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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopkins Restorative Care Center	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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on document review and interviews the facility failed to ensure a registered nurse (RN) was scheduled for at least 8 consecutive hours a day, seven days a week. This had the potential to affect all 36 residents residing in the facility.Findings include: The Daily Staffing Report dated 2/28/26, indicated 7.5 hours of RN coverage on 2/28/26. The Daily Schedule Report dated 2/28/26, confirmed there was no consecutive eight hours of RN coverage in the facility on 2/28/26. The Pathway Health Invoice dated 2/28/26, indicated the interim director of nursing (DON) at that time had been on site for 2 hours on 2/28/26, therefore not meeting the requirement of eight consecutive hours of RN coverage. On 3/12/26 at 2:01 p.m., the DON confirmed there was only 2 hours of RN coverage on 2/28/26 and stated the importance of having an RN in the building to provide triage assessments and meet federal and state requirements. The facility Nursing Services-Registered Nurse Policy last reviewed 3/5/25, indicated the facility will utilize the services of a RN for at least eight consecutive hours per day, 7 days per week.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure binding arbitration agreements were clearly communicated in a form and manner residents understood, prior to signing forms for 3 of 3 residents (R13, R26, R38) reviewed. This had the potential to affect all 12 residents admitted after 10/1/25. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 admitted to the facility on [DATE], had moderate cognitive impairment, and diagnoses included cerebral infarction (stroke). R13's Resident and Facility Arbitration Agreement indicated R13 signed the arbitration agreement on 10/28/25, certifying acceptance of the agreement. The facility's untitled, undated, listing of the 12 residents that had been admitted after 10/1/25, indicated yes. R13 agreed to binding arbitration. On 3/11/26 at 10:37 a.m., R13 denied memory of someone from the facility explaining binding arbitration and/or signing an arbitration agreement. R26's comprehensive MDS dated [DATE], indicated R26 admitted to the facility on [DATE], had severe cognitive impairment, and diagnoses included dementia. R26's Resident and Facility Arbitration Agreement indicated R26 signed the arbitration agreement on 1/7/26, certifying acceptance of the agreement. The facility's untitled, undated, listing of the 12 residents that had been admitted after 10/1/26, indicated yes, R26 agreed to binding arbitration. On 3/12/26 at 12:37 p.m., R26 denied memory of someone from the facility explaining binding arbitration and/or signing an arbitration agreement. R26 stated it doesn't sound familiar. I'm saying no to it. I don't want to give up my rights. I don't want to sign my rights away to this place. R38's comprehensive MDS dated [DATE], indicated R38 admitted to the facility on [DATE], was cognitively intact, and diagnoses included displaced fracture of left tibial spine. R38's Resident and Facility Arbitration Agreement undated, indicated R38 waived acceptance of the agreement. The facility's untitled, undated, listing of the 12 residents that had been admitted after 10/1/25, indicated waived as R38 declined binding arbitration. On 3/11/26 at 10:37 a.m., R38 denied memory of someone from the facility explaining binding arbitration to him. The facility's Resident Listing Report dated 3/12/26, indicated that 12 residents were admitted after 10/1/25. The facility's untitled, undated, listing of the 12 residents that were admitted after 10/1/25, indicated whether they each agreed or declined the arbitration agreement. The list indicated 9 residents agreed, 3 residents waived, and 1 resident's decision was pending. On 3/12/26 at 12:07 p.m., social service director (SS) stated she reviewed the cliff notes version of binding arbitration with each resident upon admission, since the facility started offering binding arbitration in October 2025. SS stated she was not provided any education on binding arbitration but was expected to offer it to each new resident. SS acknowledged she did not fully understand binding arbitration. SS stated she explained that if resident/resident representative had a concern, they were free to seek legal advice, and facility's legal department would step in. SS stated if a resident signed the arbitration agreement, they would still be able to get a lawyer. SS stated she had not explained to residents and/or resident representatives they had 30 days to rescind the agreement. On 3/12/26 at 1:57 p.m., the facility owner stated the facility was purchased in September 2025, the previous owners had not offered arbitration, so binding arbitration agreements were implemented. The owner stated the facility social worker (SS) explained arbitration as a part of the admission process. He expected SS would have received training. Regulations were expected to be followed. Facility policy on arbitration was requested and not received.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on interview and document review, the facility's binding Arbitration Agreement failed to offer a neutral and fair arbitration process by ensuring both the resident and/or resident representative and the facility agreed on the selection of a neutral arbitrator (an impartial, or unbiased third-party decision maker, contracted with, and agreed to by both parties to resolve their dispute). This had the potential to affect all 12 residents that admitted after 10/1/25.Findings include: Review of the facility's Resident and Facility Arbitration Agreement undated, indicated binding arbitration would be conducted at a place agreed upon by the Parties, or in the absence of such an agreement, at the Facility. However, the facility failed to ensure the agreement provided for the selection of a neutral arbitrator agreed upon by both parties. The facility's Resident Listing Report dated 3/12/26, indicated 12 residents were admitted after 10/1/25. The facility's untitled undated, listing of the 12 residents admitted after 10/1/26, indicated whether each agreed or declined the arbitration agreement. The list indicated 9 residents agreed, 3 residents waived, and 1 resident's decision was pending. On 3/12/26 at 1:57 p.m., the facility owner stated the facility was purchased in September 2025, and binding arbitration agreements were implemented. The owner stated regulations needed to be followed and acknowledged the selection of a neutral arbitrator was not addressed in the agreement.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 5 of 5 residents (R3, R9, R11, R24, R25) were offered an influenza immunization annually from October 1 through March 31. Additionally, the facility failed to ensure 4 of 5 residents (R3, R9, R11, R24) were offered, educated on, and provided the pneumococcal vaccination series as recommended by the Center for Disease Control (CDC), who were reviewed for immunizations. Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3 admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included Wernicke's encephalopathy (acute, serious neurological condition caused by severe vitamin B1 deficiency) and bipolar disorder. The CDC's Adult Immunization Schedule, dated 10/7/25, indicated for persons age [AGE] or older whose previous vaccination history was unknown, one dose of influenza vaccine was recommended annually. Additionally, for persons age [AGE] or older whose previous vaccination history was unknown, one dose of PCV15, PCV20, or PCV21 (used for pneumonia prevention) was recommended. However, R3's medical record lacked evidence an immunization history had been obtained for R3. R3's record lacked evidence the resident and/or resident representative had been offered, educated on, and provided an annual influenza vaccine. Additionally, R3's record lacked evidence the resident and/or resident representative had been offered, educated on, and provided a PCV immunization. R9's quarterly MDS, dated [DATE], indicated R9 admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included encephalitis and encephalomyelitis (inflammation of the brain and/or spinal cord) and seizure disorder. R9's Minnesota Immunization Information Connection (MIIC) report, dated 8/21/25, indicated R9 last received an annual influenza vaccine on 10/31/23. Additionally, the report indicated R9 received the PPSV23 immunization on 3/2/2007, and the PCV13 on 2/18/2020. The CDC's Adult Immunization Schedule, dated 10/7/25, indicated for persons age [AGE] or older, one dose of influenza vaccine was recommended annually. Additionally, for persons who previously received both PCV13 and PPSV23, one dose of PCV20 or PCV21 was recommended at least 5 years after the last pneumococcal vaccine dose. R9 was eligible after 2/18/2025. R9's Influenza Vaccine Consent Form dated 11/6/25, indicated R9 gave consent to receive the influenza vaccine. However, R9's medical record lacked evidence R9 had been provided one dose of influenza vaccine after 11/6/25. R9's Immunization Informed Consent Record dated 8/21/25, indicated resident has agreed for vaccinations as needed. However, R9's medical record lacked evidence R9 had been provided one dose of PCV20 or PCV21. R11's quarterly MDS dated [DATE], indicated R11 was [AGE] years of age, admitted to the facility on [DATE], and diagnoses included atrial fibrillation and vascular dementia. The CDC's Adult Immunization Schedule dated 10/7/25, indicated for persons age [AGE] or older, one dose of influenza vaccine was recommended annually. Additionally, for persons age [AGE] or older whose vaccination history included a PCV13, one dose of PCV20 or PCV21 was recommended at least one year after PCV13. R11's MIIC report dated 8/14/25, indicated R11 had no history of vaccination for influenza. Additionally, the report indicated R11 received the PCV13 on 10/26/22. R11's Influenza Vaccine Consent Form dated 11/6/25, indicated R11 gave consent to receive the influenza vaccine. However, R11's medical record lacked evidence R11 had been provided one dose of influenza vaccine after 11/6/25. Additionally, R11's lacked evidence the resident and/or resident representative had been offered, educated on, and provided a PCV20 or PCV21 immunization. R24's comprehensive MDS dated [DATE], indicated R24 was [AGE] years of age, admitted to the facility on [DATE], and diagnoses included sepsis (infection enters the bloodstream), and pneumonia. The CDC's Adult Immunization Schedule dated 10/7/25, indicated for persons age [AGE] or older whose previous vaccination history was unknown, one dose of influenza vaccine was recommended annually. Additionally, for persons age [AGE] or older whose previous vaccination history was unknown, one dose of PCV15, PCV20, or PCV21 was recommended. However, R24's medical record lacked evidence an (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immunization history had been obtained for R24. R24's record lacked evidence the resident and/or resident representative had been offered, educated on, and provided an annual influenza vaccine. Additionally, R24's record lacked evidence the resident and/or resident representative had been offered, educated on, and provided a PCV immunization. R25's quarterly MDS dated [DATE], indicated R25 was [AGE] years of age, admitted to the facility on [DATE], and diagnoses included dementia and diabetes. The CDC's Adult Immunization Schedule dated 10/7/25, indicated for persons age [AGE] or older, one dose of influenza vaccine was recommended annually. R25's MIIC report dated 6/6/25, indicated R9 last received an annual influenza vaccine on 10/29/24. R25's Influenza Vaccine Consent Form dated 11/6/25, indicated R25 gave consent to receive the influenza vaccine. However, R25's medical record lacked evidence R25 had been provided one dose of influenza vaccine after 11/6/25. On 3/12/26 at 10:34 a.m., the regional nurse manager/infection preventionist (IP) acknowledged R3, R9, R11, R24, and R25's medical records lacked evidence an annual influenza and/or pneumococcal vaccine had been offered and/or provided as indicated above. IP stated nurses were expected to offer vaccinations per CDC guidelines upon admission and at least annually. IP stated recommended immunizations were important for the overall health of the residents and everyone else in the facility. The facility's Influenza Vaccination policy, reviewed/revised 1/2026, indicated it is the policy of the facility to minimize the risk of acquiring, transmitting, or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. The facility's Pneumococcal Vaccine (Series) policy, reviewed/revised 1/2026, indicated it is the policy of the facility to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on record review, interview, and observation, the facility failed to ensure the second-floor east wing common area was kept clean, sanitary, and in good repair which had the potential to affect all residents, staff and visitors who utilized the common area. Findings include:On 3/11/26 at 11:03 a.m., during observation of the second-floor east wing common area a ceiling tile near a large window had a large yellow stain or substance covering the entire tile. The tile was approximately 1.5 feet (FT) wide by 1.5ft long. In the center of the tile was an area of a grey growth type matter covering approximately 8 inches by 6 inches.On 3/12/26 at 10: 36 a.m., the ceiling tile discoloration and grey growth was still in the ceiling.On 3/11/26 at 2:49 p.m., the licensed practical nurse manager (LPN)-A stated the second-floor east wing common area was used for resident activities and family visits. There was a piano for visitors or residents to play if they would like.On 3/12/26 at 9:13 a.m., the activities director (ACT)-A stated they don't use it anymore. However, families used the area to meet with their loved ones, and physicians used the area to chart or dictate. On 3/12/26 at 1028 a.m., the director of maintenance (MAIN)-A observed the above mentioned tile and described the tile to have a yellowing water stain, which was most likely from a water leak, and there was mold growing out of the center of the tile, confirmed the mold was the gray growth in the center of the tile. MAIN-A stated they were unaware of the tile and its condition but would have it replaced as soon as possible. Furthermore, MAIN-A stated the importance of maintaining the building and keeping it in good repair was what was best for the residents.The facility policy Preventative Maintenance last revised 1/2026, indicated a preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure target behaviors were adequately monitored for 1 of 5 residents (R9) reviewed for psychotropic medication use. Findings include: R9's quarterly MDS dated [DATE], indicated R9 had moderate cognitive impairment and diagnoses included encephalitis and encephalomyelitis (inflammation of the brain and/or spinal cord) and seizure disorder. R9 had physical and verbal behavioral symptoms directed toward others and rejected evaluation or care less than daily. R9'S Order Summary Report signed by the provider 2/10/26, indicated R9 had the following psychotropic medication orders:Escitalopram (antidepressant) 15mg daily for depressionHaloperidol (antipsychotic) 0.5mg three times a day for anxietyDivalproex (mood-stabilizing drug) 1000mg two times a day for anxietyTrazodone (antidepressant) 50mg at bedtime for insomnia R9's Care Plan Report undated, indicated R9 had target behaviors of calling out loudly multiple times a shift, attention-seeking, and self-limiting with cares/independence, with identified interventions initiated 12/24/25. R9's target behaviors would be monitored and documented every shift. R9's Associate Clinic of Psychology (ACP) visit notes dated 3/10/26, indicated R9 continued to display attention-seeking behaviors such as calling out, screaming, and continued to exhibit behavioral symptoms that affected functioning. Staff should continue to document R9's behaviors, including the time of occurrence, possible triggers, staff interventions, and R9's response to those interventions. Consistent documentation would help identify patterns and allow the care team to develop more effective strategies to address and reduce behaviors. On 3/11/26 from approximately 7:30 a.m. to 9:00 a.m., R9 was heard loudly screaming and calling out help, help numerous times. R9 was heard screaming and calling out from another unit of the facility. R9's Treatment Administration Record (TAR) for March 2026 indicated nurses to document in progress notes every shift resident's behavior: document if resident is screaming or yelling for ACP to eval and treat every shift, with a start dated of 3/9/26. However, nurse documentation on the TAR indicated R9 had not screamed or yelled on 3/11/26 during the day shift (6:00 a.m. to 2:00 p.m.). Additionally, R9's record lacked documentation of R9's observed behavior in progress notes for 3/11/26 day shift. On 3/12/26 at 10:12 a.m., nurse unit manager (LPN)-A stated R9 was heard calling out quite a bit yesterday. LPN-A stated nurses were expected to document every shift if R9 was calling out to help ACP monitor R9 and to help the psych AP (advanced practice provider). LPN-A confirmed the nurse documentation for 3/11/26 day shift indicated R9 had no behaviors and no new behaviors, and stated, but that's incorrect because I sat here and heard her calling out. LPN-A stated accurate documentation was important so providers could monitor and direct care appropriately. On 3/12/26 at 11:54 a.m., director of nursing (DON) stated R9's TAR contained inaccurate charting for 3/10/26 and 3/11/26 day shifts for the target behavior of screaming or yelling. DON heard R9 yelling out repeatedly both days. DON stated nurses were expected to accurately document as ordered by the provider and accurate documentation was important so that any adjustments to medications and/or interventions would be appropriate. The facility's Use of Psychotropic Medication policy, reviewed/revised 4/21/25, indicated psychotropic medications are to be used only when a practitioner determines the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the resident and/or legal representative received written notice of transfer for 3 of 3 residents (R3, R22, R46) reviewed for hospital transfers. Further, the facility failed to provide a written notice of bed hold for 2 of 3 residents (R3, R22) reviewed for bed hold and failed to notify the Ombudsman of transfers and discharges for 1 of 3 residents (R3) reviewed for Ombudsman notification.Findings include: Findings include: R3's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R3 had severe cognitive impairment and diagnoses included Wernicke's encephalopathy (acute, serious neurological condition caused by severe vitamin B1 deficiency) and bipolar disorder. R3's progress note dated 11/5/25 at 8:29 p.m., indicated R3 was sent to the hospital for right, lower extremity pain following a fall. A subsequent progress note dated 11/17/25 at 9:05 p.m., indicated R3 was readmitted to the facility on [DATE] at 6:00 p.m. R3's medical record lacked evidence a written notice of transfer had been provided to the resident and/or resident representative. Additionally, R3's medical record lacked evidence a written notice of bed hold had been provided to the resident and/or resident representative. The facility's Ombudsman Report for 11/2025, indicated the resident admissions and discharges for 11/2025. However, the report lacked notice of R3's 11/15/25 hospital transfer, and the information was not indicated on subsequent ombudsman reports. On 3/11/26 at 1:17 p.m., the director of nursing (DON) stated R3's record lacked evidence a written notice of transfer and notice of bed hold had been provided to the resident and/or resident representative. Additionally, DON verified R3's hospital transfer was not indicated on the Ombudsman Report for 11/2025. R22's readmission minimum data set (MDS) dated [DATE], indicated R22 was readmitted to the facility 2/24/26, after a brief hospital stay. R22's diagnoses included encephalopathy (a disorder, disease or dysfunction of the brain), dementia, unilateral osteoarthritis, generalized muscle weakness and difficulty in walking. R22's discharge MDS dated [DATE], included R22 had an unplanned discharge, with return anticipated, and was discharged to a short-term acute hospital. R22's bed hold agreement was requested; however, none was provided. R22's written notice of transfer was requested; however, none was provided. During interview on 3/11/2026 at 11:08 a.m. DON confirmed R22's medical record lacked evidence of a bed hold agreement and a written notice of transfer. DON stated he was unsure why these were not provided to R22 by the previous leadership staff. DON stated his expectation was each resident leaving for an unplanned discharge with a hospital stay received both a bed hold agreement and a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	written notice of transfer. R46's annual MDS dated [DATE], indicated R46 was admitted on [DATE], moderately cognitively impaired, and had the following diagnoses: anemia, heart failure, hypertension (high blood pressure), diabetes, arthritis, and Alzheimer's disease. R46 discharge return anticipated MDS dated [DATE], discharged to a short-term hospital stay with a return anticipated on 5/31/25. R46's medical record lacked evidence of written notice of transfer was provided to R46 or their representative. R46's written notice of transfer was requested; however none was provided. On 3/11/26 at 11:43 a.m., DON confirmed R46's record lacked written notice of transfer for hospitalization. The DON stated the importance of completing the notice of transfer to notify the resident or their next of kin of why they are being transferred to a higher level of care, and to follow current regulations. The facility's Transfer and Discharge policy, revised 4/21/25, indicated the facility's notice of transfer would be provided to the resident and/or resident representative in a language and manner in which they can understand, and copies of the notice of transfer would be sent to the ombudsman. The facility's Bed Hold Notice policy, dated 11/25, indicated the facility would provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of a transfer for hospitalization or therapeutic leave.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide activities of daily living (ADLs) for 1 of 4 residents (R9) reviewed for dependent care. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 had moderate cognitive impairment and diagnoses included encephalitis, encephalomyelitis (inflammation of the brain and/or spinal cord), and seizure disorder. R9's Care Plan Report undated, indicated R9 did not show potential for discharge to the community due to physical care needs and self-care deficits related to diagnoses. R9 required partial/moderate assistance with personal hygiene, bed mobility, upper body dressing, and substantial/maximal assistance with bathing, toileting, and lower body dressing. R9's Weekly Skin Assessments indicated R9's fingernails were last trimmed on 2/3/26. On 3/9/26 at 3:44 p.m., R9 stated staff were supposed to cut her fingernails, but they did not. They were too long now. R9's fingernails were of various lengths, jagged edges, and several had a brown-colored substance under them. On 3/11/26 at 7:28 a.m., R9's fingernails were of various lengths, up to half inch long. Three fingernails on R9's right hand and three fingernails on R9's left hand had a brown-colored substance under them. On 3/11/26 at 7:33 a.m., regional nurse manager/infection preventionist (IP) verified R9's fingernails were long and jagged, and three fingernails on each hand had a brown-colored substance under them. IP stated staff were expected to provide weekly nail care as a part of regular bathing. IP stated R9's fingernails should have been cleaned and clipped with R9's last weekly skin assessment on 3/9/26. IP stated clean nails were important for infection control. On 3/12/26 at 11:54 a.m., director of nursing (DON) stated staff were expected to look at residents' nails every day since they assist the residents daily. Resident fingernails should be kept clean and trimmed. DON stated it was important for resident safety and infection prevention. The facility's Nail Care policy dated 2023, indicated routine nail care, including cleaning and trimming, would be provided on a regular schedule, and care to residents' nails for good grooming and health.

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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopkins Restorative Care Center	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 - Few	Provide and implement an infection prevention and control program. Based on observation and interview the facility failed to conduct appropriate hand hygiene during a dressing change for 1 of 1 residents (R4) reviewed for wound care.Findings include: On 3/11/26 at 07:39 a.m., registered nurse (RN)-A conducted a dressing change on a resident. RN-A entered the room, put on a gown, a pair of gloves, and then a second pair of gloves. RN-A gathered items needed to conduct the dressing change. RN-A removed the old dressing, poured saline onto gauze, and dabbed the wound. RN-A removed the 2nd pair of gloves, put cream onto their finger, and applied it to the wound. RN-A then removed the 1st layer of gloves and gown. Put on a new pair of gloves. RN-A left the room to find a sharpie to date/label the dressing. After returning to the room, dated and labeled the dressing, RN-A gathered the garbage and exited the room for the second time. RN-A deposited the bag of garbage in the soiled utility room and washed their hands. RN-A stated during a dressing change, they were expected to wash their hands, before and after the event, when gloves were soiled, and when placing the new dressing. RN-A confirmed they washed their hands before they started the dressing change, and after they were done with everything. RN-A stated they should have washed their hands after they removed their gloves and when entering and exiting the room but she had not. Additionally, RN-A stated they used the 2nd layer of gloves for their convenience, which did not meet the expectation of the facility. RN-A stated it was important to perform hand hygiene appropriately to prevent infection of the wound. On 3/11/26 at 11:43 a.m., the director of nursing (DON) stated their expectation for hand hygiene during a dressing change was staff should be washing their hands upon entering and exiting the room, taking off gowns and gloves, according to facility policy and regulations. Furthermore, the DON stated the importance of hand hygiene to prevent infection, protecting the residents and the staff.The facility policy Hand Hygiene last revised 1/1/26, indicated the use of gloves does not replace hand hygiene. If your task requires gloves, preform hand hygiene prior to donning gloves and immediately after removing them.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 4 of 5 residents (R3, R9, R11, R24) reviewed for immunizations were offered and/or provided the COVID-19 vaccine to help reduce the risk of associated infection(s).Findings include: The Centers for Disease Control (CDC) Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States dated 11/4/25, indicated for adults ages 65 years and older, COVID-19 vaccination was recommended based on individual-based decision-making (also known as shared clinical decision-making) for the prevention of COVID-19 disease and its complications. For adults under age [AGE] years, COVID-19 vaccination was recommended based on individual-based decision-making with an emphasis that the risk-benefit of vaccination was most favorable for individuals who were at an increased risk for severe COVID-19 disease. R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included Wernicke's encephalopathy (acute, serious neurological condition caused by severe vitamin B1 deficiency) and bipolar disorder. R3's medical record lacked evidence an immunization history had been obtained. Additionally, R3's record lacked evidence the resident and/or resident representative had been offered a COVID-19 vaccination(s). R9's quarterly MDS dated [DATE], indicated R9 admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included encephalitis and encephalomyelitis (inflammation of the brain and/or spinal cord) and seizure disorder. R9's Minnesota Immunization Information Connection (MIIC) report dated 8/21/25, indicated R9 last received a COVID immunization on 10/18/24. R9's Vaccine Consent Form undated, indicated R9 consented to the COVID-19 vaccine. However, R9's record lacked evidence the facility had provided the requested COVID-19 vaccination. R11's quarterly MDS dated [DATE], indicated R11 was admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included atrial fibrillation and vascular dementia. R11's Minnesota Immunization Information Connection (MIIC) Report dated 8/14/25, indicated R11 had not received COVID-19 vaccinations. Additionally, R11's record lacked evidence the resident and/or resident representative had been offered COVID-19 vaccination(s). R24's comprehensive MDS dated [DATE], indicated R24 was admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included sepsis (infection enters the bloodstream), and pneumonia. R24's medical record lacked evidence an immunization history had been obtained. Additionally, R24's record lacked evidence the resident and/or resident representative had been offered a COVID-19 vaccine. On 3/12/26 at 10:34 a.m., the regional nurse manager/infection preventionist (IP) acknowledged R3, R9, R11, and R24's records lacked evidence a COVID vaccine had been offered and/or provided as indicated above. RN-A stated nurses were expected to offer vaccinations per CDC guidelines upon admission and at least annually. IP stated recommended immunization was important for the overall health of the residents and everyone else in the facility. The facility's COVID-19 Vaccination policy reviewed/revised 12/2025, indicated it is the policy of the facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by educating and offering our residents and staff the COVID-19 vaccine.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and interviews, the facility failed to ensure the required staffing information was posted daily and in an area that was accessible to residents and visitors. This had the potential to affect all 36 residents residing in the facility and their visitors who may wish to view this information.Findings include:On 3/9/26 at approximately 2:00p.m., the staff posting was observed posted on the wall of the 1st floor hallway across from the business office and other offices. All residents reside on the second floor. The first floor was only accessible to residents via an elevator which required a code to use. The staff posting was approximately 6 feet off the ground and contained the required information. However, it was not accessible or at height easy to read for residents in wheelchairs, ambulatory residents, and visitors in the building. The staff posting continued to be posted in the same spot throughout each day of the survey.On 3/11/26 at 10:56 a.m., nursing assistant (NA)-A confirmed the staff posting was only posted on the first floor and nowhere else in the building.On 3/11/26 at 11:58 a.m., the business office manager (BOM) stated they were responsible for the staff posting. BOM confirmed the staff posting was only on the first floor, that all residents lived on the second floor, and was not at a height accessible for residents in wheelchairs. Additionally, BOM confirmed the posting had not been posted on the weekends, as they were the only staff responsible, and they were in house Monday through Friday.On 3/11/26 at 12:02 p.m., the director of nursing (DON) stated their expectation was staff posted according to nursing home regulations, and the importance of providing the staffing information to the residents, staff and visitors so they can be aware if they desire.The facility's Nurse Staffing Posting Information policy last revised 1/1/26, indicated the nurse staffing sheet will be posted daily and will be available for the public to review.