Assessment (CAA) for functional abilities dated 11/5/24, identified her need for assistance with all activities of daily living (ADLs) and mobility, directing staff to provide max assist with all cares and dependent assistance with toileting and transfer cares. The CAA directed staff to proceed to the plan of care with goal of comfort and dignity with end of life cares. R5's unsigned order summary was reviewed 12/13/24, and included the following orders: - furosemide oral tablet, Give 40 milligrams (mg) by mouth one time a day for pulmonary edema (fluid buildup the lungs), heart failure with chronic kidney disease and failure, dated 3/12/24. - weight and vitals weekly (obtain re-weight if change of 5 lbs (pounds) since last weight every Thursday, dated 5/28/24. R5's treatment administration record (TAR) dated 8/2024, reflected the following documented weights: - 8/8/24: 170 [lbs]. - 8/15/24: 171 [lbs]. - 8/22/24: 165 [lbs]. - 8/28/24: lacked documentation of weight and referred to the progress notes. R5's TAR dated 9/2024 reflected the following documented weights: - 9/5/24: NA. -9/12/24: 164 [lbs]. 9/19/24: 164.3 [lbs]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/26/24: lacked documentation of weight with rationale refused. R5's TAR dated 10/2024 reflected the following documented weights: - 10/17/24: NA. - 10/31/24: 164.2 [lbs]. The dates of 10/3/24, 10/10/24, and 10/24/24, lacked documentation of weights and referred to the progress notes. R5's TAR dated 11/2024 reflected the following documented weights: - 11/14/24: NA. - 11/28/24: NA. The dates of 11/7/24, and 11/21/24, lacked documentation of weights and referred to the progress notes. R5's TAR dated 12/2024 reflected the following documented weights: - 12/5/24: 162.5 [lbs]. - 12/12/24: NA. R5's care plan dated 7/28/23 identified she was on diuretic therapy to treat her lower extremity edema. The care plan guided staff to report signs and symptoms of dehydration, hypotension, dizziness, etc. to meet her goal of having no adverse effects. Additionally, the care plan identified her risk for excess fluid volume due to her lower extremity swelling (edema) and directed staff to report signs and symptoms edema or fluid overload, including weight gain. Per progress note dated 8/1/24 at 1:07 p.m., for the order to weight and vitals - weekly obtain re-weight if change of 5 lbs since last weight), two attempts were made to collect R5's weight and/or vital signs and would be attempted again later. The progress note lacked documentation on provider notification of refusals. Per progress note dated 8/13/24 at 11:43 a.m., the interdisciplinary team (IDT) discussed R5's weight loss of approx. 25 lbs over last 4 months and potential causative factors. The progress note lacked documentation if her provider was updated on her weight loss. A progress note dated 8/29/24 at 9:47 a.m., indicated R5 refused her weekly weight three times. The progress note lacked documentation on provider notification of refusals. A progress note dated 10/17/24 at 9:44 a.m., lacked documentation regarding why weight was not documented in R5's TAR as ordered. The progress note lacked documentation on provider notification. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 10/24/24 at 9:32 a.m., indicated R5 refused weekly weight but other vitals completed. The progress note lacked documentation on provider notification of refusals. Per a nutrition assessment note dated 11/5/24 at 3:02 p.m., R5 was at risk for fluid shifts and weight fluctuations related to diuretic use. The note directed staff to continue the current nutrition plan of care. Per progress note dated 11/7/24 at 9:41 a.m., R5 refused to get out of bed for her ordered weekly weight check. The progress note lacked documentation on provider notification. Per progress note dated 11/21/24 at 9:41 a.m., R5 refused to get out of bed for her ordered weekly weight check. The progress note lacked documentation on provider notification. A provider progress note dated 9/20/24, identified R5's abnormal weight loss with her self-reported anorexia (medical term for loss of appetite) and weight loss for a few months. The provider progress note indicated under the Assessment and Plan for abnormal weight loss staff should continue to trend weight. A request for further primary care provider visit documentation or provider progress notes was requested but not received. R5's electronic medical record (EMR) was reviewed on 12/12/24, and lacked documentation on provider notification of her refusal to be weighed. Per observation on 12/10/24 at 9:08 p.m., R5 was laying in her bed on her back. She had mild swelling to both legs and did not have any stockings or wraps on her legs. Per interview on 12/12/24 at 10:00 a.m., with the registered dietitian (RD), R5 was being followed because she was a high-risk for her weight. RD reviewed her weights in R5's EMR and stated she followed her monthly and confirmed weight loss. RD verified she was due for another risk charting note soon and stated R5's weight had been stable for about a month, but was unsure what was currently going on. RD identified her diuretic use could affect her weight but stated she was on hospice and did not like to demand things when a resident was on hospice care. RD expected documentation of a resident's refusals of weights and stated it would be preferable for monthly weights to be obtained. RD identified a weight on 12/5/24, and stated, She's down a couple of pounds but expected this for a resident on hospice cares. RD denied concern for R5's weight loss. Per interview on 12/12/24 at 10:14 a.m. with R5's hospice registered nurse (HRN), R5 appeared well-cared for during hospice visits and assessments at the facility. HRN reported assessing R5's respiratory status and fluid retention/edema during visits and denied concern beyond R5's baseline. HRN stated R5 was really short of breath with exertion and even in conversation and her legs have always been very swollen. HRN verified a lack of notification regarding R5's refusals to be weight and a lack of documented weekly weights. HRN stated, it is something I am monitoring but not necessarily something I expect to be updated on, however, endorsed concern for staff not monitoring weights because if they are not monitoring weights, then I wouldn't be able to monitor them either. HRN deferred to R5's primary care provider (PCP) for management of her weights and diuretic orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 12/12/24 at 4:23 p.m., R5's primary care provider and nurse practitioner (NP) confirmed not receiving updates on R5's lack of documented weights and her refusals to be weighed. NP expected to be updated and stated if staff had provided updates, I would have reassessed the orders and the need for the Lasix, particularly because she's on hospice. NP indicated there had not been any observed changes to R5's baseline edema and denied concern regarding R5's weights, stating they seem stable for her baseline. Per interview on 12/13/24 at 9:50 a.m., with licensed practical nurse (LPN)-D, R5's edema in her legs were much improved now with a decrease in her fluid retention. LPN-D explained for residents at risk for fluid retention and/or on a diuretic, staff should watch for respiratory changes, edema, and weight changes. LPN-D stated, If I saw those things, I would notify the unit manager, update the doctor and request they assess the resident. LPN-D stated if a resident was weighed and it looked off, we would encourage a reweigh, and if a resident was consistently refusing, staff were expected to reapproach, distraction and if the refusals continued, staff were expected to update the provider about the refusals. During interview on 12/16/24 at 9:50 a.m., with LPN-A, also the unit manager, R5's EMR was reviewed for notification of change to the provider regarding her refusal to be weighed and lack of documented weekly weights. LPN-A verified there was no documentation in the EMR or provider portal on her refusals and lack of weights. LPN-A expected staff to report refusals to the nurse and expected nurses to reapproach the resident. If a resident continued to refuse the treatment or order, LPN-A expected staff to update the provider and resident's representative. During interview on 12/16/24 at 12:01 p.m., the director of nursing (DON) hoped staff would bring concerns with residents refusing to be weight to IDT to be discussed. The DON expected staff to report R5's refusals to both her hospice provider and her primary provider teams so we can make a better plan for that resident. Per facility policy titled Change in Condition of the Resident revised 9/20/22, the facility should immediately inform the resident; consult with the resident's physician; and notify , consistent with his or her authority, the resident representative(s) when there is a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy explained when a resident presented with a possible change of condition, staff should notify a resident's physician and for non-immediate notifications, staff were guided to provide the notification via the phone, fax, or method preferred by the physician being contact. Additionally, the policy directed staff to ensure the resident's change in condition was included on the 24-hour report to be reviewed later by the IDT and to updated the plan of care as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed to provided Notice of Medicare Non-Coverage (NOMNC) in the required time frame for 1 of 3 residents (R143) reviewed for beneficiary notices. Findings include: R143 admission minimum data set (MDS) dated [DATE], included R143 had moderate cognitive impairment and diagnosis of dementia. Facility progress note dated 10/7/24, included R143's power of attorney (POA) discussed a discharge for resident on 10/9/24. R143's NOMNC dated 10/9/24, included skilled nursing/therapy services will end 10/8/24. Handwritten note on document read resident elects early discharge with benefit days remaining. NOMNC was signed by resident. No evidence of POA reviewing or signing document. During interview on 12/12/24 at 11:17 a.m., family member (FM)-B stated she did not remember ever being informed about a notice of Medicare non-coverage, but was updated that therapy would be ending. During interview on 12/13/24 at 10:45 a.m., registered nurse (RN)-D confirmed the discharge NOMNC was signed the day R143 was discharged by R143 himself. RN-D confirmed R143 did have a POA but stated sometimes she had the resident sign the form even if there was a POA if she felt they were cognitively intact. She stated she did not do any formal assessment to determine cognitive status other than observation. RN-D confirmed there was discussion with R143's POA two days prior to discharge but the form was not discussed at that time. During interview on 12/13/24 at 11:19 a.m., the administrator stated there are no exceptions for the NOMNC being given two days prior to discharge. The administrator stated the POA should be given the notice to sign. Facility denied having a policy on NOMNC and stated they follow Medicare regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and documentation review, the facility failed to ensure a safe, clean, comfortable homelike environment when the facility failed to address maintenance issues identified in the dining areas, resident rooms, and throughout the building for 2 of 8 residents (R30, R36) reviewed for homelike environment. Findings include: R30's admission record printed 12/16/24, indicated he admitted to the facility on [DATE]. A complaint/incident investigation reported by R30 and dated 9/16/24, was reviewed and indicated the facility itself is very unsanitary. The report included, one part of the walls at the facility is currently missing, and staff did not appear to be doing anything to fix this. A complaint/incident investigation reported by R30 and dated 10/8/24, was reviewed and indicated the facility had environmental issues but lacked specificity on where the alleged mold was. A complaint/incident investigation reported by R30 and dated 11/27/24, was reviewed and identified a fire hazard and electrical hazard in the facility. A TELS closed work orders report printed 12/13/24 for the dates of 3/1/24 - 12/12/24 identified the following closed work orders: - the dining room baseboard trims fell off in the dining, created 4/8/24, completed 4/9/24. - walls behind bed are scratched/gauged (needs repair-puttying) for R30's room, created 8/22/24, completed 9/4/24. - LTC [sic, long-term care] dining room in second floor dining, created 2/16/24, completed 3/11/24. Per observation on 12/9/24 at 2:18 p.m. of the second-floor dining room, the following environmental concerns were identified: - the corner of the wall near the dining room entrance had gouge marks with large parts of the wall missing as well as a loose baseboard. - across from the wall with the gouge marks and missing wall, there was a wall with baseboards missing. - at the serving line in front of the steam table, there was another missing baseboard. - multiple ceiling tiles with large tan-to-light brown stains that covered approximately half of the ceiling tile's surface area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the wall on the opposite side of the room's doorway had a long, dark black and gray scuff mark that ran along the side of the wall. - throughout the dining room, multiple baseboards had black and green taped areas. - the first window across from the steamtable and serving line had brown blinds and had thick white, web-like material on the blinds and above them onto the wall. - the second window's bottom ledge showed dried white chips and dark brown flecks coming off the ledge of the wall. On one spot of the window ledge, there was an area approximately 8-inches across and 2-inches down, that had long dried white and brown chips and was nearly coming off the wall entirely. - white, web-like material was in the corner of dining room by the two windows, as well as dried white chips flaked off the walls. - the baseboard and tile on the floor across from window in the back of the dining room was warped. - the ice and water machine behind the steam table had thick white buildup around the ice dispenser, and dried white buildup in the drain area and gates. Per interview on 12/9/24 at 2:46 p.m. with dietary aide (DA)-A, the areas noted during the second-floor dining room observation had been present for the duration of DA-A's employment. DA-A reported working in the facility for two weeks. During dining observation on 12/9/24 at 5:54 p.m., R30 was eating supper in the dining room with two other unidentified residents. During observation on 12/10/24 at 3:34 p.m., the baseboard on the wall outside the door of the second-floor dining room was falling off the wall. There were dried white chips flaking off the wall underneath where the baseboard once was. The baseboard was attached only at the corner of the wall and the rest of the slab of baseboard rested on the floor. It spanned the entire wall length, which was approximately 6-feet in length. During observation on 12/11/24 at 11:09 a.m., the dining room and baseboard outside the dining room remained unchanged. During observation and interview on 12/9/24 at 5:58 p.m., R30 confirmed filing the complaint/incident investigation reports and stated he reported these grievances in resident council. He pointed to the wall behind his bed and nightstand and observed were 9 scuff marks and an electrical outlet that was coming out/detached from the wall. R30 ate his meals in the second-floor dining room and confirmed the various scuff marks, gouges in the walls, black marks, and baseboards falling off. He stated the dining room had been like that since I've been here. R30 said the overall condition of his room and the dining room made him think the building isn't healthy and safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 12/10/24 at 1:37 p.m. with family member (FM)-C, the facility's maintenance department was really lacking and the facility only repaired something when it was broken. FM-C reported a privacy curtain was falling off the tracks in a resident room and stated it was reported before, but the facility had not done anything to repair it. Additionally, FM-C reported I've seen mold around the dining room area. FM-C did not believe the second-floor dining room, R3's room, or the facility itself felt homelike. Per interview on 12/11/24 at 7:24 a.m. with housekeeper (H)-B, any staff were able to enter a maintenance request through the facility's TELS system if they identified a concern. Per interview on 12/11/24 at 7:31 a.m., nursing assistant (NA)-D confirmed the dining room was something staff had been working on. NA-D stated the administrator made daily rounds in the morning to assess the facility for things that might be wrong. During interview on 12/13/24 at 10:03 a.m., licensed practical nurse (LPN)-C confirmed staff reported their environmental concerns and submitted TELS requests for the second-floor dining room and staff did not do anything about them. LPN-C was unable to recall how long ago the requests were made, however, stated they were submitted when the previous maintenance director was still in the facility, in September, and now, we do not have a maintenance person at all, so you can imagine how that works. During interview on 12/13/24 at 10:31 a.m., housekeeper (H)-A stated they had a checklist for cleaning rooms but not the dining areas and did not wipe down ice machines, walls, or windows. During interview and environmental tour on 12/13/24 at 1:19 p.m., the administrator and housekeeping director (HD), verified the second-floor dining room needed improvement. The administrator stated the dining room needs a good look and was a project for the facility. The environmental tour continued, and the administrator verified the gouges in the wall behind R18's head of bed and stated staff have been running the bed into that. In R30's room, the administrator stated the whole wall needs to be looked at and verified being aware of the scuff marks and headboard. The administrator confirmed the electrical outlet was detached/coming out of the wall and stated it was discussed during the LifeSafety survey. R36 R36 ' s Minimum Data Set (MDS) dated [DATE], indicated intact cognitive function, and included diagnosis of mechanical complication of internal fixation device of right humerus (surgery to repair a right broken shoulder). The MDS indicated R36 was ambulatory with use of rolling walker with seat. The record review on 12/13/24 at 2:24 p.m., on 11/8/24 a deep clean of room check off sheet completed. It did not state unstable cabinetry. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview of R36's room on 12/9/24 at 3:35 p.m., R36 stated there was no heat vent in the bathroom and they needed to leave bathroom door open for heat. Four bath blankets were rolled up on the windowsill next to the glass. R36 stated they were there to prevent cold air from entering the room. The wall adjacent from window had 2 large gouges out of it, approximately 4 inches wide, 24 inches long and two inches deep, it had unpainted patchwork around the area. A privacy curtain hung with missing hooks and unable to fully close. The dull blue/gray curtain was covered in brown splotchy areas of unknown substance ranging in size from 1 inch by 1 inch to 4 inches by 3 inches. The floor to ceiling cabinetry was not securely affixed to the wall. It was very unstable, wiggled and moved with any activity. R36 stated they did not consider it a homelike environment, that the place is falling down, and no one cares. During an interview on 12/12/24 at 9:51 a.m., licensed practical nurse (LPN)-D stated the process for a concern in a resident ' s room was to discuss concern(s) with administrator. There was not a maintenance department in the facility. LPN-D observed the cabinetry and confirmed there was a safety concern and reported that to administrator. During an interview on 12/12/24 at 2:49 p.m., registered nurse (RN)-A stated any concern with a resident ' s room was brought to the administrator. RN-A stated that safety of the residents was the number one concern, and verbalized the cabinetry would be shown to the management. During an interview on 12/13/24 at 11:48 a.m., administrator discussed the maintenance policy and procedure of rooms and facility. He verified there was not a maintenance department in the facility. A corporate maintenance person came to facility once a month. The facility policy on Safe and Homelike Environment Policy dated 6/16/22 stated Policy: In accordance with residents' rights, the facility will provide a safe and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. 49617

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 1 of 1 residents (R8) reviewed for PASARR. Findings include: R8 admission Minimum Data Set (MDS) dated [DATE], included diagnosis of schizophrenia. R8's order summary report dated 4/3/24, included diagnoses of mild cognitive impairment, schizoaffective disorder (a mental health disorder with symptoms of both schizophrenia and a mood disorder), depression, bipolar disorder (extreme mood swings), and hoarding disorder. R8's preadmission screening results (PAS) dated 1/11/24, included the R8 would need a Level II assessment for mental illness. During interview on 12/11/24 at 9:11 a.m., social services (SS)-A stated she did an audit of all PAS results when she was hired and R8's previous PAS was unclear, but she thought she may have needed a Level II. SS-A resubmitted R8's PAS information at that time. SS-A stated she did not realize the PAS results indicated a Level II assessment was needed. SS-A confirmed upon review of PAS results dated 1/11/24, a Level II assessment was required. During interview on 12/12/24 at 1:50 p.m., SS-A state it was important to know if there was a mental health or developmental disorder so the facility would know how to care of them. Facility policy requested and not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure a shower was offered or provided for 1 of 3 residents (R30) reviewed for bathing. Findings include: R30's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had moderately impaired cognition with a memory deficit following a cerebrovascular accident (CVA, or a stroke), weakness and paralysis or inability to move his left dominant side after a stroke, depression, and dementia (a condition causing a decline in cognitive function, memory, and behavior). His MDS indicated he displayed no rejection of cares and required substantial to maximal staff assistance for bathing/showering cares and mobility and transfers. R30's annual MDS dated [DATE], identified bathing preferences were very important to him. R30's functional abilities Care Area Assessment (CAA) dated 6/24/24, was triggered due to his need for assistance with ADL cares and identified he was at risk for ADL decline and directed staff to the plan of care. R30's care plan revised 7/5/24, identified his self-care deficit and directed staff to provide assist of 1 with bathing and showering cares to meet his goal of receiving assistance necessary to meet his ADL needs. R30's Kardex indicated his shower was scheduled for Tuesday mornings. R30's PointOfCare (POC) ADL - Shower on Tuesday Am's Task was reviewed 12/13/24, and lacked documentation of showering/bathing cares for the last 30 days. R30's progress notes were reviewed on 12/16/24, and lacked documentation of shower refusals. During interview on 12/09/24 at 6:36 p.m., R30 stated he was last offered a shower a couple months back, but it was during a time when the facility had turned off the hot water, so he declined. R30 reported this was the last time he could recall staff offering him a shower, and he believed that to be sometime in October 2024. R30 vocalized a wish to be offered a shower at least monthly. During interview on 12/13/24 at 3:09 p.m., nursing assistant (NA)-B was unable to find documentation of R30's last shower. During interview on 12/13/24 at 3:15 p.m., licensed practical nurse (LPN)-J reviewed R30's skin assessments and explained weekly skin assessments coincided with resident's scheduled showers. LPN-J stated R30's last skin assessment was done on 12/5/24, and his most recent was completed 12/13/24. LPN-J used the skin assessment to report R30's last shower was today. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 12/16/24 at 8:16 a.m., R30, sat in his wheelchair in his room. His hair appeared shiny and slick. R30 stated he did not take and was not offered a shower throughout the survey week of 12/9/24 - 12/16/24. Per interview on 12/16/24 at 9:16 a.m., with nursing assistant (NA)-A, resident showers were documented in POC and if a resident refused, NAs should document the refusal in addition to reporting it to the nurse. Per interview on 12/16/24 at 9:33 a.m., with licensed practical nurse (LPN)-D, R30's shower day was Tuesday. LPN-D reviewed his electronic medical record (EMR) and was unable to locate R30's last documented shower. LPN-D verified there was no documentation in the progress notes about him refusing a shower. LPN-D expected NAs to report any concerns identified during a bath or shower, including a refusal, to the nurse. LPN-D stated if the NAs reported anything of concern or a refusal, I'll document that. During interview on 12/16/24 at 9:20 a.m., LPN-C stated the resident shower schedule was posted in the nurse's station and verified the posted schedule. LPN-C expected NAs to notify the nurse on duty if a resident refused a shower and stated the nurse should document the refusal as well. During interview on 12/16/24 at 9:43 a.m., LPN-A (also the unit manager) stated NAs were expected to document in POC under the tasks section if a resident had a shower and if a resident refused, NAs were expected to report to the nurse on duty and the nurse expected to document in the progress notes. LPN-A stated NAs should be aware of scheduled showers/baths because the schedule was printed and posted at the nurse's station, the schedule as discussed during shift report, and it was on their POC tasks. LPN-A expected R30's last shower date to be 12/10/24 and expected to see documentation in POC or a refusal documented in the progress notes. LPN-A confirmed there were no documented refusals in the progress notes. LPN-A was unable to provide documentation of R30's last shower in POC. Per interview on 12/16/24 at 12:01 p.m., with the director of nursing (DON), NAs were expected to offer a shower on resident's scheduled shower/bathing day and document in POC. If the resident refused a shower, NAs were expected to report to the nurse on duty, and the nurse was expected to document in progress notes. The DON reviewed R30's EMR and confirmed there was no documentation of a shower or of a refusal. The DON explained staff may have offered his shower as a part of his morning cares and if he refused, it may not be reflected as a true refusal because the skin check may or may not be done. The DON endorsed staff may not be the greatest at documenting when a bed bath was performed. The DON stated it was important to offer showering to residents to promote dignity and overall health. Per facility policy titled Resident Rights last revised 7/2022, residents would be treated with respect and dignity and care. The policy identified the resident's right to request, refuse and/or discontinue treatment, and the right to make choices about aspects of his/her life in the facility that are significant to the resident including the choice of healthcare consistent with the resident's interests, assessments, plan of care and other choices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per facility policy titled NSG - Activities of Daily Living (ADLS) dated 7/26/22, the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless avoidable. The policy identified care and services would be provided for ADLs including bathing, dressing, grooming and oral care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were offered for 1 of 1 residents (R26) reviewed for activities. Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had severely impaired cognition and was marked not applicable for transfers. The MDS identified diagnoses of muscle weakness, depression, and high blood pressure. R26's significant change MDS dated [DATE], indicated it was very important to R5 to participate in her favorite activities and to go outside and get fresh air when the weather is good. R26's Care Area Assessment (CAA) for communication dated 1/3/24, indicated R5 was usually understood and usually understands. The CAA identified she was at risk for missed information and unmet needs as her primary language was Russian, but she did know some English. The CAA indicated she was able to make her needs known and guided staff to proceed the plan of care. An activity participation review dated 9/26/24, indicated R5 did not attend any small or large group activities, rather preferred 1:1's and attended those 2-3 x a week. The review indicated R5 spends much of her time in bed, and watched TV, read books, had visits from a family friend and daughter. Furthermore, the review indicated life enrichment or activities staff visited 2-3 times per week and because R5 spoke Russian, she was able to socialize some when visited by staff and she smiles and giggles at times and appears to enjoy the visits. The review indicated R5 participated in individual activities daily and included family and friend visits and identified her favorite activities as cognitive (reads Russian books); Entertainment (Russian television); Spiritual (Jewish faith); Social (1:1, snack, socials and visits with staff, Family friend visits), and pet visits. The review lacked documentation of her preference to go outdoors for fresh air. The review identified R5's progress towards her activity goals were not met and had been revised in the care plan. Additionally, the review identified her activity-related IDT interventions/approaches had not been effective towards reaching her goals and new approaches were added to the care plan. R26's undated and unsigned order summary was reviewed 12/11/24 and reflected the following orders: - up in w/c [sic, wheelchair] one time per day for core strengthening in the afternoon for muscle wasting (a loss of muscle mass and strength), dated 9/9/24. R26's care plan last revised 9/26/24, indicated she preferred not to attend group activities due to her primary language being Russian, although she did speak and understand some English. The care plan identified she preferred to spend time in her room resting and watching television. The care plan included her meaningful interests last revised 3/18/23, of 1:1 visits with life enrichment or activities staff, television, and reading. The care plan identified interventions including the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provide 1;1 activity visit of potential interest (i.e. discussion of family, books) 2 - 3 x per week. - Will respect choice in regard to limited/no activity participation. - Will visit to offer leisure supplies/materials as able. DTR [sic, daughter] to bring Russian specific supplies. Conversely, R5's care plan identified her difficulty communicating as she spoke Russian and little English. The goal was to use an alternative method to communicate needs/wants, including a translator. Additional goals included demonstrate understanding by completing task when requested and needs would be met with comfort and dignity. The care plan directed staff to call an interpreter for translation and provided a contact number with instructions, and to involve R5 in activities that did not rely on her ability to communicate or hear, such as parties, crafts, or movies. The care plan lacked resident preference for going outside to get fresh air when the weather was good as identified in her significant change MDS dated [DATE]. A PointOfCare (POC) task record printed 12/10/24, to make sure resident is up in wheelchair every day for one hour during lunch. Inform nurse if resident refuses to get up, with a lookback period of 30 days reflected, No Data Found. The record lacked documentation staff attempted or offered to get resident up in wheelchair every day. A POC task record printed 12/10/24, for ADL - transferring Hoyer with two staff, with a look-back period of 30 days indicated out of 84 opportunities, R5 required limited assistance (resident highly involved in activity, staff provide guidance maneuvering of limbs or other non-weight-bearing assistance) on 8 instances; total-dependence (full staff performance) on 11 instances; required extensive assistance (resident involved activity, staff provide weight-bearing assistance) on 3 instances; and staff documented not applicable on 61 instances. A POC task record printed 12/10/24, for ADL [sic, Activities of Daily Living]- Activity Participation, Which Activity?, with a look-back period of 30 days indicated R5 participated in move/TV activities on 5 instances and a family/friend visit on 1 instance. The record lacked documentation of R5's preferred activity of going outside for fresh air. A POC task record printed 12/10/24, for ADL - Activity Participation - Activity, with a look-back period of 30 days indicated R5 was independent for 6 out of the 7 instances and a 1:1 for 1 of the 7 instances on the record. R5's Kardex, printed on 12/16/24, lacked documentation of her preferred activity of going outside for fresh air. The Kardex included directions to staff to make sure resident is up in wheelchair every day for one hour during lunch. Inform nurse if resident refuses to get up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/9/24 at 2:58 p.m., R5 was lying in bed wearing a hospital gown. R5 stated she wished staff would bring her outside more often. Her family member (FM)-D was at bedside visiting and R5 said something in Russian to FM-D, and FM-D translated back, she said, 'they do not take me outside.' During observation on 12/10/24 at 8:27 a.m., R5 was lying in bed wearing a hospital gown with the television on. During observation on 12/11/24 at 7:34 a.m., nursing assistant (NA)-D performed morning ADL cares and stated R5 was able to listen clearly and could point to things she wanted if she did not know the word for it. NA-D stated R5 knew a little English and was able to make her basic needs known. NA-D stated, we offer sometimes to get her up for a meal or if she wants to get up, but R5's family says if she doesn't want to, we don't need to push it. We were in the meeting, some of the nurses, and that's what they want us to do. NA-D stated R5 got out of bed once or twice a week, and if she refused, NAs were expected to report the refusal to the nurse. NA-D exited the room after morning cares without offer to reposition, get R5 up in the wheelchair, or offer of activity. There was a calendar taped to R5's closet door for September and it listed some speech eval dates but no activities identified. There was no activities calendar in R5's room. During follow-up interview on 12/11/24 at 7:54 a.m., NA-D stated R5's family brought her outside for activities and thought activities (A)-A sometimes brought her around the unit to look at things, but stated R5 was not someone who goes to other activities and would tell staff if she wanted to go. During observation on 12/13/24 at 9:53 a.m., R5 was lying in bed wearing a hospital gown with the television on. Per interview on 12/13/24 at 9:11 a.m. with A-A, residents were assessed for their activity preferences quarterly, annually, and with significant changes, and those preferences were documented in the care plan. A-A stated R5 slept at intervals throughout the day and didn't want to wake her if she was asleep. A-A indicated R5 had a history of refusing to get up and refusing activities. A-A stated for special occasions, like parties or Bingo, staff offered to get R5 out of bed for the activity, but she refuses. A-A identified R5 liked 1:1 visits and used to like reading Russian books, but stated that went in streaks. A-A confirmed, the language barrier can be an issue, but I try and articulate in English, and I will comment about her Russian television programs, and added, R5 sure likes the visits, as evidenced by her smiles during the visit. A-A stated during warmer months when R5's family visited, they would bring her outside and verified staff would notify activities if she was up in her wheelchair. A-A could not recall R5 asking to go outside directly but confirmed being unable to meet R5's activity preferences stating, I have not been able to get her up and in the wheelchair to go seeing the building. A-A believed activities helped with resident engagement, potentially reducing accidents like falls, improve resident satisfaction and helped residents feel good. A-A confirmed being the only activities staff in the facility and stated, when I'm not here, its independent activities adding having more staff in the department would definitely be helpful. A-A indicated on scheduled days off, the staff pretty much know what I do from seeing what I do, they know what the residents like from seeing what I do, and stated there was a basket of puzzles, coloring sheets, card games, and magazines in the unit manager's office on the memory care unit. A-A stated the residents off the memory care unit were more independent and some preferred to stay in bed and were not engaged. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 12/13/24 at 10:24 a.m. with the administrator, also acting as the interim co-scheduler with the director of nursing (DON), confirmed the facility's activities department could be more robust, but believed residents overall were enjoying themselves. They verified A-A was the only activities staff and stated there was capability for other staff to provide activities for residents to do when A-A was not scheduled. The administrator stated A-A visited the residents and did not believe the facility had lonely residents. The administrator believed, you can always use more resources around activities and believed this to be true for all facilities throughout the system. During interview on 12/16/24 at 12:01 p.m., the DON stated activities were super important because it helped residents feel like they were a part of something and was good for their mental health. The DON wished the facility could provide more activities and believed A-A was pushed past her limit. The DON was not aware of R5's request to go outdoors for fresh air and stated, if she's communicating, I've never heard she's communicated that to staff. The DON stated, it's difficult to know how much R5 knows about activities. The DON stated R5 could be agreeable to get up in the wheelchair for a good reason like an appointment but could decline to get up for a party. The DON expected staff to offer activities and opportunities to get up out of bed and document refusals but was unsure of nursing staff were documenting R5's refusals as they should be. Per facility policy titled Activities last revised 7/11/22, the facility would provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Per the policy, each resident's interests and needs would be assessed on a routine basis and would include an activity assessment to include a resident's interests, preferences and needed adaptations. Furthermore, the policy identified activities could include indoor and outdoor activities and directed staff to assist residents to and from activities when necessary. Additionally, the policy indicated the facility would consider accommodations in schedules, supplies and timing in order to optimize a resident's ability to participate in an activity of choice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure a resident was comprehensively assessed for appropriate treatment and services to prevent urinary tract infections (UTIs) and to restore continence to the extent possible for 1 of 1 residents (R3) reviewed for toileting programs. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], reported she had intact cognition, no hallucinations, delusions, or verbal, physical or other behavioral symptoms towards herself or others. The MDS identified R3 was dependent on staff for toileting hygiene and transfers, required substantial to maximal assist for mobility and all other transfers, had no urinary catheters, had not trialed a urinary or bowel toileting training program and was frequently incontinent of urine and bowel. Additionally, the MDS identified R3 was at risk for pressure injury wound. R3's Care Area Assessment (CAA) for urinary incontinence dated 11/8/24, confirmed the risk for skin breakdown and stated, she is at risk for MSAD [sic, moisture associated skin dermatitis] and infection. Furthermore, the CAA identified R3's history of urinary tract infections and listed preventative interventions staff implemented, including thorough peri care [sic, perineal] provided and barrier cream applied by staff as needed. R3's diagnosis report dated 12/12/24, indicated she had arthritis (inflammation of the joints causing pain, stiffness, and impaired mobility), muscle weakness, reduced mobility, right hip replacement, unsteadiness on feet, history of UTIs, depression, unspecified psychosis (a cluster of symptoms causing a person to lose touch or have a break with reality) not due to a substance or known physiological condition, anxiety, sleep apnea (a disorder that can cause people to stop breathing when they are asleep), and chronic pain syndrome. A bladder/incontinence evaluation dated 10/16/24, identified R3 took a narcotic/sedative/hypnotic medication that might have contributed to her bladder dysfunction. The evaluation summary reported, resident stable. The evaluation was otherwise blank, and lacked further documentation of other potential risk factors contributing to her bladder incontinence. A bladder/incontinence evaluation dated 11/5/24, identified R3's risk factors for incontinence included impaired mobility and her dependence on 2 persons for transfers. The evaluation identified R3 was currently incontinent of bladder and the signs and symptoms exhibited included urgency, daytime frequency, and nocturia (a medical term for waking up at night to urinate, in this evaluation, it means greater than 2 times per night). Additional risk factors identified included polypharmacy (taking many medications), a history of UTIs, and taking antidepressant and antianxiety medications. The evaluation indicated a physical examination had not been performed, no post void residual (PVR) studies had been attempted, and no treatment program initiated. The evaluation cited R3's impaired cognition and mobility in determining her mixed incontinence (stress and urge) but lacked documented treatment programs and/or interventions that may promote R3's continence or improve her current level of function. The evaluation summarized the assessment, incontinence both bowel and bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's care plan revised on 11/15/24, identified R3's activities of daily living (ADL) self-care deficit and directed staff to provide 2 staff assist with toileting, bed mobility, and transfers. Additionally, the care plan indicated staff should use a hoyer large sling for transfers to meet R3's goal to improve current level of function in ADLs. R3's care plan also identified her urinary and bowel incontinence related to deconditioning secondary to UTI lasted revised 11/15/24. The care plan outlined her goal to have no complications due to incontinence and directed staff to provide assistance with toileting and incontinence cares, use absorbent products as needed, and report signs and symptoms of UTI and skin breakdown. The care plan lacked interventions to promote R3's continence or improve current level of function. R3's care plan furthermore identified her risk for alteration in skin integrity related to her impaired mobility and incontinence. The goal, last revised 11/15/24, was to decrease and/or minimalize skin breakdown risks and resolve yeast (fungal) infection. The care plan guided staff to apply barrier cream as needed, encourage her to reposition as needed, float heels as able, observe for and report skin changes and utilize pressure redistributing devices in her bed and chair. The care plan focus lacked interventions to promote continence and/or improve her current level of functioning to reduce her risk of skin breakdown. R3's hard chart was reviewed on 12/11/24 and included the following orders: - Diflucan (antifungal) for vaginitis (inflammation of the vagina), dated 12/10/24. - cefuroxime (antibiotic) for UTI, dated 12/7/24. - urinalysis/urine culture (UA/UC, a lab test performed to diagnose and treat a UTI), dated 12/6/24. - UA (a urine lab test to preliminarily diagnose a UTI), dated 12/4/24. Per a lab report dated 12/6/24, the urine culture showed an abnormal growth of greater than 100,000 colony forming units (CFU)/milliliter (mL) Klebsiella pneumoniae (a bacteria). Copies of these orders and lab reports were requested but not received. A provider note dated 12/10/24, confirmed the hard chart orders and lab report and indicated she was seen for urinary tract infection and indicated she was started on Bactrim. Later UC resulted to be UC +> 1000,000 [sic] CFU/mL Klebsiella pneumoniae. The provider note indicated an improvement of symptoms of dysuria (painful urination), urgency, and increased incontinence. Additionally, the provider note indicated, the patient's unspecified urinary incontinence is reportedly stable. Under the Assessment and Plan:, the provider issued new orders, including the Diflucan 150 milligrams (mg) by mouth (po) x 1 dose, may repeat in 72 hours if remains symptomatic (vaginal itching). A PlanOfCare (POC) for R3's task sign-off for transferring with a lookback period of 30 days, dated 11/12/24 - 12/11/24, indicated staff documented R3 required 2 person assistance with transfers on 33 instances, 1 person assisstance on 4 instances, response not required on 44 instances, and required no physical help or set-up on 1 instance out of 85 opportunities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per physical therapy PT evaluation and plan of treatment note dated 11/22/24, R3 was referred to physical therapy for evaluation and treatment of a decline in her functional mobility per her provider. Per a physical therapy PT progress report dated 11/22/24 - 12/9/24, R3 met her goals of improved ability to transfer to a standing position from sitting with partial to moderate assistance with a front wheeled walker (FWW); to improve her ability to safely transfer and efficiently transfer to and from a bed to a chair (or wheelchair) with substantial to maximal assistance; and to safely ambulate on level surfaces 10 feet using two-wheeled walker with partial/moderate assistance to increase independence within the facility and to facilitate participation in functional activity. The progress report identified new goals, included ambulation goals at longer distances and less staff assistance with transfers. The report indicated R3 was making consistent progress towards reaching short-term and long-term goals and her condition has potential to improve as a result of skilled rehab and patient's functional performance is progressing as a result of exercises. Per physical therapy treatment encounter note(s) dated 12/12/24, staff and R3 were trained on safe transfers using the EZ stand from the edge of her bed to the wheelchair and back again using 2 staff assistance. The note reported it was okay to downgrade the transfers to hoyer and notify therapy if R3 was deemed unsafe for any reason with the transfers. The note indicated R3 and staff confirmed they have not had safety concerns with EZ stand transfers, but confirm knowledge of ability to downgrade to ensure patient safety if concern were to arise. Made repeat rehab communication form to confirm continued EZ stand transfer status of assist of 2 staff for nursing staff. During observation on 12/9/24 at 2:59 p.m., R3 was in her bed and appeared asleep. During observation on 12/10/24 at 8:29 a.m., R3's room was dark, and the shades were pulled. She was in bed with the covers over her and her eyes were closed. A continuous observation on 12/11/24 between 10:48 a.m. and 11:37 a.m. included: 10:48 a.m.: R3's call light was put on. 10:49 a.m.: nursing assistant (NA)-A entered R3's room to answer the call light and was heard stating she would be back to help her. Per interview at 10:49 a.m., R3 verified NA-A stated she would be back to help clean her up. 11:09 a.m.: the director of nursing (DON) walked down the hallway and asked where NA-A was. Within 2 minutes, the DON left the unit and was observed walking onto the elevator leaving the second floor. 11:13 a.m.: NA-A was not back to assist. An overhead page was heard announcing, 2 west, you have a resident call. 11:14 a.m.: There were no staff observed on the 2 East of the unit. An overhead page was heard announcing, 2 west nurse please call and a call-back number was read aloud. 11:18 a.m.: No staff were present on the 2 east unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:20 a.m.: Licensed practical nurse (LPN)-H walked onto the 2 east unit to the medication cart. 11:22 a.m.: LPN-H left the medication cart and walked off the 2 east unit. No staff have attempted to enter R3's room. 11:26 a.m.: Activities-(A) pushed another resident into his room and walked back out and off the 2 east unit without addressing other residents within a minute. 11:30 a.m.: NA-A walked off the elevator, walked through the nurse's station and into the nurse manager's office. No visible staff observed down the 2 west hallway or the 2 east hallway. 11:38: a.m.: An unidentified staff walked off the elevator and back to the nurse manager's office. 11: 41 a.m.: LPN-H and NA-A walk back to the 2 east unit and hallway. 11:42 a.m.: LPN-H and NA-A entered R3's room to assist with cares requested from call light request at start of observation. During interview on 12/10/24 at 1:37 p.m., R3's family member (FM)-C verbalized concerns about the staffing in the facility and stated, I think they're understaffed, and they don't have the time to respond to call lights or calls. FM-C identified evenings and mealtimes as the longest wait times when R3 puts her call light on for assistance. FM-C stated on numerous occasions while visiting during mealtimes, R3 put her call light on and staff won't respond at all and FM-C would have to go and find someone to talk to get help. FM-C reported during the evening, if R3 put her call light on and waited an extended period, she would call FM-C at home. FM-C would then call the facility using a personal phone to get staff to assist with R3's toileting cares. During interview on 12/11/24 at 9:13 a.m., R3 reported the call light wait times were just horrible, weekends are the worst. R3 believed the longest she waited was an hour and was unable to recall any times where she had waited for her call light to be answered and become incontinent or had fallen. R3 stated she was not aware of her urge to void. During follow-up interview at 10:45 a.m., R3 stated she did mind the bedpan, and had not attempted to use the bedside commode since her admission because it just doesn't work. R3 stated felt like she needs to have a bowel movement. During interview on 12/11/24 at 2:22 p.m., physical therapist (PT) verified R3 was working with physical therapy and was picked back up on 11/21/24 for decline in strength with transfers. PT stated R3 was working on transfers and gait during their sessions and she made a big jump in her progress. PT confirmed R3 could safely transfer with moderate to maximal assistance with 2 staff and a FWW, but expected NAs to use an EZ stand for transfers. PT verified R3's goals were to transfer without the EZ stand and to ambulate with staff safely. PT stated the obstacles for R3 in attaining her goals included her forgetting the sequencing side of things, for example, the confusion in what she can do and in what order. PT stated the recommendations to nursing staff were to provide verbal cueing on what steps to perform and in what order and for R3 to call for help in getting out of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 12/12/24 at 4:14 p.m., R3's nurse practitioner (NP) explained that Klebsiella pneumoniae, the bacteria found growing in her UC, was a common bacteria in the gut and verified the UTI diagnosis on 12/10 with the Ceftin antibiotic order on 12/7/24. NP further explained that Klebsiella pneumoniae was a common bacterium that could cause UTIs, stating it could be common with poor hygiene. She has told me takes awhile to get cleaned up at the facility. Incontinence and poor hygiene could contribute to developing a UTI that showed Klebsiella growth. NP elaborated it could be difficult for her to be entirely dry, being incontinent and with her mobility issues. I think she has had a delay in care due to her restricted mobility with not being able to get up and out of bed or move much. Per interview on 12/16/24 at 9:57 a.m. with LPN-A, R3 had not trialed and was not currently on a bowel or bladder toileting program. LPN-A stated occupational therapy initiated those programs and would only do so if a resident had awareness of their urge to use the bathroom, stating occupational therapy usually assessed a resident's awareness of continence during admission, and if they did not identify that as a goal, then we do not start a toileting program. LPN-A stated if a resident was in the facility long-term and staff observed they were unable to do daily tasks they were once able to do for themselves but were currently unable to perform and the resident verbalized a desire to perform those ADLs, staff could request an occupational therapy evaluation. LPN-A stated R3 would not be a candidate for a toileting program because she could not stand and because she admitted incontinent of both bowel and bladder. LPN-A confirmed she was working with physical therapy and stated, they've been trying to stand with her but we have not been. Per interview on 12/16/24 at 12:01 p.m. with the DON, a bowel and/or bladder toileting program can be initiated with an assessment or screener. The biggest things reviewed during the assessment include a resident's therapy status, transfer abilities, and skills. The DON stated it was definitely an IDT discussion and contradicted LPN-A, stating any staff person was able to bring up a concern or recommendation for a toileting program. The DON agreed occupational therapy could be responsible for guiding the program, but indicated the facility did not have an occupational therapist. The DON stated the benefits of a toileting program for residents included increased self-esteem and self-worth, decreased risk of UTIs and skin breakdown, and the potential for increased mobility for residents, and task and workload reduction for staff. The DON stated R3 could be someone we could consider for a toileting program at first glance, but digging deeper, she might not be. The DON reported R3's cognitive issues, stating she has hallucinations, and her unawareness of her urge to void as the reasons a toileting program would not appropriate. The DON believed R3 would need therapy involved directly for a toileting program to be effective, stating, saying the words 'therapy ending' to her stopped her standing with nursing staff. The DON confirmed toileting a resident at the same time every day is a good thing, and believed R3 could use a bedside commode with the EZ stand. The DON verified the facility's staffing was not ideal. The DON verified resident needs were exceeding staffing levels and agreed resident outcomes were suffering. The DON stated, our staffing is not meeting the needs of our residents. If we're only meeting bare minimum, that's not good customer service. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility assessment dated [DATE], indicated it evaluated the facility's resident population and identified resources needed to provide the necessary care and services to residents during day-to-day operations and emergencies. The assessment tool identified itself as a resource for the facility's leadership to use when making decisions for purposes regarding sufficient staffing numbers, competent staff, recruitment, and retention of staff, and continency planning for emergency events. The assessment indicated input form residents, their representatives, staff, and resident council meeting minutes were reviewed for applicable input. The assessment identified other pertinent facts or descriptions of the resident population to be considered when determining staffing and resource needs which included the following: - require a Hoyer or Sit-to-Stand lift (2-person transfer). - are on increased monitoring for behaviors or are Cares in Pairs. - require hands-on transfer assistance. - have mixed preferences for eating in the dining room, versus resident room. - needs of ancillary staff (readying those residents who receive therapy by a certain time each, for instance). The assessment indicated physical therapy and specific rehabilitation services provided services such as ADL cares to support a resident's independence in doing as much of the ADLs by himself/herself. Furthermore, the assessment indicated it provided bowel and bladder care, including incontinence prevention and care and responding to requests for assistance to the bathroom or toilet promptly in order to maintain continence and promote dignity. A request for policies pertaining to toileting programs, incontinence, and staffing were requested but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident assessments, plans of care, and facility assessment. This had the potential to affect all residents residing in the facility. Bowel and Bladder - See F690 - R3 Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], reported she had intact cognition, had no hallucinations, delusions, rejections of care, and no verbal, physical or other behavioral symptoms towards herself or others. The MDS identified R3 was dependent on staff for toileting hygiene and transfers, required substantial to maximal assist for mobility and all other transfers, had no urinary catheters, had not trialed a urinary or bowel toileting training program and was frequently incontinent of urine and bowel. Additionally, the MDS identified R3 was at risk for pressure injury wound. During a continuous observation on 12/11/24 between 10:48 a.m. and 11:37 a.m., the following was observed: - 10:48 a.m.: R3's call light was put on. - 10:49 a.m.: nursing assistant (NA)-A entered R3's room to answer the call light and was heard stating she would be back to help her. Per interview at 10:49 a.m., R3 verified NA-A stated she would be back to help clean her up. - 11:09 a.m.: the director of nursing (DON) walked down the hallway and asked where NA-A was. Within 2 minutes, the DON left the unit and was observed walking onto the elevator leaving the second floor. - 11:13 a.m.: NA-A was not back to assist. An overhead page was heard announcing, 2 west, you have a resident call. - 11:14 a.m.: There were no staff observed on the 2 East of the unit. An overhead page was heard announcing, 2 west nurse please call and a call-back number was read aloud. - 11:18 a.m.: No staff were present on the 2 east unit. - 11:20 a.m.: Licensed practical nurse (LPN)-H walked onto the 2 east unit to the medication cart. - 11:22 a.m.: LPN-H left the medication cart and walked off the 2 east unit. No staff have attempted to enter R3's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 11:26 a.m.: Activities-(A) pushed another resident into his room and walked back out and off the 2 east unit without addressing other residents within a minute. - 11:30 a.m.: NA-A walked off the elevator, walked through the nurse's station and into the nurse manager's office. No visible staff observed down the 2 west hallway or the 2 east hallway. - 11:38: a.m.: An unidentified staff walked off the elevator and into to the nurse manager's office. There were no nursing staff on either the 2 west hallway or 2 east hallway. - 11: 41 a.m.: LPN-H and NA-A walk back to the 2 east unit and hallway. - 11:42 a.m.: LPN-H and NA-A entered R3's room to assist with cares requested from call light request at start of observation. Per interview on 12/9/24 at 3:19 p.m. with nursing assistant (NA)-F, there was no staffing, no management and no one to do the scheduling right now. NA-F stated if someone called out of their shift, they normally find a replacement by asking nurses to overlap and help with the NA work. NA-F stated, it happens that we [are] short but not often. R23 The quarterly Minimum Data Set (MDS) dated [DATE], for R23 indicated moderately impaired cognition. MDS indicated on 10/12/24 cognitive loss, dementia, with decrease of functional abilities, falls, nutritional status, pressure ulcer/injury, and pain. R23 diagnosis on 1/25/24 peripheral vascular disease, absence of other left toes acquired absence of other right toes. R23 is full assist of two, non-weight bearing, has an air mat, reposition every 2 to 3 hours. Heel boot and float heels. During an observation of R23 on 12/11/24 at 8:11 a.m., nursing assistant (NA)-A completed hand hygiene, donned enhanced barrier precautions (EBP) and cleaned face and arms of R23. NA-A doffed EBP, left room, found another staff member to do peri cares and reposition. NA-D was in the dining room assisting residents with breakfast. The licensed practical nurse (LPN)-A was interrupted during a medication pass, washed hands, donned EBP performed cares and repositioned resident. During a continuous observation of R23 on 12/11/24 between 10:48 a.m. and 11:37 a.m.: - 10:48 a.m., call light on, no staff were observed in hallways - 11:10 a.m., no staff observed in hallway, call light remained on. - 11:20 a.m., no staff observed in hallway, call light remained on. - 11:36 a.m., a staff member was observed walking to the medicine cart and within one minute, walked away and off the unit. - 11:37 a.m., a staff member was observed walking in room and able to assist with cares per her call light request initiated at 10:48 a.m. Grievance/complaints (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A grievance/complaint report on 5/21/24, indicated R36 reported they were wet for 2.5 hours. They put on their call light at approximately 4:30 a.m., nursing assistant (NA)-A told R36 that they were the only NA on the floor, and they were taking a 2.5-hour break because of a 16-hour shift. R36 stated they were still wet at 6:00 a.m., and could not be changed as the day shift wasn't on yet. The follow up indicated the concern was discussed with staff their responsibility to provide cares. A grievance/complaint report on 6/4/24, R19 told licensed practical nurse (LPN)-A that nursing assistant (NA)-A did not finish changing resident, NA-A walked out of room and left R19 unattended for 35 minutes without coming back or saying anything to resident. The follow up indicated LPN-A found nursing assistants (NA)-D and NA A, on break together. The staff were brought back to the floor and completed the cares for R19. A group meeting was held with registered nurse (RN)-B, LPN-A, LPN-D, NA-A and NA-D. The result of actions where two NAs were verbally counseled. The resolution of grievance included R19 was very upset, and staff explained R19 was able to report situations at any time. A grievance/complaint report on 6/28/24, identified the interdisciplinary team (IDT) held a quarterly meeting, and R19 reported she was upset that she was not being assisted up in wheelchair due to being short staffed. The report indicated nursing confirmed staffing was insufficient. The follow up for R19 included the administration discussed care plan, observed staffing on the floor, and provided the ability to transfer R19 into wheelchair. A grievance/complaint report on 7/31/24, included R19 informed the facility they were not changed after a bowel movement. They indicated they waited for 3 hours because there was not enough staff to provide cares. R19 put on call light at least two times an hour, and was repeatedly told by staff, they were not able to provide cares. The follow up was a staff meeting, and R19 should notify the manager each time this type of incident happens. Staff involved were unnamed. A grievance/complaint report on 8/21/24, indicated R37 stated they put on their call light at 12:30 a.m. for a brief change. A staff member came into room, turned off call light, and told R37 it will get done. The staff did not return, and R37 reported they did not get changed until 6:15 a.m. The facility follow up included providing coaching for staff members. A grievance/complaint report on 8/30/24, indicated at approximately 2:00 a.m., R37 put on their call light to request a brief change and water. Licensed practical nurse (LPN)-G answered the call light, left, and did not come back for approximately 2 hours to change him. R37 put call light on, requested to sit in chair, and a staff member told him they aren't going to get him up. The follow up included a staff meeting to explain requirement to provide cares, answer call lights promptly, and honor resident wishes. A grievance/complaint report on 9/19/24, indicated R37 put their call light on at 7:30 p.m. to request a brief change for bowel movement. R37 was banging on the foot of bed to get help. Licensed practical nurse (LPN)-I told R37 that the nursing assistant (NA) left at 8:30 pm, and R37 needed to wait to be changed. R37 asked LPN-I to change him. LPN-I turned off call light and did not change him. R37 put light on again, was changed at 11:30 pm. The facility follow up was to remind staff to answer call lights and resolve the issue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident council meetings minutes 10/20/24, were reviewed on 12/16/24, and identified call light wait times were brought up as a concern. Resident council meeting minutes dated 9/18/24, were reviewed on 12/16/24, and identified call light wait times was discussed. Resident council meeting minutes dated 10/20/24, were reviewed on 12/16/24, and identified call light wait times were brought up as a concern. A resident council meeting was held on 12/10/24 at 10:00 a.m., R36 reported call lights take a long time to answer. R37 stated call lights wait times take the longest to be answered in the evening and at night. R30 reported the facility had been without a maintenance worker and the facility needs so much work because the place is falling down. R30 verbalized they did not feel the facility had enough staff to take care of the building or to take care of residents. During an interview on 12/11/24 at 8:34 a.m., nursing assistant (NA)-A stated, when the cares are difficult to complete when residents are an assist of two. The staff were interrupted during medication passes, and during meals. One staff member was in the dining room. There was not enough staff to complete morning cares on time. During an interview on 12/12/24 at 2:19 p.m., licensed practical nurse (LPN)- D confirmed there was 9 out of 18 residents on 2 east and 2 west hallways required assist of two to provide safe cares. It is difficult to complete cares when interrupted with phone calls, mealtimes, and medication pass. During an interview on 12/13/24 at 10:21 a.m., administrator, stated the staff schedule has double shifts built in. In case of a no show/sick call or emergencies, bonuses were offered to other staff. The management and ancillary staff assisted with tasks that were necessary for the residents. He verbalized the staffing for cares in pairs was a concern. The staff, residents and families brought workload concerns to facility by email, phone number, able to submit anonymously. The system to address concerns were quality assurance and performance improvement (QUAPI), interdisciplinary team (IDT) and meetings. During an interview on 12/16/24 at 10:10 a.m., director of nursing (DON) verified insufficient staffing. The DON stated the resident needs outweigh the staff available. DON stated, lack of support from corporate, and being a new DON, mentorship was needed but fell by the wayside. The DON confirmed the acuity for the residents is high, 9 out of 18 residents required assist of two staff for cares. Staffing and management were working with corporate to get staffing numbers up. The facility was actively recruiting for a health unit coordinator or receptionist to assist in tasks in the facility. This facility did not utilize pool, contract or agency nursing. The maintenance director resigned; no daily maintenance is completed. Corporate sent someone out once a month to do repairs. The system was in place for workload concerns are phone number for grievances, and email, anonymously if desired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 12/13/24 at 10:24 a.m., the administrator verified being responsible for the scheduling with the DON. The administrator reflected on the facility's recent self-reported investigations and requirement to remove staff from the schedule and verified it had not been easy to schedule around their absences but stated we've been able to provide cares. The administrator stated the levels of care were assessed during interdisciplinary team (IDT) meetings every day, including resident behaviors. The administrator believed the staffing approaches covered the acuity needs of the residents. When asked about the continuous observation on 12/11/24, and if that was a demonstration of appropriate staffing, the administrator stated, I expect a call light to be answered ideally within 10-15 minutes, and stated the expectation was to provide cares in an appropriate and safe manner. The administrator stated they discuss resident acuity and case mix daily but stated residents requiring cares in pairs are not always considered in their case mix or acuity count. The DON verified the facility's staffing was not ideal and stated the administrator had received the short end of the stick. The DON stated they both were taking hits and had received discipline by corporate management for staffing the way we do and we're still not meeting the acuity needs. The DON stated they are urging families to file formal grievances to aid in their efforts to support their staffing needs. The DON stated they did not have employees to call on as back-ups for instances of no-call/no-shows and did not have the permission to set that up. The DON verified resident needs were exceeding staffing levels and agreed resident outcomes were suffering. The DON stated, Our staffing is not meeting the needs of our residents. If we're only meeting bare minimum, that's not good customer service. A facility assessment dated [DATE], indicated it evaluated the facility's resident population and identified resources needed to provide the necessary care and services to residents during day-to-day operations and emergencies. The assessment tool identified itself as a resource for the facility's leadership to use when making decisions for purposes regarding sufficient staffing numbers, competent staff, recruitment, and retention of staff, and continency planning for emergency events. The assessment indicated input from residents, their representatives, staff, and resident council meeting minutes were reviewed for applicable input. The assessment identified other pertinent facts or descriptions of the resident population to be considered when determining staffing and resource needs which included the following: - require a Hoyer or Sit-to-Stand lift (2-person transfer). - are on increased monitoring for behaviors or are Cares in Pairs. - require hands-on transfer assistance. - Have mixed preferences for eating in the dining room, versus resident room. - needs of ancillary staff (readying those residents who receive therapy by a certain time each, for instance). The assessment indicated physical therapy and specific rehabilitation services provided services such as ADL cares to support a resident's independence in doing as much of the ADLs by himself/herself. Furthermore, the assessment indicated it provided bowel and bladder care, including incontinence prevention and care and responding to requests for assistance to the bathroom or toilet promptly in order to maintain continence and promote dignity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The assessment concluded the staffing level process was to consider the corporate staffing requirements and identified the facility-specific requirements at a census of 43 residents or more, the staffing levels should be 3 licensed nurses on the day and evening shifts and 2 nurses on the overnight shift; 4 NAs on the day and evening shifts and 2 NAs overnight with 2 nurse managers at least 8 hours per day Monday through Friday. Additionally, the assessment indicated an acuity consideration of over one third of our residents require two-person assistance with transfers, either stand-by assist or Hoyer or EZ stand lifts and due to behavioral issues, one third of our residents are care planned to be Cares in Pairs and require two individuals to be present during all cares. Additionally, the assessment always included memory care's requirement of 2 staff on the floor at all times for safety with wandering residents. Meal Service The facility assessment dated [DATE], indicated meals are served from the same dining room at the same time for all units, delivering meals that are hot and palatable is best done with full staff. The assessment also indicated meals were delivered in a space preferred by the resident, either in their room or in the dining room and staff must accommodate both preferences and deliver meals in a timely manner to ensure food safety be maintained. During observation and interview on 12/10/24 at 8:15 a.m., residents were seated in the memory care dining area, and a resident asked where breakfast was at. The resident stated breakfast was supposed to start at 8 a.m. and stated the current time. At 8:17 a.m., another resident asked when the food was going to arrive. Nursing assistant (NA)-G stated breakfast was coming soon and gave the resident some drinks. At 8:19 a.m. , the nurse stated the food would arrive in a few minutes. At 8:24 a.m., dietary aide (DA)-A entered the memory care area with breakfast in a closed container and a cart of juice and coffee. When interviewed on 12/11/24 at 8:56 a.m., NA-G stated breakfast was usually served around 8:10 and 8:15 a.m. and was an improvement. During meal observation and interviews on 12/11/24 at 11:59 a.m., cook (C)-A brought a serving cart with food and items to serve from the main kitchen on the first floor to the second floor. C-A placed food in the transitional care unit (TCU) and long-term care (LTC) dining room steamer and completed other tasks for meal service. At 12:07 p.m., dietary aid (DA)-A prepared silverware on meal trays and other tasks. Two residents were served in the dining area. At 12:11, culinary district manager (DM) stated they were waiting for nursing staff to be ready to serve before dishing up the plates. At 12:17 p.m., registered nurse (RN)-C entered the dining area from the memory care area, and DM stated they were waiting for staff to start meal service. At 12:22 p.m., licensed practical nurse (LPN)-B entered the dining area from the memory care area, and DM stated they were waiting for staff to start meal service. Then C-A started to plate lunch, and DA-A placed completed meal trays into an enclosed cart. At 12:31 p.m., multiple residents were sitting in the memory care area dining room and only a few residents had drinks in front of them. At 12:33 p.m., DA-A entered with the drink cart. At 12:37, nursing assistant (NA)-E entered the memory care area with the food cart. At 12:47 p.m., social worker (SW) was in the dining area between the TCU and LTC care area standing next to an enclosed cart filled with room trays and stated they were waiting for a juice cup. At 12:52 p.m., SW pushed the cart into the LTC hallway and served the first person their meal tray and continued serving the rest of the residents in the hallway room by room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Medication administration During medication observation and interview on 12/11/24 at 7:15 a.m., licensed practical nurse (LPN)-H had two medication cups with medications on the medication cart and then placed into the top drawer of the medication cart. LPN-H prepared medication for R2 and then added the prepared medications to one of the medication cups from the top drawer. LPN-H stated they were preparing medications for R2 now and for R2's next medication pass time when surveyor approached and panicked so checked the medications due now as given already and saved the medications to give R2 at the next medication pass in the top drawer. LPN-H stated they usually labeled the prepped medication cup with the resident's name and room number. LPN-H stated they often prepped residents' medications early or else they would not have their work completed until 4:00 p.m. each day. LPN-H stated the long-term care and transitional care units had a total of two nurses and two nursing assistants, but about twice a week had one nurse and one to two nursing assistants. LPN-H assisted with resident ADLs and other tasks when there was one nursing assistant for the transitional care unit and long-term care area. LPN-H felt pressured to find ways to save time when there was only one nurse and had appointments, labs, new orders, wounds, and intravenous medications to manage. LPN-H stated they spoke with management before, and management staffed according to resident census. When interviewed on 12/9/24 at 3:19 p.m., nursing assistant (NA)-F stated sometimes there were not enough staff, and there was no staffing coordinator and a lack of management in general. 49617 51577

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49617 Based on interview and document review, the facility failed to complete annual performance reviews for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-H, NA-M) whose employee files were reviewed. This had the potential to affect all 37 residents who resided at the facility. Findings include: A review of employee records on 12/12/24 between 1:24 p.m., and 2:37 p.m., lacked documentation of completed annual performance reviews. All 5 sampled employees were employed at the facility for greater than one year. Per interview on 12/12/24 at 2:11 p.m., the administrator stated it was their understanding the previous director of nursing (DON) completed competencies with annual reviews. The administrator stated, I'm looking through file cabinets and if I can't find them, I can't say that we have them without them. Per interview on 12/16/24 at 12:01 p.m., the DON had no luck locating the annual performance reviews or recent completed competencies for the sampled NA's. The DON stated the facility would be restarting those reviews beginning January 1st and indicated it was important because staff needed to be aware of what they were doing well and what could be improved upon. Additionally, the DON stated annual reviews were a good way to build rapport with staff and helped build the team. The facility assessment last reviewed 8/8/24, indicated the facility's training program was based on the facility's resident population and was an ongoing training for all new and existing staff including managers, nursing, and other direct care staff. The assessment identified annual reviews were a part of the training sessions and would be completed to meet regulatory requirements. Furthermore, the assessment indicated, skills and competencies were completed on hire and annually to test continued competence in assessment, safe patient handling, infection control, medication administration, wound care, feeding and bathing; skills competencies testing is based on the usual and customary duties performed by each staff member. The assessment also included the annual review process in staff recruitment and retention section. A policy pertaining to annual reviews was requested but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure prescription topical medications were applied and documented in accordance with professional standards of practice for 1 of 2 residents (R26) observed during morning activities of daily living (ADL) cares. Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and substantial to moderate staff assistance with personal and toileting hygiene cares. The MDS identified diagnoses of muscle weakness, depression, and high blood pressure. R26's undated and unsigned order summary was reviewed 12/11/24, and reflected the following active physician orders: - Nystatin external powder 100000 unit/gm (gram) (Nystatin (Topical)) Apply to skin folds topically as needed for rash under breasts, dated 9/9/24. - Nystatin powder (Nystatin (Bulk)) Apply to groin topically every 12 hours as needed for groin, dated 10/8/24 A request for R26's most recently signed order summary was requested but not received. R26's medication administration record (MAR) dated 10/2024, lacked documentation of as needed (PRN) Nystatin powder administration for rash under breasts, as well as groin. R26's MAR dated 11/2024, lacked documentation of as needed (PRN) Nystatin powder administration for rash under breasts, as well as groin. R26's MAR dated 12/2024, lacked documentation of as needed (PRN) Nystatin powder administration for rash under breasts, as well as groin. R26's treatment administration record (TAR) dated 10/2024, indicated an order for, weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol . This order was marked as completed on 10/3/24, 10/11/24, 10/18/24, and 10/25/24. R26's TAR dated 11/2024, indicated an order for, weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol . This order was marked as completed on 11/1/24, 11/8/24, 11/15/24, 11/22/24, and 11/29/24. R26's TAR dated 12/2024, indicated an order for, weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol . This order was marked as completed on 12/6/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's care plan dated 9/9/24, identified her self-care deficit and guided staff to provide assistance with personal hygiene and bathing cares. Additionally, the care plan identified a risk for skin integrity concerns and indicated a head-to-toe assessment would be performed by a licensed nurse. During observation on 12/11/24 at 7:34 a.m., nursing assistant (NA)-D performed morning cares with R26. NA-D washed under R26's underarms and breasts and patted the areas dry with a clean hand towel. NA-D stated R26 had dry skin and every morning NA-D applied lotion and the doctor ordered this powder for under R26's arms and breasts. NA-D showed the surveyor a bottle with a prescription label affixed to it that read, Kaylesta (Nystatin) powder. NA-D stated they gave me this to put on for the dry skin and NA-D applied the powder from the bottle under R26's arms and breasts. NA-D further explained R26 had issues with her skin intermittently because she's a large woman with a lot of skin there. NA-D stated NAs monitored the skin and would report when the areas were improving or worsening to the nurses as well if NAs used the powder on R26. Per interview on 12/13/24 at 9:46 a.m., licensed practical nurse (LPN)-D expected prescription medications, including topical powders like Nystatin, be applied by nurses because nurses were responsible for the assessment piece and to determine if a resident had reactions to the medication. Per interview on 12/13/24 at 9:53 a.m. with LPN-C, prescription topical medications, like Nystatin powder, should be kept in the locked medication cart and should be applied by a nurse unless a resident had been assessed to safely administer their own medications and had the order in place. LPN-C reviewed R26's MAR and confirmed there were no documented administrations of Nystatin powder on 12/11/24, or for the MAR dated 12/2024. LPN-C was unaware of any skin concerns for R26. LPN-C was unable to locate a skin assessment for R26 identifying any current skin concerns for R26. LPN-C stated a NA applying a prescription topical powder without a nurse's knowledge and keeping it at bedside sounds like an educational piece. LPN-C verified the prescription bottle of Nystatin powder in R26's room before locking the bottle in the medication cart. Per interview on 12/16/24 at 12:01 p.m., with director of nursing (DON), only the nurse should apply medications that are prescribed unless a resident had been assessed to administer them safely themselves and had an order to do so. The DON stated this was important because nurses needed to follow the rights of medication administration. The DON stated prescription medications, including topical powders like Nystatin, should be kept in the nurse's cart. Per facility policy titled Medication Administration dated 1/2024, medications were expected to be administered in accordance with manufacturer's specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The policy directed staff to have medications prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state regulations to prepare medications. Further, the policy directed the individual who administered the medication to record the administration on the resident's MAR immediately following the medication being given and if administer a PRN (as needed) medication, the individual administering the medication should also document the date and time, dose, route of administration, complaints or symptoms for which the medication was given, results achieved from giving the dose and the time the results were noted, and a signature or initials of person recording the administration and/or of the person recording effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 4 of 5 residents (R1, R5, R8, R14) reviewed for unnecessary medications. Findings include: R1 R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment, inattention and disorganized thinking which fluctuated, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnoses of heart failure, hypertension (high blood pressure), thyroid disorder, arthritis (conditions which cause inflammation of the joints), osteoarthritis (chronic disease when cartilage which lines joints are worn down and bones rub against each other), and adjustment disorder with mixed anxiety and depressed mood. Further, R1 took an antipsychotic and antidepressant. R1's Order Summary Report dated 12/12/24, indicated the following orders: - 11/27/24, Depakote oral tablet delayed release 500 mg (used for manic depression). Give one tablet by mouth at bedtime. - 11/27/24, trazodone HCL [hydrochloride] oral tablet 150 mg (an antidepressant often used for sleep). Give 75 mg by mouth at bedtime . - 11/27/24, trazodone HCL oral tablet 50 mg. Give 25 mg by mouth as needed, with no end date noted. - 11/30/24, Seroquel oral tablet 25 mg (quetiapine fumarate) (an antipsychotic). Give one tablet by mouth as needed TID (three times a day), with end date of 12/13/24. - 12/10/24, Seroquel oral tablet 100 mg (quetiapine fumarate). Give one tablet by mouth at bedtime. - 12/10/24, quetiapine fumarate oral tablet 25 mg. Give 12.5 mg by mouth two times a day. - 12/11/24, Neurontin oral capsule 300 mg (gabapentin) (often used for pain). Give one capsule by mouth three times a daily. R1 did not have side effect and/or adverse effect monitoring in place. R1's Pharmacy Review assessment dated [DATE], indicated recommendations were made and to view Clinical Pharmacy Report. The section New Medications/General/Recommendation notes indicated: Memory; migraines, chronic pain; HLD, HF, adjustment disorder 11/24 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
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Clinical Pharmacy Report dated 11/4/24, was reviewed onsite and directed nursing to identify an end date for trazodone or provider rationale and documentation for extended end date, and add in psychotropic side effect monitoring. A copy was not provided. R1's Pharmacy Review assessment dated [DATE], indicated recommendations were made and to view Clinical Pharmacy Report. The section New Medications/General/Recommendation notes indicated: Memory; migraines, chronic pain; HLD, HF, adjustment disorder 12/24 REC: clarifications 11/24 PRN. R1's Clinical Pharmacy Report dated 12/2/24, was reviewed onsite and noted to have repeated both recommendations from 11/4/24. A copy was not provided. R5 R5's significant change Minimum Data Set (MDS) dated [DATE], indicated she had severe cognitive impairment with diagnoses of heart failure, kidney failure, respiratory failure, anxiety, depression, and lymphedema (a chronic condition causing swelling from lymph or protein-rich fluid in the body's tissues). The MDS further indicated R5 received hospice care. R5's unsigned order summary was reviewed 12/13/24, and included the following orders: - albuterol-budesonide inhalation 90-80 micrograms (mcg) / actuation (ACT), 2 puff inhale orally every 6 hours as needed for shortness of breath, dated 10/29/24. - furosemide oral tablet, Give 40 milligrams (mg) by mouth one time a day for pulmonary edema (fluid buildup the lungs), heart failure with chronic kidney disease and failure, dated 3/12/24. - lorazepam oral concentrate 0.125 milligrams (mg) / milliliter (mL), Give 0.25mL every 4 hours as needed for agitation 0.5mg=0.25mL, dated 11/05/24. - lorazepam oral tablet 0.5mg, Give 1 tablet sublingually every 3 hours as needed for anxiety, dated 10/29/24. - morphine sulfate (concentrate) oral solution 20 mg/mL, Give 0.25mL by mouth every 4 hours as needed for shortness of breath/pain, dated 12/13/24. - quetiapine fumarate oral tablet, Give 150mg by mouth at bedtime, for anxiety, depression, dated 2/29/24. - sertraline hydrochloride (HCl) oral tablet 50mg, Give 50mg by mouth one time a day for depression, dated 10/14/24. A request R5's most recent signed order summary was requested during survey and not received. R5's care plan last revised 11/18/24, identified her use of psychotropic medications (antidepressants, antianxiety, and antipsychotics) and diuretic therapy to treat her lower extremity therapy. The care plan directed staff to perform medication regimen reviews (MRRs) as needed, identify available resources and needs for treatment, and attempt GDRs per orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A pharmacy review notes dated 9/5/24, 10/14/24, and 11/4/24, indicated recommendations were made. The notes referred to the clinical recommendations reports. A PharMerica note to attending Physician/Prescriber MRR dated 9/5/24, provided a recommendation for periodic lipid panel for R5's medications. The provider signed the MRR on 10/31/24 and deferred to R5's hospice team. A PharMerica note to attending Physician/Prescriber MRR dated 11/4/24, provided a recommendation regarding duplicative therapy. The MRR lacked provider signature or follow-up. A PharMerica note to attending Physician/Prescriber MRR dated 11/4/24, provided a recommendation regarding R5's lorazepam order. The note stated as needed (PRN) psychotropic orders required no more than 14 days duration or, if deemed necessary beyond, a clinical rationale and specific duration documented by provider. The MRR lacked provider signature or follow-up. A PharMerica nursing recommendations for the recommendations created between 11/4/24 and 11/6/24, indicated R5's albuterol-budesonide inhalation aerosol order should NOT be a combination product and directed staff to review data entry. The MRR lacked nursing signature or follow-up. A PharMerica note to attending Physician/Prescriber MRR dated 12/3/24, provided a recommendation regarding R5's lorazepam orders. The note requested the provider add parameters for when to use the lorazepam tablets versus the concentrate. Additionally, the note repeated the request for the PRN lorazpem order to include an end date of no more than 14 days, and if deemed necessary to include a clinical rationale and a specific duration. The MRR lacked provider signature and follow-up. R5's EMR was reviewed and lacked documentation of MRR follow-up. A request was made for provider response and/or documentation of MRR follow-up and was not received. R8 R8 admission Minimum Data Set (MDS) dated [DATE], included an admitted [DATE]. R8's diagnosis included schizophrenia. R8's order summary report dated 4/3/24, included diagnosis of mild cognitive impairment, schizoaffective disorder (a mental health disorder with symptoms of both schizophrenia and a mood disorder), depression, bipolar disorder (extreme mood swings), and hording disorder. PharMerica Nursing Recommendations dated 8/9/24, included a recommendation to complete labs that were ordered in May but not completed and to place results in the chart. No facility notes were placed in the follow-Through section of the form. PharMerica Nursing Recommendations dated 10/11/24, again recommended completion of labs ordered in May that were never completed. Again, the facility failed to place notes in the follow-through section of the form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) stated they were unsure if R8 declined the labs or the provider did not order. CP stated they needed to be able to see the provider's follow-up to their recommendations or labs drawn on residents. R14 R14's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and reported no behaviors, hallucinations, or delusions. The MDS indicated R14 had heart failure, high blood pressure, kidney failure, obstructive sleep apnea (sleep disorder causing your breathing to repeatedly stop or be reduced while you sleep), respiratory failure, anxiety, depression, bipolar disorder, and dementia (a neurological condition causing a decline in thinking, memory, and behavior). The MDS indicated she was diabetic and received insulin injections over the lookback period, in addition to antidepressants and antianxiety medications. The MDS lacked documentation on if a drug regimen review was assessed and if issues were found. Furthermore, the MDS confirmed medication follow-up was not assessed/no information and the MDS lacked documentation on medication intervention assessment. R14's Care Area Assessment (CAA) for psychotropic drug use dated 8/13/24, indicated the consultant pharmacist (CP) reviewed her medications and made recommendations to the interdisciplinary team (IDT) monthly and as needed. A signed order summary dated 6/6/24, identified the following orders: - carvedilol oral tablet milligram (mg), Give 6.25mg by mouth two times a day, for heart failure, dated 2/12/24. - doxepin hydrochloride (HCl) oral capsule 10mg, Give 20mg by mouth at bedtime for insomnia related to obstructive sleep apnea, dated 2/12/24. - fluoxetine HCl oral capsule 20mg, Give 20mg by mouth in the morning for depression, dated 2/12/24. - furosemide oral tablet, Give 40mg by mouth one time a day dated 2/12/24. - novolog injection solution 100 unit/milliliter (mL) (Insulin Aspart), Inject 17 unit subcutaneously before meals for diabetes, dated 4/8/24. - Remeron tablet (Mirtazapine) Give 7.5mg by mouth at bedtime for depression, dated 2/12/24. - Wellbutrin Sustained-Release (SR) oral tablet Extended Release (ER) 12 Hour 100mg (bupropion HCl), Give 100mg by mouth one time a day for depression, dated 2/12/24. A request for R14's most recent signed order summary prior to survey entrance was requested but not received. R14's medication administration record (MAR) dated 12/2024 reflected the following active and administered medication orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- carvedilol oral tablet milligram (mg), Give 6.25mg by mouth two times a day, for heart failure, dated 9/13/24. - fluoxetine HCl oral capsule 20mg, Give 20mg by mouth in the morning for depression, dated 6/19/24. - furosemide oral tablet 20mg, Give 3 tablet orally one time a day, for heart failure, give 3 tablets (60mg), dated 11/14/24. - isosorbide mononitrate ER 24 Hour oral tablet, Give 60mg by mouth one time a day, for high blood pressure and chronic kidney disease, dated 11/16/24. - lidocaine external gel 4%, Apply to right shoulder topically every 12 hours for shoulder pain, dated 11/25/24. - mirtazapine oral tablet 7.5mg, Give 1 tablet my mouth at bedtime for depression, dated 11/19/24. - novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/mL (Insulin Aspart), Inject 14 unit subcutaneously with meals for diabetes with chronic kidney disease, dated 10/31/24. - Wellbutrin SR oral tablet Extended Release 12 Hour 100mg (bupropion HCl), Give 100mg by mouth one time a day for depression, dated 6/19/24. R14's care plan, last revised on 8/21/24, identified her use of antidepressants and dependence on insulin and risks associated with each medication. The care plan included goals to be free of complications related to the use of the medications and directed staff to administer medications per orders. The care plan lacked documentation or guidance for staff related to R14's use of furosemide, a diuretic (water pill). A pharmacy review note dated 10/11/24 indicated recommendations were made. The review indicated R14 had previous gradual dose reductions (GDRs) of her doxepin on 10/4/24 and mirtazapine on 9/25/24. The note referred to the clinical recommendations report. R14's progress notes were reviewed and lacked documentation of medication regimen review (MRR) follow-up by provider and/or nursing staff. A pharmacy review note dated 12/3/24, indicated recommendations were made. The review indicated an increase to R14's mirtazapine on 11/19/24, and referred to the clinical recommendations report. The progress notes were review and lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica Nursing Recommendations report dated 10/11/24, identified three recommendations or clarifications pertaining to R14's carvediolol medication administration instructions, isosorbide medication formulation, and a clarification regarding the lidocaine formulation. The nursing recommendation lacked documentation of MRR follow-up by provider and/or nursing staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PharMerica MRR Recommendation Summary: Medical Director and Director of Nuring (DON) dated 10/11/24, identified three recommendations or clarifications pertaining to R14's carvediolol medication administration instructions, isosorbide medication formulation, and a clarification regarding the lidocaine formulation. The MRR summary lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica Nursing Recommendations report dated 11/4/24, was received and indicated the resident was out of the facility during the MRR and requested staff evaluated the need for MRR. The report lacked documentation of follow-up. A request for R14's MRRs, clinical recommendations and related follow-up for 6 months were requested but not received. When interviewed on 12/13/24 at 10:57 a.m., licensed practical nurse (LPN)-A stated they received recommendations from the pharmacist and followed up with the primary care physicians to ask if they approved of the pharmacy recommendations or not. LPN-A followed through with what the primary care physician approved. When interviewed on 12/13/24 at 2:26 p.m., LPN-B stated they sometimes received emails from the pharmacist about recommendations they had after order review and followed up on the recommendations right away. LPN-B stated the director of nursing (DON) received the pharmacist recommendation forms, then the managers followed up on the recommendations and returned the pharmacist form to the DON after completion. LPN-B confirmed R1's trazodone did not have an end date and did not have side effect monitoring in place for psychotropic medication. When interviewed on 12/16/24 at 11:01 a.m., the DON stated they printed out the pharmacist recommendation forms and made copies in green. DON gave the original copy to the doctors and nurses to address and placed the green copy in a binder, so they knew the recommendation still needed to be followed up on. DON stated if providers do not follow up on pharmacy recommendations within one month, they asked the provider again. DON received emails and followed up immediately on anything dire. When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) expected pharmacist recommendations to be followed up on within 30 days or by the next visit. CP gave recommendations again when not completed, but the timing on when to give the second reminder depended on what the initial recommendation was, since the providers liked to see the residents before acting or not on some recommendations. CP confirmed the facility had not placed in an end date for R1's trazodone and would have expected them to complete after the recommendation in November of 2024, since they needed to know why trazodone was administered and needed to re-evaluate the use per regulations. CP also confirmed R1 did not have side effect monitoring for psychotropic medication in place as was recommended previously. Per facility policy titled Medication Reconciliation last revised 10/24/22, the facility reconciled medication throughout a resident's stay to ensure the resident was free of any significant medication errors. The policy indicated the monthly process was the provide the consultant pharmacist access to all medication areas and records for completion of pharmacy services activities. Furthermore, the policy directed staff to respond to any medication irregularities reported by the pharmacist within relevant time frames. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49035 49617

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to provide appropriate side effect monitoring (including vital and orthostatic blood pressure monitoring) and obtain informed consent for psychotropic medication and ensure a PRN (as needed) psychotropic medication order included an end date for 1 of 5 resident (R1) reviewed for unnecessary medication use. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment, inattention and disorganized thinking which fluctuated, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnoses of heart failure, hypertension (high blood pressure), thyroid disorder, arthritis (conditions which cause inflammation of the joints), osteoarthritis (chronic disease when cartilage which lines joints are worn down and bones rub against each other), and adjustment disorder with mixed anxiety and depressed mood. Further R1 took an antipsychotic and antidepressant. R1's Order Summary Report dated 12/12/24 indicated the following orders: - 11/27/24, Depakote (anticonvulsant used to treat seizure and bipolar disorders) oral tablet delayed release 500 mg. Give one tablet by mouth at bedtime related to adjustment disorder with mixed anxiety and depressed mood. - 11/27/24, trazodone HCL [hydrochloride] (antidepressant used to treat depressed mood and other depression-related symptoms) oral tablet 150 mg. Give 75 mg by mouth at bedtime for trouble sleeping. - 11/27/24, trazodone HCL oral tablet 50 mg. Give 25 mg by mouth as needed for trouble sleeping, with no end date noted. - 11/30/24, Seroquel (quetiapine fumarate; antipsychotic used to treat schizophrenia, bipolar disorder, and depression) oral tablet 25 mg. Give one tablet by mouth as needed TID (three times a day) for anxiety, restlessness and agitation related to adjustment disorder with mixed anxiety and depressed mood, with end date of 12/13/24. - 12/10/24, Seroquel oral tablet 100 mg. Give one tablet by mouth at bedtime for insomnia. - 12/10/24, quetiapine fumarate oral tablet 25 mg. Give 12.5 mg by mouth two times a day for agitation and/or impulsiveness. - 12/11/24, Neurontin (gabapentin; anticonvulsant used to treat seizures and nerve pain) oral capsule 300 mg. Give one capsule by mouth three times a daily for anxiety and/or pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan printed on 12/16/24, indicated R1 was at risk for adverse effects related to use of psychotropic medications, which was initiated 10/29/24. The care plan included an intervention revised on 10/20/24 to evaluate effectiveness and side effects of medications for possible decrease and/or elimination of psychotropic drugs. The care plan did not indicate vital or orthostatic blood pressure monitoring. R1's MAR/TAR (medication administration record; treatment administration record) dated November and December 2024, indicated R1 received trazodone PRN on 11/27/24, 12/2/24, and 12/7/24. R1's MAR/TAR for November 2024, directed staff to enter R1's vital signs weekly every Tuesday PM [evening] with start date of 11/5/24 and end date of 11/27/24. Vitals were recorded on 11/5/24, 11/12/24, 11/19/24, and 11/26/24 indicated R1 was hospitalized . R1's medical record had no indication of vital monitoring after 11/27/24. Further, R1's medical record had no indication of orthostatic blood pressure monitoring. R1's medical record had no indication of consent by the resident, family, or guardian for use of gabapentin. When interviewed on 12/13/24 at 10:57 a.m., licensed practical nurse (LPN)-A stated nursing spoke with resident or family member to give education about psychotropic medications and obtained consent and signed a form placed in residents' paper chart. LPN-A stated orthostatic blood pressures were taken every few months and scheduled in the MAR/TAR. LPN-A stated nursing wrote progress notes if residents refused orthostatic blood pressure monitoring. LPN-A stated they monitored residents' vitals daily when first admitted and then weekly vitals with bathing and skin assessment unless resident acutely ill. LPN-A stated vitals were recorded in the MAR/TAR and transferred over to the medical record's vitals tab. LPN-A stated they observed for side effects of psychotropic medications daily per the MAR and TAR. LPN-A stated trazodone prn should be scheduled for 14 days, and prn trazodone use would be evaluated after the set time frame to see if still needed and document a reason to uphold the order. When interviewed on 12/13/24 at 2:26 p.m., LPN-B stated R1 entered the facility on psychotropic medications, and they reviewed R1's medications with R1's family member and filled out the consent form for R1. LPN-B confirmed they did not get a consent for gabapentin and was not sure if they needed to and stated nursing needed to monitor for side effects of gabapentin such as drowsiness, dry mouth, and tremors. LPN-B stated not all psychotropics required orthostatic blood pressure monitoring and were scheduled once a month if needed on the TAR. LPN-B confirmed R1 did not have orthostatic blood pressure monitoring, and R1 may need orthostatic blood pressure monitoring for use of Seroquel. LPN-B stated resident vitals were checked once a week with their shower and skin assessment. LPN-B stated vitals were entered into the MAR/TAR and automatically went to the vitals tab. LPN-B confirmed R1 did not have weekly vital monitoring scheduled. LPN-B stated they placed in orders to monitoring for psychotropic medication side effects every shift per the medical record order set. LPN-B confirmed R1 did not have psychotropic monitoring in the MAR/TAR or vital or orthostatic blood pressure monitoring in the care plan. LPN-B confirmed R1's order for prn trazodone did not have an end date and did not have a provider documented reason for the indefinite order. DON expected prn trazodone to have a 14 day stop date. DON stated it was important for prn psychotropics to have a stop date to ensure the providers were evaluating the medications use and side effect monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 12/16/24 at 11:01 a.m., the director of nursing (DON) expected nursing to obtain consent for psychotropic medication, which included gabapentin depending on if used for a psychological change. DON agreed gabapentin used for anxiety and/or pain needed a consent for administration. DON stated obtaining consents were important to ensure resident or responsible party were aware of side effects, which included irreversible side effects. DON expected nursing to have orthostatic blood pressures recorded monthly for R1, unless R1 had issues with blood pressure. DON expected residents' vitals to be taken at least once a week. DON stated R1 was noncompliant and expected to see notes of refusals. DON expected R1 to have three days of vital monitoring when returned from hospital on 12/27/24. DON expected nursing to monitor for psychotropic side effects according to pharmacist recommendations. When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) CP expected nursing to obtain consent for R1's gabapentin use after a risk and benefit education. CP verified R1's prn trazodone did not have a stop date and an end date was important to have to ensure the medication was re-evaluated per regulations. CP expected staff to monitoring for orthostatic blood pressures for antipsychotics and confirmed R1 should have psychotropic medication side effect monitoring in place but did not. The Psychotropic Medications policy dated 10/24/22, indicated a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs included but were not limited to antipsychotics, antidepressant, anti-anxiety, and hypnotics. The policy directed staff to educate residents and/or representative on the risks and benefits of psychotropic drug use. Further, the policy indicated prn orders for all psychotropic drugs would be used only when the medication was necessary to treat a diagnosed specific condition, which was documented in the clinical record, and for a limited duration, such as 14 days. Additionally, the policy directed staff to monitor effects of psychotropic medications on residents' physical, mental, and psychosocial well-being on an ongoing basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 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** 48299 Based on observation, interview, and document review, the facility failed to ensure staff performed appropriate hand hygiene during medication administration for 2 of 3 residents (R2, R6) observed during medication administration, and failed to implement enhanced barrier precautions (EBP) for 6 of 7 residents (R4, R9, R14, R18, R26, R29) reviewed for precautions. Further, the facility failed to develop and implement a Legionella risk assessment and plan to mitigate the growth of Legionella. This had the potential to affect all 37 residents, staff and visitors. Findings include: Hand Hygiene R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact with diagnoses of coronary artery disease (arteries which supply blood to the heart become narrowed or blocked), heart failure, hypertension, and diabetes mellitus. R6's quarterly MDS dated [DATE], indicated R6 was cognitively intact with diagnoses of hypertension, urinary tract infection, diabetes mellitus, dementia, anxiety, and depression. During a medication observation and interview on [DATE] at 7:15 a.m., licensed practical nurse (LPN)-H prepared medication for R2 at the medication cart outside of R2's room. LPN-H entered R2's room and took R2's temperature and oxygen saturation level. LPN-H exited the room and did not perform hand hygiene and typed information into the computer, then LPN-H locked the cart and gave medication cup to R2. R2 took medication independently. LPN-H returned to the medication cart, did not perform hand hygiene, and prepared medication for R6. LPN-H found a tray to place R6's medication on, placed on gloves to clean the tray, removed gloves, and performed hand hygiene. LPN-H brought medication to R6 and observed R6 take medication independently. R6 stated they had a cream LPN-H to apply. LPN-H exited the room, did not perform hand hygiene, and looked at R6's orders on the computer. LPN-H returned to R6's room and touched and looked at the tube of cream in R6's room. LPN-H stated they would confirm and apply the appropriate cream later and left R6's room. LPN-H returned to the medication cart to chart the medications given to R6 and did not perform hand hygiene. LPN-H started to look at another resident's medication list and readied a new medication cup. LPN-H confirmed they performed hand hygiene after cleaning the tray and removing gloves but missed opportunities to perform hand hygiene between giving medications to one resident and preparing medications for a different resident. When interview on [DATE] at 2:25 p.m., LPN-B stated staff should perform hand hygiene when leaving a resident room before preparing another resident's medications. LPN-B stated staff did not want to transfer germs from one resident to another. When interviewed on [DATE] at 11:01 a.m., the director of nursing (DON) expected staff to perform hand hygiene in between medication passes to lessen the risk of germs spreading from one resident to another. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Hand Hygiene policy dated [DATE], directed staff to perform hand hygiene when indicated, using proper techniques consistent with accepted standards of practice. The policy included a Hand Hygiene Table which directed staff to perform hand hygiene before preparing or handling medications. EBP R4's admission record printed [DATE], included an admitted [DATE]. R4's care plan printed [DATE], included R4 had a pressure ulcer (wound caused by pressure) on his coccyx (tailbone). The care plan failed to include interventions for EBP. Observation of R4's room did now show evidence of signage or personal protective equipment (PPE) for EBP on [DATE], and [DATE]. R9's admission record printed [DATE], included an admitted [DATE], and a diagnosis of pressure ulcer of the right heel. R9's care plan printed [DATE], failed to include interventions for EBP. Observation of R9's room did now show evidence of signage or personal protective equipment (PPE) for EBP on [DATE], and [DATE]. R14's admission record printed [DATE], included an admitted [DATE], and a diagnosis of neuromuscular dysfunction of bladder (causes a person to not be able to control their bladder emptying). R14's care plan printed [DATE], included R14 had a Foley catheter. R14's care plan failed to include interventions for EBP. Observation of R14's room did now show evidence of signage or personal protective equipment (PPE) for EBP on [DATE], and [DATE]. R18's significant change Minimum Data Set (MDS) dated [DATE], included an admitted [DATE], and an active diagnosis of benign prostatic hyperplasia (enlargement of the prostate gland). R18's MDS included he had an indwelling catheter. Observation of R18's room did now show evidence of signage or personal protective equipment (PPE) for EBP on [DATE], and [DATE]. R26's admission record dated [DATE], included an admitted [DATE]. R26's care plan printed [DATE], included R26 has a urostomy (an opening in her stomach for urine to leave the body). R26's care plan failed to include interventions for EBP. Observation of R26's room did now show evidence of signage or personal protective equipment (PPE) for EBP on [DATE], and [DATE]. R29's admission record printed [DATE], included an admitted [DATE], and diagnosis of neuromuscular dysfunction of the bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R29's care plan printed [DATE], included R29 had an indwelling catheter. R29's care plan failed to include interventions for EBP. Observation of R29's room did now show evidence of signage or personal protective equipment (PPE) for EBP on [DATE], and [DATE]. When interviewed on [DATE] at 9:49 a.m., nursing assistant (NA)-D stated nursing assistants did not follow enhanced barrier precautions, and enhanced barrier precautions were for nurses. During interview on [DATE] at 2:00 p.m., director of nursing (DON) was unable to state when a resident should be placed on EBP. She states she would follow the CDC guidelines. When the DON referred to the printout of CDC guideline in the infection control binder, she confirmed the guidelines were to implement EBP whenever a resident had an open wound are an indwelling medical device, such as a catheter. The DON confirmed they were not following EBP correctly in the facility and provided a list of residents who had either an indwelling medical device or an open wound. Facility policy titled Enhanced Barrier Precautions dated [DATE], included the facility would initiate EBP for residents with wounds and/or indwelling medical devices. 49035 Legionella The facility is not required to do testing unless a concern is identified. They are required to have a schematic of the water system and a program to mitigate growth of legionella. During entrance conference on [DATE] at 1:52 p.m., administrator was asked to provide a copy of the facility Legionella risk assessment and plan to mitigate the growth of Legionella. A plan was not provided. On [DATE], a 2nd request was placed to the administrator for a copy of the Legionella plan and evidence of implementation. No documentation was provided. On [DATE] at 8:49 a.m., a requested for information on the Legionella water management plan was sent to the director of nursing (DON). No documentation was provided. O [DATE] at 2:30 p.m., the administrator requested clarification on what was needed for evidence of Legionella plan. The administrator stated, we flush toilets and run the water on first floor weekly. The administrator was unable to provide a schematic of the buildings water flow and no additional documentation was provided. Facility document titled Legionella Surveillance Policy dated [DATE], included the facility would establish a primary and secondary strategy to prevent and control Legionella infections.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure a bed remote control was monitored and kept in safe condition for 1 of 1 resident (R16) reviewed for bed controls. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated R16 had severely impaired cognition and diagnoses of heart failure, diabetes mellitus, depression, and dementia. R16 had no impairment to upper and lower extremity and was independent with mobility, such as rolling left and right, sit to lying, and lying to sitting on side of bed and required more assistance with transfers and dressing. During observation and interview on 12/9/24 at 2:42 p.m., R16 laid in bed with the bed controller within reach. The bed controller cord had a black covering which had a half inch or less gap between the controller with the buttons and insulated wires were visible and not frayed. R16 stated they used their bed controller independently. When interviewed on 12/13/24 at 2:12 p.m., nursing assistant (NA)-G stated R16 required extensive assistance for most ADLs but was able to turn herself side to side in bed and used the bed controller independently. NA-G did not notice wires on R16's bed controller but would report to nursing and maintenance if observed. NA-G stated the facility had a TELS (a building management platform) system to report concerns to maintenance. When interviewed on 12/13/24 at 2:16 p.m., licensed practical nurse (LPN)-I stated they had not heard about any bed controller concerns recently but would report to maintenance or director of nursing if such a concern occurred. LPN-I stated electrical concerns caused risk of shock and at times have needed to disconnect residents' bed and move them to another room to ensure safety. When interviewed on 12/13/24 at 2:18 p.m., LPN-B expected staff to place a maintenance request in TELS if they saw exposed wires to protect resident safety. LPN-B observed R16's bed controller and ensured it worked. LPN-B stated there were exposed wires but were not frayed so would let the administrator know the controller needed to be replaced. The TELS Work Orders dated 3/1/24 to 12/12/24, did not indicate R16's bed controller needed repair. When interviewed on 12/16/24 at 10:02 a.m., the administrator stated they saw the bed controller and replaced it. Administrator expected staff to enter a TELS request if a bed controller needed replacement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Work History Report dated January to October 2024, indicated Bed-Electric audits were completed 8/10/24 and described as not good. The report described the beds as shortage of good beds on 8/17/24, very short on 8/24/24, short on good beds on 8/31/24, beds are poor condition, and we are low on 9/7/24. The task was indicated as skipped with description no maintenance director at this time on 9/14/24. The Perform Bed Inventory Check for Beds-Electric indicated no action recorded on 9/21/24 and 9/28/24. Bed safety audits were completed on 9/30/24. The task did not record any action on 10/5/24. The task indicated no maintenance director at this time and action skipped on 10/12/24. The task did not record any action on 10/19/24 and 10/26/24. The Physical Environment: Electrical Equipment Policy dated 6/16/22, indicated the maintenance director would maintain schedules for routine inspection and maintenance of all machinal, electrical, and patient care equipment. The policy directed inspection, testing, and maintenance of electrical equipment to be tracked in the TELs building management platform.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48299 Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair throughout the facility were addressed to help promote a functional, sanitary, and safe environment. Additionally, the facility failed to ensure an ice and water dispensing machine in the second floor TCU and LTC (transitional care unit and long-term care) dining room was clean and free of excess mineral build up and properly functioning. This had the potential to affect all 37 residents residing in, visitors, and staff working in the facility. Findings include: A resident council meeting was held on 12/10/24 at 10:00 a.m., and residents in attendance reported the condition of the facility was a shithole. The residents stated they were aware there was no maintenance in the building to fix the multiple problems in resident rooms, dining rooms, hallways, and the holes in the walls. MAIN KITCHEN During observation on 12/11/24 at 11:37 a.m., the wall across from the main kitchen refrigerator had multiple blackish-brownish colored speckles. The area under the three-compartment sink had multiple crumbs on the floor and the wall below the sanitizer end of the three-compartment sink had brownish colored speckles. The wall next to an oven-like compartment used keep food at holding temperature had streaks of tannish colored substance down the wall. When interviewed on 12/13/24 at 10:01 a.m., a.m., dietary manager (DM) stated staff have daily cleaning assignments. Account manager (AM - serving as director of culinary services) and DM verified the wall across from the refrigerator with the blackish-brownish colored speckles, and DM stated black colored serving carts must bump against the wall. The speckles on the wall were throughout an area of approximately five feet across and two feet vertical. MEMORY CARE DINING AREA When interviewed on 12/10/24 at 8:37 a.m., family member (FM)-A stated the memory care dining area had missing appliances, cabinet pieces missing, and other mismatched items. FM-A stated the dining area did not feel like a home, and the whole interior of the building appeared tired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and interview on 12/11/24 at 9:03 a.m., the memory care dining area had orange-yellow-colored splotches about the size of a quarter at the entrance to the right on the wall. About six air vents lined the wall near the ceiling on both sides of the dining room and had grayish-blackish colored fuzzy substance speckled throughout various areas of each vent. One vent near one corner of the dining room had brownish-black speckled color particles and streaks extending on the wall from each of the four corners of the vent. The valance which hung above the window next to the vent was darker colored by brownish-black speckles. The other corner of the dining area had another valance above a window and had thick, grayish colored particles covering the side of the valance closest to a vent. There was a sink on top of a brown cabinet. One side of the cabinet had a missing brown area about one and a quarter foot by one inch and a circular area of cabinet missing the outer brown area about one inch by one and half inches and two other similar missing areas. Two sides of a blue wall had various white scuff marks, with one spot eight inches by one inch and others were similar in size or less. A spot of cabinetry near the refrigerator was missing and a yellowish tan area with areas of white plaster shown on the wall about three feet down and two feet across. A spot of the cabinetry liner was missing. Other various parts of the walls had faint tannish color streaks down them. When interviewed on 12/11/24 at 9:32 a.m., nursing assistant (NA)-G stated the area missing in between cabinets near the refrigerator used to be an oven and had been so for a year or more. NA-G confirmed the condition of the wall where the oven used to be and stated they would not want their home looking that way. NA-G confirmed the other memory care area dining observations and stated they focused attention to the residents so had not noticed the dining room appearance but would not want their home to have the appearance of the dining room. During environmental tour on 12/13/24 at 1:17 p.m. with the administrator and housekeeping director (HD), the administrator stated there was a stove which was removed from the memory care dining area and had been that way a couple months or more. The administrator verified the area needed repainting or to be blocked. Administrator and HD verified the other conditions of the memory care dining area, and the administrator stated the scuffs on the wall were most likely from food carts or wheelchairs. The administrator stated the dining room was not horrible but needed a make-over. Upon review of the main kitchen on the first floor, the administrator and HD confirmed the wall looked like it had splatter, grime, or evidence of rubbing from a caret, and stated the wall needed to be wiped down. When interview on 12/13/24 at 2:56 p.m., licensed practical nurse (LPN)-B stated they have seen the HD steam clean the valances before. LPN-B stated the memory care residents were calm and conversed as able in the dining area so in that sense was homelike, but family members and staff had concerns about the appearance of the dining area for at least two years. LPN-B stated housekeeping cleaned in the dining room after meals but not much of other actions were taken to fix the appearance of the dining area. ICE MACHINE During interview on 12/10/24 at 1:37 p.m., family member (FM)-C reported getting water and ice from the machine behind the steamtable in the second-floor dining room independently without staff assistance. FM-C stated the machine was malfunctioning and stated, the ice machine needs maintenance, it sprays everywhere, and it goes everywhere. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 12/11/24 at 12:11 p.m., dietary aide (DA)-A raised one water pitcher, which was already nearly full, to the water dispenser in the second-floor TCU and LTC dining area and held the pitcher so the mouth of the pitcher almost touched the water dispenser. After a second, DA-A stopped and moved the pitcher to the ice machine to add ice which raised the water line to fill the rest of the pitcher. DA-A used the ice machine to fill up two more water pitchers in this manner. [NAME] sediment was around the ice spout, on the grate, and speckled on the back splash. When interviewed on 12/13/24 at 10:08 a.m., DM stated staff tried to wipe down the ice and water dispensing machine as much as possible to keep clean. The machine had preventative maintenance, but the facility needed a new maintenance director. DM stated the facility had hard water and the grate and other areas of the ice machine needed to be broken down for a deep cleaning. DM attempted to fill a cup with water, and the water dispenser spurted water in different directions and filled the cup when the cup was held closer to the spout. DM stated the nozzle needed to be cleaned or placed correctly, so one stream of water could fill the cup. During interview on 12/13/24 at 10:31 a.m., housekeeper (H)-A stated they had a checklist for cleaning rooms but not the dining areas and they did not wipe down ice machine. The Work History Report created 12/12/24 with due date timeframe of 1/24 to 10/24, indicated the ice machine and/or ice bins task was completed on 8/26/24 and included check filter, clean coils, sanitize interior, delime as necessary. The same task was marked as completed on 3/8/24. The report lacked indication the exterior surfaces were cleaned. Per interview on 12/12/24 at 2:11 p.m. with the administrator, the facility was without a maintenance director since 9/2024. The administrator stated, I hear about things, and I just go fix them, and was unsure how comprehensive the maintenance reports were. The administrator explained the facility received help from a corporate maintenance person every two weeks. The Physical Environment: Electrical Equipment Policy dated 6/16/22, indicated the maintenance director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment. The policy indicated essential equipment shall be repaired or replaced as soon as practicable. The facility assessment last reviewed 8/8/24, indicated the process to ensure adequate supply, appropriate maintenance of or replacement of building and/or other physical structures and equipment was the TELS maintenance program and activities. The assessment identified the administrator was responsible for reviewing the TELS program and activity daily, weekly, and monthly for preventative maintenance, Life Safety monitoring, and reporting along with daily work-order tracking. The assessment identified examples, including, bathroom safety bars, sinks for residents and for staff, lifts, lift slings, room and common space furniture, steam table, waste management, sliding doors, nurse call system, and emergency power. Per facility policy titled Resident Rights last revised 7/2022, residents would be treated with respect and dignity and care for each resident would be given in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life. 49617

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. Building B. Wing	12/16/2024

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49617 Based on interview and document review, the facility failed to ensure required in-service training based on annual performance reviews was completed for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-H, NA-H) whose employee files were reviewed. This had the potential to affect all 37 residents who resided at the facility. Findings include: A review of employee records on 12/12/24 between 1:24 p.m. and 2:37 p.m., lacked documentation of completed annual performance reviews. Furthermore, the employee records lacked documentation of in-service training that addressed areas of weakness determined by performance reviews. All 5 sampled employees were employed at the facility for greater than one year. Per interview on 12/12/24 at 2:11 p.m. with the administrator, it was believed the previous director of nursing (DON) completed competencies with annual reviews. The administrator stated, I'm looking through file cabinets and if I can't find them, I can't say that we have them without them. Per interview on 12/16/24 at 12:01 p.m., the DON had no luck locating the performance reviews, completed in-service trainings based on weaknesses determined by reviews, or competences for the sampled NAs. The DON stated the facility would be restarting those reviews beginning January 1st and indicated it was important because staff needed to be aware of what they were doing well and what could be improved upon. Additionally, the DON stated annual reviews were a good way to build rapport with staff and helped build the team. A policy pertaining to annual reviews or in-service trainings was requested but not received. The facility assessment last reviewed 8/8/24, indicated the facility's training program included was based on the facility's resident population and was an ongoing training for all new and existing staff including managers, nursing, and other direct care staff. The assessment identified annual reviews were a part of the training sessions and would be completed to meet regulatory requirements. Furthermore, the assessment indicated, skills and competencies were completed on hire and annually to test continued competence in assessment, safe patient handling, infection control, medication administration, wound care, feeding and bathing; skills competencies testing is based on the usual and customary duties performed by each staff member.