STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Springs at Minnetonka	16913 Highway 7 Minnetonka, MN 55345

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 42580 Based on interview and document review, the facility failed to assist the resident council in setting up regular meetings. This had the potential to affect 12 of 12 residents (R1, R2, R5, R6, R7, R9, R10, R12, R14, R17, R19, R20) who met to discuss resident council. Findings Include: Resident Council (RC) notes documentation indicated the following documented meetings: 4/5/24, 10/27/23, and 7/24/23, were the only meeting notes documented after 6/2023. During interview on 5/14/24 at 11:23 a.m., activity director (AD)- stated they was in charge of setting up resident council meetings but was on a medical leave from 11/2023, and returned in 3/2024, with no one else setting up and arranging resident council meetings in her absence. AD explained did not think about arranging RC meeting coverage in her absence but should have had someone else take the responsibility of setting up RC meetings monthly. AD- also verified RC meetings were not consistently being held monthly. During resident council (RC) meeting with surveyor on 5/15/24 at 2:30 p.m., R1, R2, R5, R6, R7, R9, R10, R12, R14, R17, R19, and R20 confirmed monthly RC meetings were not being held consistently and also verified the AD- was on leave and no one else had filled the role in her absence with meetings not held when AD was away on leave. The residents indicated they would have liked monthy RC meetings during the AD's absence. The facility policy titled Resident Council updated 1/2023, indicated all residents of Hope Springs at Minnetonka (HSM) were encouraged to participate in the Resident Council. The Resident Council and officers were composed of residents from HSM. Meeting were held: Third Wednesday of each month. Depending on the activity schedule, the meeting date and time may vary. The meeting was scheduled on the monthly activity calendar. The designated staff sponsor assembling the group and facilitating the meeting is activity director Activity Director (or designee in absence situation),

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 42580 Based on interview and document review, the facility failed to ensure residents had access to petty cash, including on weekends, for 3 of 3 residents (R6, R10, R12) who had personal funds deposited with the facility. This had the potential to affect all 20 residents who utilized a personal funds account. Findings include: During interview on 5/13/24 at 2:40 p.m., R10 verified she had a personal account with the facility and stated the facility had allocated every Wednesday as money pass day and could only have access to personal funds during money pass on Wednesdays. R10 further stated she could not get money on the weekends or other days of the week. During interview on 5/13/24 at 4:33 p.m., R12 verified she had a personal account with the facility but that she only had access to the money on Wednesdays which was assigned by the facility as money pass day. R12 stated she could not access personal account funds on the weekends or other days of the week besides Wednesdays, when the facility would distribute money from resident account for the week as they needed. During interview on 5/15/24 at 2:30 p.m., R6 stated she had asked the facility to get money during the week before but was notified by the facility staff she could only get access to personal funds on money pass day which the facility had assigned on Wednesdays and could not get funds on the weekends or other days of the week. During interview on 5/15/24 at 10:11 a.m., the administrative assistant (AS)- stated the facility had designated Wednesdays as money pass day and residents could get access to their account on that day, although could also get on other days including on weekends. AS- clarified residents were made aware that Wednesdays was the assigned day for money pass from their personal accounts. The facility policy titled Resident Personal Account dated 7/2021, indicated at admission to Hope Springs Minnetonka (HSM), residents or their representative/financial POA had an option to start a resident account at HSM for the resident's personal needs money. While providing resident's access to their funds on site, the facility believed personal dignity and responsibility is gained by having some independence to manage their money (with the assistance from staff as needed). The money was kept in a locked safe in the administrative office. Only the Activity Director and the Administrator had a key to the safe. Money pass out times was typically Wednesday afternoon and may vary depending on the daily activities. Money pass was not available for weekend or holidays. The facility encouraged residents to plan ahead. The facility understood there are times when a resident may need unplanned cash for the weekend. A small amount of cash was locked in the nursing station for such emergencies. The nursing staff provided the information on Monday to the Activity Director to update records.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 42580 Based on observation and interview the facility failed to ensure mail was delivered to residents on Saturdays and also failed to ensure mail was delivered unopened to residents. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 2 of 12 residents (R5, R6) at the resident council meeting who verbally confirmed not receiving mail on Saturdays and that their personal mail was opened by the facility. Findings Include: During interview on 5/13/24 at 1:26 p.m., R5 stated staff were opening her mail and reading them and had been receiving her mail opened before it was delivered to her ongoing. R5 verbalized she did not like that her mail was being opened by the facility and had communicated to the facility that she wanted her mail delivered unopened. During interview on 5/15/24 at 2:30 p.m., R6 stated her personal mail was being delivered opened by the facility and that she had asked the facility not to open her mail however, this practice remained ongoing. During interview on 5/15/24 at 10:11 a.m., the administrative assistant (AS)- stated the facility did not distribute resident's mail on Saturdays because the front office was locked and none of the weekend staff had access. AS- also explained they would open resident's mail to process their medical and financial items in the mail and would then give the residents their other mail unopened. AS- further explained the residents also signed a form to give authorization to the facility to open and process resident's mail. AS- was unable to provide documentation R5 had signed an authorization to open their mail but stated they would be initiating the process with R5. AS- had not reevaluated R6's request not to have her mail opened by the facility staff and was unable to provide documentation R6's request to receive unopened mail, had been addressed. The facility policy titled resident mail dated 7/2021, indicated upon admission, residents or their family/POA/guardian are explained to the importance of Hope Springs at Minnetonka (HSM) assisting with business mail. A form is presented for the authorizing person to sign that allows HSM staff to open and manage business mail. Mail and packages are delivered to the main entrance or business office. The Administrative Assistant will deliver person mail and packages to residents. Business mail, unless otherwise communicated, is handled by the business office. Often resident business mail is time sensitive and additional information is required that the staff of HSM may provide.

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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. 42580 Based on observation, interview and document review, the facility failed to ensure survey results were posted in a location visible and easily accessible to residents and visitors. This had the potential to affect all 20 residents residing in the facility and their visitors. Findings include: The facility's survey results were observed on 5/15/24 at 3:25 p.m., on the second floor at the nurse's station, in a folder tucked among several binders on the counter. The survey binder was not visible when entering the facility and was not accessible to residents or visitors as it was stored behind the nurses' station and not visible. During resident council meeting on 5/15/24 at 1:00 p.m., R1, R2, R5, R6, R7, R9, R10, R12, R14, R17, R19, R20, who had attended the meeting indicated they were not aware where the survey results were located and were interested in reading the survey results. On 5/15/24 at 3:35 p.m., The administrative assistant (AA) stated they were responsible to post the survey results in an accessible location. AA also stated they had previously placed the binder at the front entrance but somehow the survey results had been placed at the second-floor nurses station and not accessible for residents and visitors to read. AA verifiedstated the survey results should have been placed in a more accessible location so residents and visitors would not have to ask where the results were located. The administrator was not available for interview. The facility policy titled State Survey Results and other Postings dated 6/2021, Hope Springs at Minnetonka (HSM) is required to post for public view (including residents and family/guardians) the following items: HSM license to operate issued by the State of Minnesota. The Nursing Home administrator ' s license. Hazardous Waste /Generator License. CMS Certificate of Waiver and last state survey results. Other awards and memberships are optional. The location of the public viewing area is on first floor across from the business office. This allows for the items to be visible when the business office is not open.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview and document review, the facility failed to develop a comprehensive care plan that included resident-specific interventions for 2 of 2 residents (R11, R19) reviewed for care planning. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was cognitively intact, had diagnoses of chronic pain, constipation, bladder dysfunction, anxiety, depression, post-traumatic stress disorder, and schizophrenia. R11's Care Areas Assessment (CAA) dated 7/31/23, identified the following triggered concerns: Visual function Communication Indwelling catheter Psychosocial well-being Mood Activities Falls Nutritional status Dehydration/Fluid maintenance Pressure ulcer/injury Psychotropic drug use Pain Acitivies of daily living (ADL) functional/rehabilitation potential (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's care plan printed 5/15/24, lacked desired goals and person-centered interventions for visual function, communication, indwelling catheter, activities, dehydration/fluid maintenance, pressure ulcer/injury, and pain. The care plan included an ADL focus, however, did not have instruction or information regarding bathing, bed mobility, dressing, eating, oral care, personal hygiene, toilet use, or transfers. In addition, the care plan lacked interventions related to R11's constipation diagnosis. During interview on 5/13/24 at 3:51 p.m., R11 stated they had chronic pain syndrome and couldn't take many medications due to migraine headaches, and indicated staff were not offering any non-pharmacological interventions to help with the pain. R11 also stated they had a complicated intestinal situation and was scheduled to see a specialist. During interview on 5/14/24 at 11:26 a.m., registered nurse (RN)-A stated the director of nursing wrote the care plans, and RN-A had not taken part in that. During interview on 5/15/24 at 9:33 a.m., nursing assistant (NA)-A stated they had a paper with resident information to help guide cares. They stated R11 complained about anxiety and pain, but there were no interventions identified on the care guide. During interview on 5/15/24 at 9:43 a.m., licensed practical nurse (LPN)-A stated R11 had chronic pain and saw a lot of doctors, but the doctors did not want R11 to take over the counter pain medications because of potential side effects. LPN-A stated R11 used a topical cream for pain, but LPN-A did not know if there were interventions on the care plan since the DON was responsible for creating and updating it. R19's quarterly MDS dated [DATE], included they were cognitively intact, had diagnoses of schizophrenia, extrapyramidal and movement disorder (uncontrollable movements as a side effect to psychotropic medications used to treat mental health conditions), constipation, and burns involving 30-39 percent (%) of their body with 30-39% third degree burns. R19's CAA dated 6/19/23, identified the following triggered concerns: Cognitive loss/dementia Behavioral symptoms Nutritional status Pressure ulcer/injury Psychotropic drug use ADL functional/Rehabilitation Potential R19's care plan last revised 4/3/24, included a COVID-19 and Nutrition focus, however lacked person-centered interventions relating to each of the other identified areas of concern. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/15/24 at 12:39 p.m., director of nursing (DON) stated they were responsible for creating and updating the care plans and each triggered MDS area of concern should be addressed, including anything having to do with medications and diagnoses. DON stated, My care plans are not what I would like them to be. DON reviewed the care plans for R11 and R19 and confirmed they were incomplete and lacked person-centered interventions. The Care Plan Baseline and Comprehensive Care Plans policy dated 6/23, included A Comprehensive care plan should be Resident centered and should include everything included in the Baseline Care Plan as well as: Resident choices, preferences, and goals Services and interventions to be furnished to attain or maintain, or improve the Resident's highest practicable physical, mental, and psychosocial well-being. Psychosocial needs, individual activities, and leisure preferences The Resident's preference and potential for future discharge. Discharge plans as appropriate. Trauma informed care. The care plan should be updated as needed with any changes of care or interventions.

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care/assistance for a resident with a prosthesis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to provide assistance and coordination of services to ensure timely referral and treatment for prosthetic fit for 1 of 1 resident (R17) reviewed who needed a prosthesis. Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], indicated they were cognitively intact, used a wheelchair for mobility, and had diagnoses of vascular disease, diabetes, malnutrition, and right lower leg amputation. R17's Admission Orders included R17 could walk with a walker up to 100 feet with modified independent and an order to remind R17 to put on right leg prosthesis between 10:00 a.m., and 11:30 a.m., daily. R17's provider Nursing Home Visit note dated 11/16/23, included, Per RN, patient has not been utilizing the R (right) leg prosthesis due to complaints of itchy/skin irritation. In addition, discussed with RN to follow up with prosthetic company regarding reassessing patient for prosthesis exchange. R17's New Admission Appointment Referral dated 11/16/23, included a provider order to Follow up with prosthesis company to reassess R BKA [right below the knee amputation], and included the order was noted by the director of nursing (DON) and one other staff person. R17's care plan dated 11/24/23, included R17 had an activities of daily living (ADL) self-performance deficit related to amputation of right leg and indicated R17 was wheelchair bound. The care plan directed staff to ensure R17 wore appropriate footwear for transfers, however lacked information regarding the fitting or actual use of their right leg prosthesis. R17's care conference note dated 3/11/23, included the meeting was attended by R17, family member (FM)-A, DON, and the social worker, and indicated R17 wanted to walk using their prosthetic. During observation and interview on 5/13/24 at 1:37 p.m., R17 was seated in their wheelchair in their room. A right leg prosthetic was standing upright leaning next to a piece of furniture by the window. R17 stated they wished to wear it again, but it gave them blisters and needed to be re-fit. During interview on 5/14/24 at 11:24 a.m., nursing assistant (NA)-B stated R17 had a prosthetic leg but never used it and was unsure why. R17 did not receive therapy, was not on a walking program, and used a wheelchair for mobility. During interview on 5/14/24 at 11:26 a.m., registered nurse (RN)-A stated they did not know R17 had a leg prosthetic, and R17 had never used a walker since they arrived at the facility. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/14/24 at 12:04 p.m. director of nursing (DON) stated R17 had a prosthetic leg and a walker but did not use them, and indicated the prosthetic company needed to be contacted to see if the leg needed to be adjusted because it caused blisters. DON stated the prosthetic company had not yet been contacted since R17 was admitted six months prior, but if R17 wanted to be able to walk using the prosthesis the facility needed to follow up to help improve R17's self-esteem and allow them to be able to walk like they used to. During observation on 5/15/24 at 8:12 a.m., R17's prosthetic leg was standing in their room in the same place as previous described. During interview on 5/15/24 at 9:06 a.m., FM-A stated they attended R17's last care conference with R17 where they discussed R17's wishes to use their prosthetic leg. FM-A indicated the facility had not talked with them about it since and was unaware of any action that might have been taken to adjust the fit of the leg to minimize any pain or blisters. A policy on prostheses and coordination of care was requested but not provided.

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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. 44651 Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight consecutive hours per day. This deficient practice had the potential to affect all 20 residents who resided in the facility. Finding include: Review of the facility PBJ (Payroll Based Journal) Staffing Data Report dated 10/1/23 - 12/31/23, identified the facility failed to have RN coverage for the dates of: 10/1/23, 10/14/23, 10/15/23, 10/16/23, 10/18/23, 10/19/23, 10/20/23, 10/21/23, 10/22/23, 10/24/23, 10/28/23, 11/04/23, 11/5/23, 11/11/23, 11/19/23, 11/23/23, 11/25/23, 11/26/23, 11/27/23, 11/29/23, 11/30/23, 12/1/23, 12/4/23, 12/6/23, 12/9/23, 12/10/23, 12/22/23, and 12/23/23. The undated, facility payroll sheets confirmed the facility did not have RN coverage for the dates of: 10/18/23, 10/19/23, 10/20/23, 10/21/23, 10/22/23, 11/4/23, 11/5/23, 11/19/23, 11/23/23, 11/29/23, 11/30/23, 12/1/23, 12/4/23, 12/6/23, 12/23/23. During interview on 5/14/24 at 11:26 a.m., RN-A stated the facility was required to have at least one RN on site every day, including weekends. During interview on 5/15/24 at 11:18 a.m., director of nursing (DON) stated they were responsible for staffing for the facility, and confirmed there were gaps in RN coverage due to vacation time. They stated the facility tried to have an RN every day, but they only had a few RNs on staff, and the facility would rather have a licensed practical nurse (LPN) who knew the residents and did things correctly than pay someone sixty dollars an hour just because they are an RN. During interview on 5/15/24 at 3:54 p.m., administrative assistant stated the administrator was very aware of the staffing requirements, and indicated if there was a need the DON could fill the shift, or they could use agency staff. During interview on 5/16/23 at 2:13 p.m., administrator confirmed they had limited RN staff, and was unaware there were many days without an RN on site for eight hours per day. They stated they could fill the RN hours with agency nurses; however, their own LPN staff were much better than agency nurses who did not know the residents. The Staffing Contingency Plan dated 6/23, included to maintain continuity of operations and care for residents in the event of a staffing shortage, staff will be asked if they are available to pick up a shift. The Facility Assessment Tool dated 3/11/24, indicated the facility required 8-11 licensed nurses providing direct care, and one RN or LPN charge nurse for each shift. The tool lacked identification of need for 8 consecutive hours of RN coverage daily.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44651 Based on interview and document review, the facility failed to act upon the consultant pharmacist's recommendation for 2 of 5 residents (R11, R15) reviewed for unnecessary medications. Furthermore, the consulting pharmacist failed to address duplicative medication orders for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was cognitively intact, had diagnoses of chronic pain, anxiety, depression, post-traumatic stress disorder, and schizophrenia, and did not take an opioid medication. R11's care plan dated 5/15/24, lacked identification of pain focus and opioid medication. R11's Order Summary Report dated 5/15/24, included an order for hydromorphone HCl (an opioid pain medication) 2 milligrams (mg) every three hours as needed for pain starting 11/17/23. R11's Medication Administration Records (MARs) for 1/1/24 - 5/15/24, indicated R11 had not taken any doses of hydromorphone during that time. R11's progress notes included the following: 1/31/24 - See note to provider regarding request to d/c (discontinue) PRN hydromorphone as no longer needed. 3/31/24 - Notes to provider from Jan/Feb regarding review of hydromorphone for d/c are pending review. 4/30/24 - Notes to provider from Jan/Feb regarding review of hydromorphone for d/c are pending review. During interview on 5/15/24 at 11:18 a.m., director of nursing stated the consulting pharmacist (CP) sent the facility a report of recommendations via email each month. DON printed it off, completed any nursing recommendations, and placed the printout in a folder in their office for the provider to address the next time they came if there was something they needed to address. They stated any recommendations were usually completed within two weeks from the date they were received. DON stated they were not aware of a pharmacy note for R11, and upon review, indicated they did not have one in their files for the hydromorphone in January. They indicated recommendations were generally completed when they received them to help eliminate any unnecessary medications. In an email dated 5/15/24 at 4:03 p.m., DON provided R11's Pharmacist Recommendation to Provider dated 1/31/24, which identified R11 was prescribed PRN (as needed) hydromorphone after spinal surgery in mid-November, had not taken any since 12/4/23, and requested the provider discontinue the order. (continued on next page)

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	245606	A. Building B. Wing	05/16/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/16/24 at 9:04 a.m., CP stated they sent monthly recommendations to the facility via email containing a list of all residents who did not have action items, in addition to individual notes for those who required follow-up. If not completed by the next review, CP flagged it in their notes to review the following month. If still not addressed, they re-sent the recommendation. CP indicated sometimes the facility staff and/or providers were slow to respond, but eventually they usually got them completed. They reviewed R11's medications and confirmed they recommended discontinuing their hydromorphone in January since R11 had not taken it since 12/4/23 and thought it best to have it removed from the medication carts and R11's MAR. 44647 R15 R15's quarterly MDS dated [DATE], indicated R15 was cognitively intact and had diagnoses of major depression disorder (MDD) and anxiety. R15's provider order dated 12/18/2020, indicated R15 required liothyronine sodium (medication used for depression) for 25 micrograms (mcg) daily for MDD. R15's pharmacy progress note dated 3/31/24 at 3:15 p.m., indicated staff to see note to provider regarding review of liothyronine for continued need. R15's pharmacist monthly regimen review (MRR) dated 3/31/24, indicated liothyronine was not mentioned in recent progress notes as a psychotropic. Was liothyronine still needed? When interviewed on 5/16/24 at 5:47 p.m., the DON verified R9's pharmacy recommendation was in a folder in the DON's office. DON further stated the recommendation was not provided to R15's provider. DON stated the pharmacy recommendations were placed in a folder that was kept in her office. When providers come to the facility, they are provided the recommendations and if she was not at the facility when the provider was, the provider would not have access to the folder or pharmacy recommendations. R9 R9's admission Minimum Data Set (MDS) dated [DATE], indicated R9 was cognitively intact and had diagnoses of schizoaffective disorder and chronic pain. A review of R9's provider orders indicated R9 had the following orders: -on 1/19/24, acetaminophen (non-narcotic pain medication) 325 milligrams (mg) give every for hours as needed (PRN)for pain was prescribed. There were no parameters for when to administer this dose. -on 1/19/24, acetaminophen 650mg give every 4 hours PRN for pain was prescribed. There were no parameters for this dose. -on 3/7/24, Tylenol (acetaminophen 1000mg three times a day for chronic pain was prescribed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's medication administration record for 3/2024-5/13/24, indicated R9 had been currently using all Tylenol orders prescribed. R9's pharmacy progress note dated 3/31/24 at 5:38 p.m., indicated R9's records were reviewed, and no irregularities were noted. R9's pharmacy progress note dated 4/30/24 at 11:57 p.m., indicated R9's records were reviewed, and no irregularities were noted. When interviewed on 5/15/24 at 5:47 p.m., the Director of Nursing (DON) verified R9 should not have 2 PRN orders for Tylenol and was not sure why. The DON verified there was no recommendations from the clinical pharmacist (CP) during the initial monthly medication review. DON expected the CP to identify the duplicate medication in the monthly medication review. When interviewed on 5/16/24 at 9:04 a.m., the CP verified the Tylenol orders for R9. CP stated noticing two PRN orders was easy to overlook as two orders were written for acetaminophen and the other was under Tylenol. CP further verified there were no direction to how much Tylenol was safe for R9 to take, and this was something that could be put in place to help nurses understand and minimize risk for administering too much. The Gradual Dose Reduction (GDR) policy dated 8/20, included a drug regimen review was performed each month by the consulting pharmacist. A policy for pharmacy reviews and follow up was requested but not provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review the facility failed to ensure duplicative medications were not prescribed for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include: R9's admission Minimum Data Set (MDS) dated [DATE], indicated R9 was cognitively intact and had diagnoses of schizoaffective disorder and chronic pain. A review of R9's provider orders indicated R9 had the following orders: -on 1/19/24, acetaminophen (non-narcotic pain medication) 325 milligrams (mg) give every for hours as needed (PRN)for pain was prescribed. There were no parameters for when to administer this dose. -on 1/19/24, acetaminophen 650mg give every 4 hours PRN for pain was prescribed. There were no parameters for this dose. -on 3/7/24, Tylenol (acetaminophen) 1000mg three times a day for chronic pain was prescribed. R9's medication administration record for 3/2024-5/13/24, indicated R9 had been currently using all Tylenol orders prescribed. When interviewed on 5/15/24 at 5:37 p.m., licensed practical nurse (LPN)-B stated there shouldn't be two PRN medications for the same medication and wasn't aware of any resident who would have an order like that. LPN-B verified R9 had two orders for PRN Tylenol and the scheduled Tylenol order. LPN-B further stated with 3000 mg of scheduled Tylenol already ordered, having 2 PRNs can become too much Tylenol given during a 24-hour period. LPN-A stated a Tylenol order will usually direct the amount of Tylenol a resident was safe to take, either up to 3000 mg or up to 4000 mg during a 24-hour period. R9's orders did not reflect a maximum amount that was safe for R9 to use. LPN-B further stated this was something that needed more direction from the provider. When interviewed on 5/15/24 at 5:47 p.m., the Director of Nursing (DON) verified R9 should not have 2 PRN orders for Tylenol and was not sure why. DON thought one may have been a standing order that was placed. DON expected nursing staff to pick up on the duplicate orders and call the provider for clarification. Furthermore, the DON would expect the clinical pharmacist (CP) to also note in their monthly medication review. When interviewed on 5/16/24 at 9:04 a.m., the CP verified the Tylenol orders for R9. CP stated noticing two PRN orders was easy to overlook as two orders were written for acetaminophen and the other was under Tylenol. CP further verified there were no direction to how much Tylenol was safe for R9 to take, and this was something that could be put in place to help nurses understand and minimize risk for administering too much. CP further stated there was a potential to give too much Tylenol in a 24-hour period if nurses were not checking how much had already been administered. (continued on next page)

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	245606	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy related to medication reconciliation and unnecessary medications was requested however was not provided.

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	245606	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure dental status was accurately assessed and routine dental services were provided for 1 of 2 residents (R6) reviewed for dental concerns. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated they were cognitively intact, had diagnoses of renal insufficiency or failure, diabetes mellitus, hemiplegia (a severe or complete loss of strength or paralysis on one side of the body), and hemiparesis (a mild loss of strength on one side of the body), The MDS indicated R6 was independent with oral hygiene and did not reject cares. R6's annual MDS dated [DATE], indicated R6 had no natural teeth and did not indicate loosely fitting dentures. R6's dental care area assessment was triggered but not provided. R6's care plan dated revised 4/9/24, indicated R6 was independent after set-up with oral hygiene and did not mention dentures. During interview on 5/13/24 at 7:08 p.m., R6 stated they told the facility they wanted to see the dentist and it had been a long time since they have been to the dentist. R6 stated they wore their dentures once in a while, but they fell out and staff were aware. During observation on 5/15/24 at 7:37 a.m., nursing assistant (NA)-A assisted R6 with morning cares in bed, transferred R6 to the wheelchair, and R6 wheeled self to the bathroom sink. R6's dentures were near the sink, but NA-A nor R6 touched the dentures. During interview on 5/15/24 at 8:50 a.m., NA-A stated administrative assistant (AA) made dental appointments. NA-A stated R6 randomly wore their dentures when family, friends, or guardian visited. NA-A was not aware R6 had concerns with dentures fitting. During interview on 5/15/24 at 2:28 p.m., licensed practical nurse (LPN)-A stated they do not do a lot of oral assessments but would look in a resident's mouth if they complained of a sore and referred to director of nursing (DON) or other registered nurses who completed resident assessments. LPN-A stated R6's dentures fit, but R6 did not wear them. During interview on 5/15/24 at 2:51 p.m., administrative assistance (AA) stated they looked at referral sheets to know when the next dental appointment should be scheduled or scheduled dental appointments when residents had a toothache or other concern. AA was aware R6 wanted a dental appointment and stated they spoke on 5/15/24 and R6 stated their dentures were not bothering them but it was time to have them looked at. AA stated they scanned in dental notes, and resident refusals of services would also be in the resident's chart. AA looked through R6's chart and did not see any indication of a dental visit. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/15/24 at 5:00 p.m., DON stated they offer dental services to anyone who needed them and encouraged residents to be seen every six months for cleaning. DON stated they do not have dental assessments besides when residents were first admitted . The facility made appointments for residents with dentures when there were concerns with their dentures. DON stated R6 did not wear their dentures and not aware of denture concerns. DON stated they completed the dental portion of the MDS based on progress notes and hearing any changes or concerns from residents and staff. DON was working on contacting other nurses who completed assessments and the MDS regarding specific dental assessments to complete the MDS. DON stated regular dental visits and assessments were important to ensure dentures fit appropriately and residents did not have sores from dentures, were able to use dentures appropriately and eat well. The facility policy Physician Visits dated 7/23, indicated other provider services may be scheduled as needed. The policy directed nursing staff or administrative assistant to schedule resident appointments. The facility contracted with podiatry and vision providers and documented in resident chart if refused services. A policy on dental assessments was not provided.

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	245606	A. Building B. Wing	05/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure frozen, refrigerated, and dry food items were properly stored, labeled, and dated and disposed of after expiration date. Furthermore, the facility failed to ensure dishware was cleaned and sanitized in a manner to reduce the risk of foodborne illness. This had potential to affect all residents and staff who eat from the main kitchen. Findings include: Food storage During the initial kitchen observation on [DATE] at 12:46 p.m., the refrigerators in the main kitchen contained the following: - opened 2% [NAME] select white milk and skim vitamin a and d white milk with no opened date. - slices of circular meat wrapped in plastic wrap with no opened date or label identifying what the item was. - Hormel roast beef was opened and in a Ziplock bag. The Hormel bag read [DATE] as the prepare by or freeze date but did not have an open date. - an unopened tight sealed package of meat was thawing in a serving container with typed label of [DATE]. The freezer contained the following: -multiple unopened, tight sealed packages of meat with no date or other information identifying what the items were. -spring rolls in plastic bag, which had been opened, with no date or label to identify what the items were. The bottom of the bag had crystals of ice. -an opened package of brats with MFG (manufacturing date) date [DATE] were in a Ziplock bag with no opened date and crystals of ice throughout the bag. -a packaging bag of round patties was opened and not dated or labeled with any information. The dry storage contained the following: -opened pretzel crips cinnamon sugar from Snack Factory had a date typed date of [DATE] but did not specify as an expiration or best by date and did not have an opened date. -creamy caesar dressing portion control pouches with an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-lite ranch dressing portion control pouches with an expiration date of [DATE]. During interview on [DATE] at 1:26 p.m., cook (C)-A stated C-B completed ordering and inventory of all items in the refrigerators, freezer, and dry food area. C-A verified the milk was opened without an opened date and stated they did not label the milk because they go through it so fast. C-A placed an opened date on items such as buttermilk and heavy cream, which they do not go through as fast. C-A stated opened items were placed in Ziplock bags and labeled with an opened date. C-A stated the circular meat in the plastic wrap was used for sandwiches on their alternative menu and verified the meat did not have an opened date. C-A verified the Hormel roast beef did not have an opened date. C-A stated the meat with typed label of [DATE] must have been taken out of the freezer the day prior to thaw for the evening meal this day and was not sure what the printed date indicated. C-A verified the frozen meat packages of ground beef were not labeled with what the item was or date indicating when the item was placed in the freezer or expired. C-A stated the frozen meat packages came in bulk boxes so if the box was discarded then the food item information was gone. C-A stated the spring rolls should be dated and were from last week, and C-A verified the crystals of ice as freezer burn and stated should be thrown out. C-A stated items in a Ziplock bag meant they had been opened and should have a date to indicate when the item was opened. C-A verified the brats did not have an opened date and state would toss food items with freezer burn. C-A verified the round patties were opened and did not have an opened date. C-A stated the pretzels should have an opened date and be thrown out since the printed date on the packaging was unclear. C-A verified the portion control pouches of dressing were expired and stated the pouches should be thrown out. During follow-up kitchen tour on [DATE] at 9:21 a.m., cases of pop such as lemon lime, root beer, and orange soda were on the floor along a wall between the kitchen area and dish machine area. The corner area contained a sink, rack of clean dishes, and a broom. C-A verified the cases of pop were for the residents and on the floor and said someone else took care of the pop. During interview on [DATE] at 2:20 p.m., administrator, who oversaw culinary, stated opened items should be dated when opened and labeled with what the item was when removed from the original box. If an item was not dated, the item was not to be used and discarded. Administrator stated items should not be in the freezer long enough for freezer burn and should be discarded. Administrator stated food rotation occurred on the weekends and new items went to the back so items in front would be used first and expired items were removed. Administrator stated food needed to be six inches off the floor including the noted cases of pop. The facility policy Food Receiving and Storage dated ,d+[DATE], indicated food would not be stored on the floor and must be at least 18 inches from the floor. The policy directed dry food removed from original packaging would be labeled and dated with a use by date, and all foods stored in the refrigerator or freezer will be covered, labeled and dated with use by date. Dish machine (continued on next page)

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	245606	A. Building B. Wing	05/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and interview on [DATE] at 9:21 a.m., the dish machine was a CMA Dishmachine 180UC. The dish machine had a wash temperature label which read ,d+[DATE] and a final rinse temperature label which read ,d+[DATE]. There was a three compartment sink next to the dish machine, and C-A placed silverware from the third sink compartment into the dish machine. C-A stated they took a bucket and placed the sanitizer in the bucket, and then measure the sanitizer level with the test strips before pouring the contents of the bucket into the third sink compartment where it was diluted with water. The sanitizer was labeled 146 multi quat sanitizer from Ecolab. The test strips were chlorine test papers code 4250-BJ from [NAME]. C-A stated sanitizing in the sink was an extra step. The dish machine reached a temperature of 138, and C-A pressed the drain button. The temperature reached 141 as C-A drained the dish machine and opened the door to take the silverware out. C-A verified the temperatures identified and stated the temperature fluctuates and would be concerned if the temperature was less than 120 or 100. A final rinse temperature did not appear in the indicated digital spot, and C-A verified no number showed in the final rinse section and was okay because of the sanitizer. C-A placed the silverware to dry. C-A stated when the dish machine was not working correctly, they would get the machine fixed and manually washed and sanitized the dishes. The HSM Dietary Temperature checks worksheet for [DATE] identified the dish sanitizer as 160 to mid-170s and the alkaline strips ,d+[DATE]. C-A stated the dish sanitizer section was the temperature of the dish machine, and the last column Alkaline strip was the level of the sanitizer in the bucket before diluting with water in the sink. During follow-up observation and interview on [DATE] at 1:04 p.m., C-A rinsed dirty dishes in the first sink compartment and then placed the dishes in the second compartment, which C-A filled with the liquid pot and pan detergent on the wall dispenser. C-A scrubbed the plates from the second compartment and placed the plates in the third compartment. C-A then rinsed cups in the first compartment and placed into the second compartment. C-A put the plates into the dish machine, then pressed fill. The dish machine's wash temperature started at 161 then went down to 140. The dish machine stopped, and the temperature went up to 148. C-A took the cups from the second compartment and placed in the third compartment with the sanitizer. C-A tested the level of the sanitizer in the third sink compartment, and the test strip did not change color to indicate appropriate sanitization level. C-A stated the test strip changed to the appropriate color when tested in the bucket before diluting with water in the sink. C-A stated the dish machine first rinsed, then washed, sanitized, and dried. C-A stated the dish machine gets hot enough but had issues with the sensor not working. C-A stated if the sensor was not working there was no other way to check the temperature of the dish machine, but the heat could be felt and so knew it was hot enough. C-A stated the dish machine dispensed how much sanitizer it needed and did not know how to test the sanitizer of the dish machine. During interview on [DATE] at 2:20 p.m., administrator stated they had a new dish machine and thought past issues were resolved. Administrator stated the dish machine was a chemical sanitizer, and the test strips were used to test the pH level of the standing water on the bottom of the dish machine. The facility's Dish Machine Sanitizer policy and procedure dated ,d+[DATE], indicated the dish machine in the kitchen was a chemical sanitizer and was tested by placing test strip alongside a drip from an individual dishware inside of the dish machine after first use of the machine daily. The dish machine was designed to operate at washing and rinse temperature of 130 degrees.

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	245606	A. Building B. Wing	05/16/2024

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 44651 Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Q1), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. Findings include: Review of the facility PBJ Staffing Data Report dated 10/1/23 - 12/31/23 (Q1), identified the facility failed to have RN coverage for the dates of: 10/1/23, 10/14/23, 10/15/23, 10/16/23, 10/18/23, 10/19/23, 10/20/23, 10/21/23, 10/22/23, 10/24/23, 10/28/23, 11/04/23, 11/5/23, 11/11/23, 11/19/23, 11/23/23, 11/25/23, 11/26/23, 11/27/23, 11/29/23, 11/30/23, 12/1/23, 12/4/23, 12/6/23, 12/9/23, 12/10/23, 12/22/23, and 12/23/23. The report also indicated the facility failed to have licensed nursing coverage 24 hours per day on the following dates: 10/12/23, 10/17/23, 11/4/23, 11/19/23, 12/23/23, and 12/29/23. In addition, the report identified the facility was triggered for low weekend staffing. Review of the facilities undated payroll sheets indicated the facility did have RN coverage 10/1/23, 10/14/23, 10/15/23, 10/16/23, 10/24/23, 10/28/23, 11/11/23, 11/25/23, 11/26/23, 11/27/23, 12/9/23, 12/10/23, 12/22/23. As well, the payroll sheets identified the facility did not have any gaps in 24 hour per day licensed nursing coverage, nor were there any obvious indications of low weekend staffing. During interview on 5/16/23 at 2:13 p.m., the administrator indicated PBJ data was submitted by the facility business office, and they were unsure why it did not accurately reflect staffing hours. A policy pertaining to submission of PBJ data to CMS was requested but not provided.

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	245606	A. Building B. Wing	05/16/2024

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44651 Based on interview and document review, the facility failed to implement a Quality Assurance and Performance Improvement (QAPI) plan assuring care and services were identified to maintain acceptable levels of performance and continual improvement, and failed to conduct ongoing quality assessment and assurance activities, develop, and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 20 residents which resided in the facility. Findings include: The facility's QAPI meeting minutes, attendance, and evidence of the facility's ongoing performance improvement projects (PIPs) was requested, however not received. During interview with director of nursing and administrator on 5/16/24 at 2:30 p.m., the administrator stated the facility held quarterly QAPI meetings but had not developed any performance improvement projects and did not have any formal documentation relating to the correction of previous and repeated quality deficiencies. They stated they had plans to start in the future, however their focus in the past year had been on getting settled into a new building. The facility Quality Assurance and Performance Improvement (QAPI) plan dated 11/10/23, indicated the newly formed QAPI committee will establish itself and a plan, conduct a facility assessment, identify areas of concern and opportunities for improvement, begin working on a PIP, and make changes that will result in lasting improvement.

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	245606	A. Building B. Wing	05/16/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44647 Based on interview and record review the facility failed to develop an infection prevention control program that included written standards, policies and procedures that included when and to whom possible incidents of communicable disease or infections should be reported, when and how transmission-based precautions (TBP) and enhanced barrier precautions (EBP) should be implemented to prevent infections, hand hygiene procedures to be followed by staff involved in direct resident care and a process fpr surveillance and monitoring of infection control practices were implemented by staff. Furthermore, the facility failed to ensure the antibiotic stewardship protocol included a system to monitor antibiotic use. This had the potential to affect all 20 residents who reside in the facility. Findings include: The facility's policy titled Infection Control revised 6/2023, directed staff to follow to utilize infection control procedures related to standard precautions and droplet and airborne TBP. However, the policy lacked direction or procedure for EBP, contact precautions and enteric precautions. The policy further lacked direction on when and how to implement TBP and what forms of PPE was required for droplet, airborne, contact, and enteric precautions. The policy lacked direction on staff education requirements or a process of monitoring to infection control practices were implemented by staff. The facility's policy titled Hand Washing revised 6/2023, directed staff on how to wash hands with soap and water. The policy lacked direction of when hand hygiene was required in relation to glove use and resident care activities. The facility policy titled Antibiotic Stewardship revised 6/2023, indicated minimum criteria for antibiotic use for residents. However, the policy lacked a process/protocol for monitoring residents' response to the use of an antibiotic to determine if the antibiotic was still indicated or adjustments were needed. The policy further lacked a process to monitor antibiotic use and how pharmacy, providers and leadership participated in antibiotic stewardship. A facility policy for reporting communicable infections was requested however was not received. A facility policy for process surveillance of the infection control program was requested however was not received. When interviewed on 5/15/24 at 12:32 p.m. licensed practical nurse (LPN)-A stated if a resident had any signs of infection or change, they would alert the Director of Nursing (DON) and the provider. The provider would determine next steps. LPN-A stated there was not a specific way to monitor residents when they have an infection or when an antibiotic was used. LPN-A stated use of TBP would depend on how the infection spreads. LPN-A further stated when the DON was notified about the signs of an infection, she would direct us if any TBP were required and what should be done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Springs at Minnetonka	16913 Highway 7 Minnetonka, MN 55345

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 5/15/24 at 2:23 p.m., the DON, also working as the infection preventionist (IP) verified the infection control policies lacked information and processes for EBP and TBP. DON further stated there was not a lot of infections in the facility and so much of the process was just telling staff what was needed. DON verified there was no specific way to monitor staff for compliance with infection control practices. DON stated staff were watched on cameras to determine if wearing the correct PPE or hand hygiene was happening and kept an eye on practices when out on the unit. DON further stated there was no documentation of this. DON verified the hand hygiene policy did not reflect when hand hygiene was needed with direct resident cares. Furthermore, the DON stated the antibiotic stewardship program did not include any specific monitoring of improvement to help determine appropriate use. DON brought the infections and antibiotic use to the quality committee for review them individually, but there was no data or discussion on antibiotic use. DON stated policies were updated yearly by the administrative assistant and the administrative assistant would reach out if there were questions. DON acknowledged the infection control policies needed work. DON further stated being a small facility the policies and procedures for infection control were developed by her. The DON stated they had responsibilities of the IP, minimum data set (MDS) nurse on top of DON responsibilities and there was a lot to keep track of.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review the facility failed to ensure influenza immunization were offered to 2 of 5 (R20, R11) residents reviewed for immunizations. Findings include: R20's admission Minimum Data Set (MDS) dated [DATE], indicated R20 was cognitively intact and had diagnoses of bipolar disorder and depression. Furthermore, R20's MDS indicated no influenza vaccination was given this season and the influenza vaccine was not offered. R20's Minnesota Immunization Information Connection Report (MIIC) dated 1/11/24, indicated R20 had not received the influenza vaccine for the 2023-2024 season. R20's medical record lacked indication R20 had been offered, received or declined the influenza vaccination. R20's declination of influenza vaccination was requested however was not received. R11's MDS dated [DATE], indicated R11 was cognitively intact and had diagnoses of schizoaffective disorder and depression. Furthermore, R11's MDS indicated R11 had been offered and refused the influenza vaccination. R11's medical record lacked indication R11 was offered, received or declined the influenza vaccination. When interviewed on 5/15/24 at 12:32 p.m., licensed practical nurse (LPN)-A stated nurses on the floor did not determine what vaccinations were needed for residents. LPN-A further stated the Director of Nursing (DON) was in charge of that. When interviewed on 5/15/24 at 2:23 p.m., the DON, who also was the infection preventionist (IP) stated resident vaccines were provided from the providers in clinic or from the facility. The DON further stated the providers usually looked up vaccination status during their visits and writes the recommendations and orders. Then the resident was offered/educated and either signed a consent or declination. DON verified the influenza season runs into the first week in April and tries to go look for the influenza orders in the fall. DON stated she believed R11 had declined but was not able to find the declination. DON stated she may have forgotten to obtain declination signatures for residents who declined the influenza in the fall as other resident charts who had declined did not have declinations either. DON stated R20 admitted in January and there had been two admissions that week. DON verified that may have been overlooked and did not see any consent/declination in R20's medical record either. DON further stated offering vaccinations was important to help minimize risk of getting influenza. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Standing Orders for Vaccinations revised 4/2023, directed staff to administer vaccinations after education and consent was obtained. Furthermore, the policy directed staff administer influenza vaccination annually to all residents febrile or allergic to egg. The policy lacked a process of how and when the resident vaccination status was assessed.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 44647 Based on interview and record review the facility failed to ensure staff were educated to standards, policies, and procedures of their infection control program. This had the potential to impact all 20 residents who reside in the facility. Findings include: Staff education for infection control was requested however wasn't received. When interviewed on 5/15/24 at 12:32 p.m., licensed practical nurse (LPN)-A stated if a resident had any signs of infection or change, they would alert the Director of Nursing (DON) and the provider. The provider would determine next steps. LPN-A stated there was not a specific way to monitor residents when they have an infection or when an antibiotic was used. LPN-A stated use of TBP would depend on how the infection spreads. LPN-A further stated when the DON was notified about the signs of an infection, she would direct us if any TBP were required and what should be done. LPN-A stated there had been an in-service on enhanced barrier precautions (EBP) recently and wasn't sure about education about the policies and procedures. When interviewed on 5/15/24 at 2:23 p.m., DON stated she did on the spot training when infection control concerns come up and recently did education on (EBP). DON stated almost all staff were able to attend but had a problem getting video to upload to youtube for those who missed it to review. DON further stated recently the facility obtained an online education platform through healthcare academy but had not gotten used to having online and education in and getting it completed. DON further stated education was important to ensure everyone followed the same processes to prevent infections. A facility policy titled Infection Control revised 6/2023, lacked direction on staff education requirements.