

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Hope Springs at Minnetonka		STREET ADDRESS, CITY, STATE, ZIP CODE 16913 Highway 7 Minnetonka, MN 55345	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on observation, interview and document review the facility failed to ensure residents who self-administered topical medications creams were assessed for safe and appropriate use for 2 of 3 residents (R11 and R15) reviewed for self-administration of medications.</p> <p>Findings include:</p> <p>R11:</p> <p>R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was admitted to the care facility on 4/6/23 and was cognitively intact.</p> <p>R11's Orders, indicated R11 had an order for Betamethasone Valerate External Cream 0.1% (a steroid cream used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), apply to affected skin as needed for rash unsupervised self-administration. Apply to affected skin twice daily PRN [as needed] for rash up to five days a month and two times a day for rash for two weeks.</p> <p>R11's care plan, dated 6/26/24, indicated for staff to provide medications as ordered, including Betamethasone cream PRN for rash outbreaks.</p> <p>R11's electronic medical record (EMR) indicated R11's last skin observation by a licensed nurse was 11/8/24.</p> <p>R11's EMR lacked evidence that R11 had been assessed for safe self-administration of medication including how to use it, where, and how often.</p> <p>During an interview on 2/13/25 at 10:57 a.m., licensed practical nurse (LPN)-A stated that she did not believe R11 should be able to administer her own medicated cream as she had recently self-declared blindness. LPN-A stated nursing staff should be doing an assessment to ensure residents are visually and cognitively able to self-administer medications. LPN-A further stated it was questionable whether R11 had a [neck] rash and although R11 kept the cream in her room, she should be asking staff to assist her with applying the cream.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 11:09 a.m., R11 stated she kept the medicated cream in her bathroom. R11 stated she had been using the cream on her neck twice a day and the rash had cleared up but now she was using it for a rash on her right thigh. R11 stated nursing staff were not assessing her skin and were not offering, or asking, if she needed help applying the cream. She was doing it on her own.</p> <p>During an interview on 2/13/25 at 12:32 p.m., the consultant pharmacist (CP) stated Betamethasone Valerate External Cream 0.1% can cause thinning of the skin which is why it is generally prescribed with a time limit. The CP stated she would want to ensure R11 had the same rash on her thigh the cream was prescribed for on her neck before she used it on the rash on her thigh.</p> <p>During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) confirmed R11 had not been assessed for self-administration of her medicated cream. The DON stated she believed R11 had been fine to self-administer medications when they were prescribed but was not as reliable now and was unsure if R11 could safely self-administer medications at this time. The DON stated she was unaware of a rash on R11's thigh and she should be assessed for safe and proper use.</p> <p>48299</p> <p>R15:</p> <p>R15's annual MDS dated [DATE], indicated R15 was admitted to the care facility on 12/17/20 and was cognitively intact.</p> <p>R15's Order Summary Report printed 2/14/25, indicated:</p> <p>-Hydrocortisone External Cream 1% (Hydrocortisone (Topical)) (topical corticosteroid which treats skin conditions). Apply to lower extremities and/or [abdomen] topically as needed for pruritus (itching) unsupervised self-administration apply to lower extremities bid prn (twice daily as needed) for leg rash- may keep at bedside.</p> <p>-Micotrin AP External Powder 2% (Miconazole Nitrate (Topical)) (antifungal medicine used to treat certain kinds of fungal or yeast infections of the skin). Apply to areas of irritation. Apply to under breasts and between skin fold when irritation is present as needed BID.</p> <p>-Terbinafine HCl External Cream 1% (Terbinafine HCl (Topical)) (an antifungal medication which treats fungal infections of the skin). Apply to rash on abdomen topically two times a day for rash unsupervised self-administration. Apply BID until clear. Ok to keep at bedside.</p> <p>-Voltaren Gel 1% (Diclofenac Sodium) (nonsteroidal anti-inflammatory drug which treats joint pain caused by arthritis). Apply to [bilateral] wrists and hands topically every six hours as needed for pain- moderate unsupervised self-administration. Apply 4 grams every six hours prn. May keep at bedside.</p> <p>R15's care plan, indicated the following interventions:</p> <p>-1/29/21, administer analgesia (refers to the relief or absence of pain) as per orders. Give half hour before treatments or care.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-8/29/24, R15 self-administered clotrimazole cream under abdominal fold for rash and has as needed for cortisone cream.</p> <p>R15's progress note dated 8/27/24 at 12:23 [12:23 p.m.], indicated R15's providers saw R15 for a continued rash around their abdomen and lower legs and ordered clotrimazole cream twice daily to waist area until rash healed and may keep clotrimazole and hydrocortisone at bedside to use until healed.</p> <p>R15's progress note dated 11/22/24 at 14:47 [2:47 p.m.], indicated R15's providers saw R15 and ordered micotin antifungal powder to apply under breasts and between skin folds when irritation was present as needed twice daily.</p> <p>R15's EMR lacked evidence that R15 had been assessed for safe self-administration of medication including how to use it, where, and how often.</p> <p>During an interview on 2/13/25 at 11:45 a.m., licensed practical nurse (LPN)-A stated they did not complete self-administration assessments since they were an LPN. LPN-A stated residents were assessed for self-administration when medications first ordered, and R15 cleaned their own skin folds and self-applied needed creams. LPN-A checked with R15 daily to ensure areas cleaned or if R15 had concerns.</p> <p>During observation and interview on 2/13/25 at 12:55 p.m., R15 stated the use voltaren gel once or twice a day for their knees, thumbs joints, and wrists and keep the gel in their room. R15 stated they kept hydrocortisone in their room and used when their skin folds were irritated. R15 stated they also had an antifungal powder in their bathroom which R15 used when they had a rash. R15 stated the doctor ordered the powder, and staff provided R15 the powder and knew about it too. R15 stated they asked the doctor to write they may keep the powder and other treatments at bedside. R15 went to the bathroom to grab their powder, and the powder was miconazole nitrate 2% antifungal powder with a pharmacy label.</p> <p>During an interview on 2/13/25 at 3:35 p.m., the director of nursing (DON), verified R15 did not have a self-administration assessment and needed an assessment rather than only the doctor's orders.</p> <p>A facility policy titled Self-Administration of Medications Assessments, dated 8/2023, indicated if a resident wished to self-administer medications the interdisciplinary team must assess the resident's cognitive, physical, visual ability to carry out/administer medications. If resident wishes to self-administer medications/treatments such as insulin's, eye drops, lotions and/or wish medications left for self-administration, resident will be instructed in proper technique and then monitored for 10 days for correct task completion. Staff will document on MAR.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure food preferences were honored for 1 of 1 resident (R4) reviewed for choices related to food.</p> <p>Findings include:</p> <p>R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 had intact cognition, disorganized thinking, verbal behavioral symptoms directed towards others, and did not reject cares. R4 required supervision or touching assistance with eating and was independent with most activities of daily living. R4 had diagnoses of orthostatic hypotension (condition where blood pressure drops when standing up from a sitting or lying position), dementia and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions).</p> <p>R4's oral intake care plan revised 12/13/24, indicated R4 had potential for inadequate oral intakes related to history of varying appetite secondary to mental health and had been hospitalized for not eating and weight loss. Care plan interventions indicated R4 liked Mexican food, soups, desserts, macaroni and cheese, carrot cake, chicken wrap, pizza, tuna, and hot cereal. R4 disliked Chinese food, liver, gizzards and hearts, and red met.</p> <p>R4's Kardex Report printed 2/14/25, indicated R4 was independent with eating, may need encouragement to come to meals, and offer strawberry ensure if R4 did not want to eat.</p> <p>R4's progress note dated 12/13/24 at 10:19 [10:19 a.m.], indicated R4 was semi-vegetarian and tried to avoid red meats but liked ham and sometimes pork. R4 liked chicken, fish, tuna, eggs, dairy, and hot cereal. R4 triggered for weight loss related to decreased intakes and agreed to try to eat more.</p> <p>During an interview on 2/10/25 at 3:19 p.m., R4 stated the facility did not have enough vegetarian options. R4 stated they ate chicken, ham, and turkey but did not like other types of meat. R4 stated the facility had alternative options but got the regular entree if they did not sign up for another option before the set time. R4 stated they spoke with the dietician about their food preferences, and R4 believed they would live longer if they cut out certain types of meat.</p> <p>During an interview on 2/11/25 at 12:23 p.m., dietary aid (DA)-A, who also cooked, stated they had a book and white board which listed residents' food preferences. DA-A stated they offer alternative options for meals, and residents had to sign up for the alternative option before a certain time.</p> <p>During observation on 2/11/25 at 1:03 p.m., the white board in the kitchen dish machine room did not indicate any food preferences for R4. The dietary book undated, indicated R4 had No special beverage or food instructions.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 10:40 a.m., nursing assistant (NA)-A stated R4 had a fasting behavior and was not a huge meat person. NA-A stated the facility tried to give R4 smaller portions, or R4 signed up for a meal alternative or wrote no meat. NA-A stated they encouraged R4 to eat what they wanted and leave what they did not want to eat. NA-A stated they have cleared the meat off R4's plate before, so then R4 ate everything else on the plate.</p> <p>During observation on 2/12/25 at 12:06 p.m., R4 was given the barbequed pork with potatoes and an apple, broccoli salad. At 12:10 p.m., R4 was eating the potatoes and salad but not the barbequed pork. At 12:13 p.m., R4 ate a dessert and had eaten everything on their plate but the barbequed pork. The life enrichment director (ACT)-A took R4's plate and threw the meat away.</p> <p>During an interview on 2/12/25 at 12:23 p.m., DA-B, who also cooked, stated they knew residents' food preferences through verbal interactions. DA-B stated R4 wavered and had different preferences. DA-B stated R4 requested no meat at times and other times wanted the meat portion of the meal or a hot dog.</p> <p>During an interview on 2/12/25 at 2:21 p.m., registered nurse (RN)-A stated R4 refused to eat or drink at times. RN-A stated they were not able to leave the second floor to assist in the dining room for meals on the first floor, so the nursing assistants and dietary staff knew residents' food preferences.</p> <p>During an interview on 2/13/25 at 12:35 p.m., NA-C stated R4 fasted at times and encouraged R4 to drink when they did not eat. NA-C stated R4 will pace back and forth from the meal table and make statements such as I can't, I can't. NA-C stated R4 looked ahead at the menu themselves and signed up for an alternative entree if they wanted. NA-C stated R4 ate meat sometimes and other times did not. NA-C stated they let [R4] be when they did not eat the meat portion of their meal and took R4's plate when R4 stated they were done.</p> <p>During an interview on 2/13/25 at 12:32 p.m., ACT-A stated they took R4's plate on 2/12/24, because R4 stated they were finished. ACT-A stated R4 had a thing about meat, such as R4 did not eat the soup for lunch because it had beef in it. ACT-A stated R4 went on fasts sometimes when their weight got higher than what they wanted. ACT-A stated the kitchen offered alternative options, so most residents and staff were good at knowing what food they liked or did not like. ACT-A stated they did not check with R4 if they were full or wanted anything else before taking R4's plate and throwing away the untouched barbeque pork.</p> <p>During an interview on 2/13/25 at 4:03 p.m., the director of nursing (DON) stated the dietician asked residents about their likes and dislikes related to food, and the cook talked to the residents, so they knew about residents' food preferences. DON stated R4's mental illness was not stable and conflicted from hearing negative thoughts related to eating. DON stated R4 requested more vegetables, and R4 was not consistent with what they wanted. DON thought NA-A talked to people who got up late in the day or didn't look at the menu to ask what they wanted to eat before meals. DON stated they observed R4 looking at the menu prior to meals and was able to sign up for alternative entrees. DON stated staff made sure R4 drank enough to avoid weight loss, weakness, and hospitalization. DON stated residents had little control over themselves, so it was important for them to get food they liked.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy New Admission Dietary assessment dated ,d+[DATE], directed the cook to interview each new resident for likes and dislikes, and the dietician to meet with residents for a nutrition related physical exam and initial assessment. The dietician updated resident assessments, progress notes, MDS, and care plan on a quarterly basis.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on interview and document review, the facility failed to ensure provider orders code status [e.g. full code or do not resuscitate (DNR)] were updated, consistent, and accurate throughout the resident's medical record for 1 of 4 residents (R4) reviewed for advance directives.</p> <p>Findings include:</p> <p>R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was admitted to the care facility on [DATE]. The MDS indicated R4 had intact cognition, disorganized thinking, verbal behavioral symptoms directed toward others, and diagnoses including orthostatic hypotension (condition where blood pressure drops when standing up from a sitting or lying position), dementia and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions).</p> <p>R4's care plan dated [DATE], lacked documentation of code status.</p> <p>R4's Health Care Directive dated [DATE], indicated they did not want CPR (cardiopulmonary resuscitation; emergency procedure which combined chest compressions and rescue breathing to help someone who is not breathing or whose heart is not beating) attempted if their heart and breathing stopped. R4 wanted a natural death. R4 understood if they chose this option, they would see their health care provider about writing a DNR order.</p> <p>R4's Transfer Orders from Regions Hospital signed [DATE], indicated R4's code status was full code.</p> <p>R4's Discharge Orders from Regions Hospital signed [DATE], indicated R4's code status was full code.</p> <p>R4's Care Conference note dated [DATE], indicated R4, the social workers, and director of nursing attended the care conference. The note indicated R4 wanted CPR in the past and now changed their mind.</p> <p>R4's Admission Record printed [DATE], indicated R4 did not want resuscitation and did not want intubation.</p> <p>R4's orders printed [DATE], did not indicate R4's code status.</p> <p>During interview on [DATE] at 2:13 p.m., registered nurse (RN)-A stated code statuses were reviewed at care conferences and during admission by the director of nursing (DON). RN-A knew residents' code statuses from the face sheet binder. The face sheet binder had a copy of R4's Admission Record and Health Care Directive, both which did not have a provider signature.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on [DATE] at 3:31 p.m., the director of nursing (DON) confirmed there was no provider order or involvement in R4's DNR status. The DON preferred everyone to have a POLST and stated not everyone had one, which included R4. The DON stated provider involvement was important to ensure residents were educated about DNR status by a professional with a higher degree. The DON stated they reviewed code status at each care conference.</p> <p>The facility's POLST policy dated ,d+[DATE], directed staff to assist the resident or resident's guardian/representative with completing a Providers Orders for Life Sustaining Treatment (POLST) form. If the resident or guardian/representative chooses to decline CPR, intubation, etc., HSM staff documented on the POLST, and two staff members witnessed the POLST to become effective. The POLST was then faxed to the primary physician for signature.</p> <p>The facility's Advanced Directives/CPR policy dated ,d+[DATE], reflected the same process as the POLST policy. The policy indicated the care plan reflected resident wishes and whether an advance directive existed. The policy directed staff to reference the Facesheet binder in the event a resident was found without a pulse.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on interview and document review the facility failed to ensure a process for missing clothing was followed and residents received appropriate follow up after reporting concerns of missing clothing for 3 of 5 residents (R1, R4, and R9) reviewed for personal property.</p> <p>Findings include:</p> <p>R1:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was admitted to the care facility 7/24/23 and was cognitively intact.</p> <p>During an interview on 2/11/25 at 8:41 a.m., R1 stated missing clothing was a common occurrence in the facility and she was currently missing a blue hoody. R1 confirmed she had let the facility nursing assistants (NA) know but had not received any follow up.</p> <p>R5:</p> <p>R5's quarterly MDS dated [DATE], indicated R5 was admitted to the care facility 10/1/24 and was cognitively intact.</p> <p>During an interview on 2/12/25 at 8:54 a.m., R5 stated she had not been getting all of her clothing back after getting it washed and was currently missing a pair of jeans, socks, and underwear. R5 stated she had told the NA who distributed the laundry and the director of nursing (DON). R5 further stated it had been approximately 1 month and she had not received any follow up.</p> <p>The facility's Missing Item Report, kept in a three-ring binder at the nursing station, dated 9/2/24 - 2/10/25, lacked evidence of R1's and R5's reported missing clothing.</p> <p>During observation on 2/12/25 at 10:30 a.m., a pair of unmarked resident jeans were laying on a chair near the nursing station. Facility staff were unable to confirm who they belonged to.</p> <p>During an interview on 2/12/25 at 11:55 a.m., NA-A stated she was aware R1 was missing a blue hoody and R5 was missing clothing items including a pair of jeans. NA-A stated the process for missing laundry was when an item was reported missing, staff would check the laundry room, laundry cart and other resident rooms for the item. If it could not be found that it should be written on the missing items report kept at the nursing station. NA-A stated R1's and R5's missing clothing was reported off to her by another NA so she did not look for the clothing herself or write it in the missing item report.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 12:59 p.m., the DON stated she was aware of R5's missing clothing but was not aware R1 was missing clothing. The DON stated since there was only one NA and one nurse working at a time, the staff could not be expected to leave the floor and search for missing items every time it was reported. The DON stated she encouraged all staff to use the missing items report, however confirmed the facility lacked follow up on the report and with missing items. The DON also stated clothing was labeled with a sharpie that would wash off after a few washes creating issues of clothing items not being labeled with resident identifying information.</p> <p>48299</p> <p>R9:</p> <p>R9's quarterly MDS dated [DATE], indicated R9 had moderately impaired cognition, inattention, disorganized thinking, hallucinations, delusions, verbal and other behaviors, and rejected cares. R9 had no upper or lower extremity impairments and used a walker. R9 required partial and/or moderate assistance for dressing and supervision for footwear application and removal, toileting, personal and oral hygiene, and ambulation. The MDS indicated R9 had arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety, and schizophrenia.</p> <p>R9's progress note dated 11/14/24 at 8:17 a.m., indicated R9 had a history of paranoia with staff and/or people taking clothes, or R9 reported missing possessions from their room.</p> <p>During an interview on 2/10/25 at 2:39 p.m., R9 stated they were missing an expensive jacket, and the facility was not able to locate it.</p> <p>During an interview on 2/12/25 at 10:37 a.m., nursing assistant (NA)-A stated they looked in the laundry area, looked downstairs, and in every room when a resident reported a missing item. NA-A stated the facility had a missing item binder where they wrote down a description of the missing item. NA-A stated clothes were initialed and clean clothes were kept behind a label with resident information, so staff knew whose clean clothes were hanging on the rack. NA-A stated they were unaware of a missing jacket for R9.</p> <p>During an interview on 2/12/25 at 12:17 p.m., anonymous resident stated they lost clothes every wash and were missing black pants, jeans, bras, socks, and shirts. Resident stated their clothes had their initials on them, and nursing assistants told resident they looked for their clothes. Resident stated missing clothes was a serious problem and cost the resident a lot of money.</p> <p>During observation review on 2/12/25 at 1:22 p.m., the missing items log did not have an entry for R9's jacket.</p> <p>During an interview on 2/12/25 at 2:10 p.m., RN-A stated the nursing assistants took care of any missing laundry or missing items. RN-A stated the facility had a grievance and missing items log and they were aware R9's family reported a missing jacket. RN-A stated R9 had gained weight and some clothes which were too small for R9 were packed away, so R9 could believe they were missing clothes they were not. RN-A was not sure if the jacket was found or not and knew the family talked to the DON.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 2:43 p.m., NA-B stated they wrote a note or verbally reported to housekeeping when residents brought up concerns of missing laundry. NA-B stated they should get a list started related to missing items. NA-B was not aware of R9's missing jacket.</p> <p>During an interview on 2/13/25 at 3:09 p.m., the director of nursing (DON) stated they thought the life enrichment director checked the missing items log but was not sure if there was a misunderstanding. DON stated the facility had seen R9 wear the jacket which was described as missing. DON stated R9 threw items away at times and outgrew some of their clothes, so staff packed clothes which were too small for R9 outside of their room. DON stated R9's parents went through R9's items weekly and got R9 agitated when they reported items as missing and stolen. DON stated the facility did not find the jacket and talked to the family, and the family was unhappy it was missing.</p> <p>A facility policy related to resident missing items was requested and not available at the time of survey.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on interview and document review, the facility failed to ensure completed Minimum Data Set (MDS) assessments were accurately coded to reflect correct medication use for 5 of 5 residents (R1, R3, R6, R9, and R15).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual), dated 10/2024, indicated medications are to be indicated as taken by a resident based on pharmacological classification, not how it is used. The RAI Manual further indicated herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin).</p> <p>R1</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was admitted to the care facility 7/24/23 and was cognitively intact. The MDS further indicated R1 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication and lacked mention of R1 receiving a anticonvulsant medication despite receiving two different anticonvulsant medications during the look back period.</p> <p>R1's Diagnoses list, printed 2/13/25, indicated R1 had several medical and mental health diagnoses including major depressive disorder, anxiety disorder, dementia, and bipolar disorder.</p> <p>R1's Orders indicated R1 was on several medications including Melatonin (a dietary supplement) 6 milligrams (mg) by mouth one time a day at bedtime, dated 7/24/23; Gabapentin (an anticonvulsant medication) 200 mg by mouth three times a day, dated 7/24/23; and Lamotrigine (an anticonvulsant medication) 25 mg by mouth one time a day, dated 7/25/23.</p> <p>R3</p> <p>R3's quarterly MDS, dated [DATE], indicated R3 was admitted to the care facility on 9/21/09 and was cognitively intact. The MDS lacked mention of R3 receiving anticoagulant and anticonvulsant medication despite being prescribed both medications.</p> <p>R3's Diagnoses list, printed 2/13/25, indicated R3 had several medical and mental health diagnoses including bipolar disorder, major depressive disorder, anxiety disorder.</p> <p>R3's Orders indicated R3 was several medications including Lamotrigine (an anticonvulsant medication) 75 mg by mouth one time a day at bedtime, dated 5/22/24 and Eliquis (an anticoagulant medication) 5 mg by mouth two times a day, dated 2/25/22.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) stated she was also responsible for completing the MDS. The DON confirmed both R1 and R3 had inaccuracies coded on their MDS, stating it would be expected that each medication is coded as the medication drug class and not what the medication is given for. The DON stated she believed Melatonin should have been classified as a hypnotic, despite the RAI manual stating otherwise.</p> <p>48299</p> <p>R6</p> <p>R6's significant change MDS dated [DATE], indicated R6 was admitted to the care facility on 10/28/24 and was cognitively intact. The MDS indicated R6 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication, and lacked identification of R6 receiving an anticoagulant medication despite receiving an anticoagulant during the look back period.</p> <p>R6's Diagnoses list, printed 2/11/25, indicated R6 had several medical diagnoses including chronic embolism (blockage in a blood vessel) and thrombosis (occurs when blood clots block blood vessels) of other specified veins and other specified veins, peripheral vascular disease (slow and progressive circulation disorder cause by narrowing, blockage, or spasms in a blood vessel), and insomnia.</p> <p>R6's Medication Administration record dated 11/1/24 to 11/30/24, indicated R6 received Eliquis (an anticoagulant medication) 2.5 mg by mouth two times a day and Melatonin (a dietary supplement to promote sleep) 5 mg by mouth at bedtime.</p> <p>R9</p> <p>R9's quarterly MDS dated [DATE], indicated R9 had a reentry to the care facility on 11/4/24, and moderately impaired cognition. The MDS indicated R9 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication.</p> <p>R9's Admission Record, printed 2/11/25, indicated R9 had diagnoses including insomnia, schizoaffective disorder (chronic mental health condition characterized by symptoms such as hallucinations, delusions, mania, and depression), catatonic schizophrenia (type of schizophrenia which involves a syndrome where the brain does not manage muscle movement signals as it should), and generalized anxiety disorder.</p> <p>R9's Orders indicated R9 was on medications which included Melatonin 6 mg by mouth at bedtime, dated 5/22/24.</p> <p>R15</p> <p>R15's annual MDS dated [DATE], indicated R15 was cognitively intact, and lacked identification of R6 receiving an anticonvulsant medication despite receiving an anticoagulant during the look back period.</p> <p>R15's Diagnoses list, printed 2/14/25, indicated R15's diagnoses included major depressive disorder, anxiety disorder, and attention-deficit hyperactivity disorder.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R15's Orders indicated R15 was on several medications including Gabapentin (an anticonvulsant medication) 100 mg by mouth two times a day and 300 mg by mouth at bedtime, dated 6/13/24.</p> <p>During an interview on 2/13/25 at 3:09 p.m., the DON confirmed R6, R9, and R15 had inaccuracies coded on their MDS.</p> <p>The facility provided MDS policy dated 10/23, indicated staff chart in the electronic medical record on resident's care, behaviors, needs, eating, and activities. A licensed practical nurse assisted the DON with interviewing residents and floor staff completed assessments for annual and quarterly MDS. The DON completed significant change and discharge MDS.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on observation, interview, and document review, the facility failed to assess and monitor skin alterations for 1 of 2 residents (R8) reviewed for skin integrity. Furthermore, the facility failed to follow up with urology after several urinary tract infection and failed to comprehensively monitor and assess (i.e bladder scanning to assess for urine retention, proactive UTI assessments or assessing if R3 required more assistance with toileting or bathing) to timely treat, if needed, and prevent hospitalization for 1 of 1 resident (R3) reviewed for hospitalization .</p> <p>Findings include:</p> <p>R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3 was cognitively intact and was independent with most activities of daily living and required set up assistance with bathing.</p> <p>R3's progress notes dated 8/6/24 - 2/12/25, indicated R3 had three UTIs in the past six months resulting in two hospitalization s and was displaying current UTI symptoms.</p> <p>On 8/6/24 it was documented R3 had complaints of strong smelling/cloudy urine and reported falling to her knees last week. Reportedly the director of nursing (DON) was notified.</p> <p>On 8/7 24 it was documented R3 reported feeling weak with ambulation and having intermittent burning pain with urination and odorous urine. R3 further stated she felt like she had a UTI. The note indicated, will updated DON.</p> <p>On 8/29/24 it was documented R3 had a change in condition with increased confusion and inability to stand. R3 was hospitalized ,</p> <p>On 8/29/24 it was confirmed R3 was being treated at the hospital for a UTI, 23 days after symptoms started, 23 days after first documented symptoms.</p> <p>On 9/15/24 it was documented R3 had complaints of cloudy and odorous urine, stating she felt weak. It was documented R3 did not appear weak when ambulating and was reminded to drink water. Per progress note next shift notified.</p> <p>On 9/16/24 it was documented R3 denied painful urination but had complaints of feeling weak with ambulation and odorous urine.</p> <p>On 9/25/24 it was documented that R3 had a care conference and voiced concerns about her cloudy urine, stating she feared she may have another UTI. R3 agreed to drink more water. DON was to consult R3's physician.</p> <p>On 9/30/24 it was documented in a pharmacy note that R3 had been referred to urology.</p> <p>On 10/2/24 it was documented the physician wrote an order for a urine culture, 17 days after symptoms started. The physician also increased R3's Mirabegron (a medication used to treat overactive bladder) and discontinued R3's Tamsulosin (a medication to treat urine retention).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/6/24 it was documented R3 requested staff visualize her urine which was documented as yellow, slightly cloudy, and odorous, stating she thinks she had pain with urination and felt weak with ambulation.</p> <p>On 11/7/24 it was documented R3 was hospitalized for increased weakness after a fall and was diagnosed at the hospital with acute cystitis (inflammation of the bladder) and had a urine culture pending.</p> <p>On 1/14/25 it was documented R3 stated she wanted a urine culture because she thought she had a UTI again. R3 reported burning with urination, cloudy urine and feeling weak for a couple of weeks. R3 was encouraged to drink water and R3's concerns were passed on at shift change.</p> <p>On 1/18/25 it was documented R3 reported symptoms of a UTI for the past few weeks. The DON recommended R3 to drink more water and to take tub baths and showers.</p> <p>On 2/12/25 it was documented R3 continued to report burning with urination, cloudy urine and feeling weak, 29 days after first reporting symptoms. R3 did not have a fever. The DON was aware and instructed R3 to drink water, which R3 did not like to do.</p> <p>R3's electronic medical record (EMR) lacked documentation of ongoing, comprehensive assessments or updated interventions (i.e bladder scanning to assess for urine retention, proactive UTI assessments or assessing if R3 required more assistance with toileting or bathing) to help prevent and/or timely treat UTIs and hospitalization s.</p> <p>R3's care plan indicated R3 had had an increased risk for Urinary Tract Infection AEB [as evidenced by] acute pyelonephritis and urinary incontinence. The care plan lacked intervention updates since 9/3/24 despite continued UTIs and current UTI symptoms.</p> <p>During an interview on 2/12/25 at 8:30 a.m., nursing assistant (NA)-A stated R3 was able to let staff know when she felt like she had a UTI, stating it was obvious because R3 would become very weak. NA-A stated R3 was incontinent of bladder but changed her own brief and toileted herself.</p> <p>During an interview on 2/12/25 at 8:45 a.m., R3 stated she felt like she had another UTI and felt weak. R3 stated she wished the facility would treat her for UTIs at the facility instead of sending her to the hospital.</p> <p>During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated staff try to encourage R3 to drink water but R3 preferred to drink soda. RN-A stated R3 could often tell staff when she thought she had a UTI but was not always correct.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 12:59 p.m., the DON stated R3 was on a prophylactic antibiotic in the past. At the time it was discovered she had infected kidney stones, and they were removed and R3 had ureter stents placed in March of 2024. R3 saw the urologist on 4/17/24, which was when the prophylactic antibiotic was stopped, and an order was given for R3 to follow up with urology if she started have UTIs again. The DON confirmed R3 had not been back to see the urologist despite multiple UTIs since that time. The DON stated staff would encourage R3 to drink water however R3 preferred soda. The DON confirmed the care planed lacked updated interventions to prevent UTIs stating the facility could not afford a bladder scanner. The DON stated the medical director had not been notified of R3's recurring UTIs but she would notify them and would inquire about getting a urine culture for R3 due to her current UTI symptoms.</p> <p>A facility policy on UTIs was not available at the time of survey.</p> <p>48299</p> <p>R8</p> <p>R8's quarterly Minimum Data Set (MDS) dated [DATE], indicated R8 had intact cognition and no delirium. R8 had delusions, verbal behaviors towards others, wandered one to three days, and did not reject cares. R8 had diagnoses of hypertension (high blood pressure), diabetes mellitus (chronic disease which affects how the body uses sugar for energy), arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety disorder, depression, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R8 had no upper or lower extremity impairments and used a walker. R8 required substantial and/or maximal assistance with shower/bathing. R8 required partial and/or moderate assistance with toileting hygiene, toilet transfers, tub/shower transfers, and dressing. R8 was independent with footwear application and removal, rolling left and right, sit to lying and lying to sitting on side of bed, and with chair and/or bed-to-chair transfers. R8 was occasionally incontinent of urine. R8 took antipsychotic, antianxiety, antidepressant, hypoglycemic, and anticonvulsant medication, was not at risk for pressure ulcers, had moisture associated skin damage, and applications of ointments/medications other than to feet.</p> <p>R8's Care Assessment Area (CAA) worksheet dated 7/16/24, indicated R8 required supervision or touching assistance for sit to lying and lying to sitting on the side of the bed, and R8 was at risk for skin alterations, infection, sepsis, increased dependence on staff, decreased leisure, isolation, and further decline.</p> <p>R8's pressure ulcer care plan revised 10/14/24, indicated R8 was at risk for pressure ulcer development related to compression stockings. Interventions dated 5/13/24, directed staff to inform R8/family/caregivers of any new area of skin breakdown and remove compression stockings each evening, wash and hang to dry, and apply clean stockings each morning.</p> <p>R8's incontinence care plan dated 5/13/24, indicated R8 had mixed bladder incontinence related to confusion, impaired mobility, inability to communicate needs at times of confusion. The care plan goal dated 5/13/24, indicated R8 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions dated 5/13/24, directed staff to ensure R8 had unobstructed path to the bathroom, and R8 used Depends for occasional urinary incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R8's Kardex Report printed 2/12/25, indicated R8 received transfer assistance in and/or out of tub/shower and limited to extensive assistance for bathing and more assistance if confused.</p> <p>R8's Order Summary Report printed 2/12/25, indicated an order for miconazole powder with instructions to apply to abdomen, breasts, peri-area as needed twice daily for redness/rash skin irritation (yeast areas) with date of 10/2/24.</p> <p>R8's Skin Observation Tool dated 7/29/24, indicated R8 had a cyst type sore to their posterior right thigh and was tender to touch.</p> <p>R8's Skin Observation Tool dated 1/3/25, indicated R8 had a superficial scratch-like abrasion to their left abdominal fold.</p> <p>No other Skin Observation Tool assessments were recorded from 7/29/24 to 2/13/25.</p> <p>R8's Point of Care Response History had No Data Found for Skin Observation in the past 30 days.</p> <p>R8's progress note dated 1/31/25 at 08:39 [8:39 a.m.], indicated R8's skin was intact.</p> <p>During an interview on 2/10/25 at 4:07 p.m., R8 stated they have a sore in the crack of their butt. R8 stated staff they had the spot for a while, and staff placed cream on the area which helped.</p> <p>During observation and interview on 2/12/25 at 8:23 a.m., registered nurse (RN)-A stated R8 brought themselves to the bathroom and walked into R8's bathroom. R8 had their pants and incontinent product pulled down and bent over by waist with buttocks pulled apart. There was an open spot of skin approximately a quarter to half inch in length and width at the top area of R8's butt crack. R8 was placing their fingernails in the spot and stated the area was sore. RN-A looked closely at the area, looked around R8's bathroom, and stated there were no washcloths in R8's bathroom to wash the area. R8 pointed to the green tube of calmoseptine by their bathroom sink and stated the tube was the cream which helped. RN-A assisted R8 to sit on the toilet and left R8's room. R8 stated they had the spot for a long time, the area hurt when they wiped themselves, and cream helped the pain. R8 was provided privacy to use the bathroom.</p> <p>During observation and interview on 2/12/25 at 8:36 a.m., RN-A entered R8's room. R8 was on their bed with their pants pulled up, and R8 stated they were exhausted. RN-A exited R8's room and stated they could tell someone had taken care of the area previously and had to look at the chart to see if the area was noted before. RN-A stated the area looked like a skin split approximately half to three quarters of an inch.</p> <p>During an interview on 2/12/25 at 8:48 a.m., nursing assistant (NA)-A stated they reported new skin concerns to nursing staff, so they could assess if the area needed barrier cream, nystatin powder, or be left open to air. NA-A stated nurses completed weekly skin checks. NA-A stated R8 was independent most of the time and was already up by the time they got to work in the morning. NA-A stated the night shift reported they placed barrier cream on R8's bottom more than weeks ago, because the area looked red and for comfort.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 2:32 p.m., RN-A stated they did not return to R8 to look at their bottom and still needed to check R8's chart to see if the area was a change in condition. RN-A stated there was not a schedule to complete skin checks, and they facility had a lot of independent residents. RN-A stated the shower aid or other staff would tell them if there were any skin concerns, and then RN-A would check the resident's skin.</p> <p>During an interview on 2/12/25 at 2:53 p.m., NA-B stated R8 did not need help in the bathroom unless they had a bowel movement. NA-B stated they applied barrier cream to a lot of residents, including R8. NA-B stated R8's crack bothered R8, and NA-B applied cream to a red area on R8's bottom after R8 had a shower the week prior. NA-B stated they did not need to let the nurse know, because the area on R8's butt crack was just a little pink. NA-B stated they alerted the nurse when residents had skin changes, such as an open tear.</p> <p>During an interview on 2/13/25 at 3:13 p.m., the DON expected staff to alert nursing staff about any skin alterations, and the nurses documented on resident's skin after a skin assessment. DON stated R8 was independent with toileting during the day and needed more assistance at night. DON stated they were not aware of any open skin area or shearing on R8. DON stated they wanted to ensure R8 had the right treatment to decrease risk for infection and worsening of the area.</p> <p>The facility's Skin Monitoring policy dated 10/2021, directed the nursing assistants to check the residents' skin during each shower and notify the nurse of any skin alterations and any possible explanation. The policy directed staff to complete a Skin Observation Tool assessment for any skin alteration, such as a bruise, rash, open area, skin tear, blister, or any other skin alteration. Staff were to schedule a weekly assessment by a registered nurse as well as a treatment plan for healing when a skin alteration was found. Staff were to notify the DON of any skin issue for follow-up.</p>		

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NAME OF PROVIDER OR SUPPLIER Hope Springs at Minnetonka		STREET ADDRESS, CITY, STATE, ZIP CODE 16913 Highway 7 Minnetonka, MN 55345	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on observation, interview and document review, the facility failed to ensure a resident who wished to smoke off facility grounds was properly assessed for safety, and risks of unsupervised smoking were discussed for 1 of 1 resident (R5) reviewed for smoking. The facility further failed to ensure residents at risk for falls were assessed for a root cause and new interventions were put in place to prevent falls for 2 of 3 residents (R10 and R8) reviewed for falls.</p> <p>Findings include:</p> <p>R5</p> <p>R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact. The MDS further indicated R5 utilized a walker for locomotion and was independent with most activities of daily living (ADLs) except bathing.</p> <p>R5's progress note, dated 1/6/25, indicated R5 asked staff if it was okay for her to go outside and walk down the trail. Staff assured R5 it was okay as long as staff knew where she was. That afternoon R5 came back to facility smelling of smoke. R5 confirmed she was aware the care facility was a non-smoking facility but she would like to smoke off property. R5 was also informed that if her decision was to continue smoking, she would need to find alternative placement. R5 verbalized feeling overwhelmed and it was suggested that she take some time to think about what she wanted to do.</p> <p>R5's electronic medical record (EMR) lacked evidence a safe smoking assessment was completed on R5, risks of smoking unsupervised were discussed with R5, and any interventions were care planned to ensure R5's decision to occasionally smoke off campus was as safe as possible (i.e. ensuring staff knew when she was leaving campus, monitoring clothes for burn holes, etc).</p> <p>During an interview on 2/12/25 at 8:54 a.m., R5 stated she wanted to have the right to smoke off campus occasionally but did not want to leave the facility as she liked living there. R5 stated she had gone off campus by walking up the path off the parking lot twice to smoke. R5 stated when she came back the second time the aide had noticed she smelled like smoke and notified the director of nursing (DON). R5 stated she still had a pack of cigarettes and a lighter in her room but had not smoked since. R5 further stated staff had not assessed her for safe smoking, just told her she could not smoke as it was a non-smoking facility.</p> <p>During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated she was aware R5 had, and wanted to continue to smoke off campus, stating the facility had put up signs to indicate there was no smoking on the facility grounds. RN-A stated R5 was talked to by the DON and administrator but that a safe smoking assessment was not completed because they [residents] are not supposed to smoke. RN-A further stated R5 was asked about starting a nicotine patch but was not sure if she wanted one and had not been followed up with.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 12:59 p.m., the DON stated they held a meeting with the ombudsman and R5 had stated she did not want to smoke, however a few days ago she had informed the administrative assistant she did want to smoke. The DON confirmed they had not completed a safe smoking assessment for R5 or put any interventions into place to ensure R5 was as safe as possible if she chose to smoke off campus because they were a non-smoking facility, and she did not admit smokers.</p> <p>A facility policy on smoking assessments was requested but not received.</p> <p>R10</p> <p>R10's quarterly MDS dated [DATE], indicated R10 had moderate cognitive impairment, was independent with ambulation, and had one fall without injury since last assessment.</p> <p>R10's last two fall assessments, dated 9/10/24 and 11/5/24, both indicated that R10 was at risk for falls.</p> <p>R10's progress notes, dated 8/2/24 - 9/14/24, indicated R10 had three falls in the past 6 months, two out of three of them happening on a Thursday.</p> <p>On 8/2/24, it was documented R10 was found on the floor in her room.</p> <p>On 9/13/24, it was documented R10 was hospitalized after a fall in her bathroom while standing at her sink, resulting in a head strike and laceration above her left eye.</p> <p>On 11/5/24, it was documented R10 was found on the floor in her room and reported hitting her head.</p> <p>R10's care plan, printed 2/14/25, indicated R10 had a history of falls, most current on 11/5/24. R10's care plan indicated several fall interventions dated 2/23/24, and 9/17/24, including monitoring orthostatic blood pressure monthly (checking for blood pressure changes with position changes which may cause dizziness), using a wheelchair while at her bathroom sink and reminding R10 to always have her walker with her. The care plan lacked intervention updates for R10's falls in August and November.</p> <p>R10's Kardex, printed 2/14/25, was utilized by the facility nursing assistants (NA) to know what cares to provide a resident and any special instructions. The Kardex lacked any mention of R10 being a fall risk or any fall interventions.</p> <p>R10's electronic medical record (EMR) indicated the last 2 orthostatic blood pressure that were taken or recorded was on 6/13/24 and 9/9/24.</p> <p>The facility's Fall Tracking Book lacked any mention of the fall on 8/2/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R10's EMR identified that R10 was weak after receiving weekly ETC (Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions) on Wednesdays, however failed to implement new, care planned interventions for falls and post ECT monitoring despite R10 almost always falling on the Thursday after ECT.</p> <p>During an interview on 2/15/25 at 8:30 a.m., NA-A stated R10 was independent with most ADLs, including grooming and ambulation. NA-A stated when R10 came back from ECT she was weak and staff would offer her a wheelchair to go to lunch or watch her close at lunch if she refused her wheelchair. NA-A was unaware of any other fall interventions or post ECT monitoring.</p> <p>During an interview on 2/12/25 at 10:30 am, registered nurse (RN)-A stated R10 had ECT every Wednesdays and she would have the NAs keep her in her wheelchair when she arrived back to the facility. RN-A stated that was the only fall intervention or post ECT monitoring she was aware.</p> <p>During an interview on 2/13/25 at 12:59 p.m., the DON stated it would be expected that will each fall the nurse would be implementing a new intervention and writing the fall, root cause and interventions on the fall log. The DON stated at times she would be included in the conversation to help think outside the box to ensure a new intervention was always implemented. The DON confirmed R10's care plan and Kardex lacked interventions for post ECT monitoring and while staff were monitoring R10 closer when she returned to the community from ECT, the weakness continued into Thursday when most falls were happening. The DON further confirmed it would be expected that orthostatic blood pressures were monitored monthly as stated in R10's care plan.</p> <p>A facility policy titled Falls/Incidents, dated 8/2021, indicated nursing staff should determine the cause of the fall after each fall and implement and record what new intervention was being implemented to help prevent future falls.</p> <p>48299</p> <p>R8</p> <p>R8's quarterly Minimum Data Set (MDS) dated [DATE], indicated R8 had intact cognition and no delirium. R8 had delusions, verbal behaviors towards others and wandered one to three days, and did not reject cares. R8 had diagnoses of hypertension (high blood pressure), diabetes mellitus (chronic disease which affects how the body uses sugar for energy), arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety disorder, depression, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R8 had no upper or lower extremity impairments and used a walker. R8 required partial and/or moderate assistance with toileting hygiene, toilet transfers, and dressing. R8 was independent with footwear application and removal, rolling left and right, and with chair and/or bed-to-chair transfers. R8 was occasionally incontinent of urine. The MDS indicated R8 had one fall with no injury since the last assessment. R8 took antipsychotic, antianxiety, antidepressant, hypoglycemic, and anticonvulsant medication.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R8's Care Area Assessment (CAA) worksheet for falls dated 7/16/24, indicated R8 was at risk for falls related to fall history and antianxiety and antidepressant medication use. The CAA noted R8 had a history of falls in their room when getting up from their recliner and using their walker. R8 was at risk for falls, injury, discomfort, increased dependence on staff, decreased leisure, isolation, and further decline.</p> <p>R8's Fall Risk assessment dated [DATE], indicated R8 had one to two falls in the past three months, was ambulatory and continent, had intermittent confusion and/or forgets limitations, required use of assistive device, had systolic blood pressure drop less than 20 mmHg (millimeters of mercury) between lying and standing in three minutes, took three to four of medications the medication classes listed within the past seven days, and had three or more present predisposing conditions or diseases. R8 was at risk for falls.</p> <p>R8's Fall Risk assessment dated [DATE], indicated R8 had one to two falls in the past three months, was ambulatory and incontinent, was alert, had normal gait and/or balance, did not have a drop in systolic blood pressure between lying and standing, did not take psychoactive or other listed medication classes in the past seven days, and did not have predisposing conditions or diseases. The assessment indicated R8 was not at risk for falls.</p> <p>R8's fall care plan revised 11/13/24, indicated R8 was at moderate risk for falls related to confusion, gait and/or balance problems, incontinence, poor communication and/or comprehension, psychoactive drug use, and unaware of safety needs. The fall care plan indicated R8's last fall was on 11/13/24. Fall interventions included:</p> <ul style="list-style-type: none"> -11/13/24, be sure R8's call light within reach and encourage to use call light for assistance as needed. R8 needed prompt response to all requests for assistance. -11/13/24, encourage appropriate use of assistive device. -7/4/24, encourage R8 to sleep in bed and not recliner to promote good sleep and to prevent falls from R8 trying to get out of chair with the footrest up when R8 was confused. -4/13/24, ensure R8 wore appropriate footwear non-skid socks when ambulating or mobilizing in wheelchair. <p>R8's Kardex Report printed 2/12/25, directed staff to keep R8's call light within reach, encourage R8 to use for assistance as needed, and provide prompt response to R8's requests for assistance. Staff were to ensure R8 had an unobstructed path to the bathroom, wore appropriate footwear non-skid socks when ambulating or mobilizing in wheelchair, and encourage R8 to use assistive device.</p> <p>R8's progress note on 1/28/25 at 3:55 a.m., indicated R8 pushed their call light and was found sitting on the floor in front of their recliner in their apartment. The note indicated R8 stated they slid out of the recliner when trying to pick up a blanket which was on the floor. Range of motion of upper and lower extremities were intact and equal, vital signs were stable, and no injuries or pain were noted or reported. R8 used the bathroom and sat in their recliner covered with blankets. The director of nursing was notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility fall book indicated R8 had an unwitnessed fall from their recliner in their room on 1/28/25. The note indicated R8 tried to reach their blankets which were on the floor. Interventions included to remind R8 to use call light all the time to get assistance from staff and encourage R8 to sleep in bed instead of recliner.</p> <p>R8's medical record lacked evidence of fall prevention interventions based on a root cause analysis after the fall on 1/28/25.</p> <p>During interview on 2/12/25 at 10:52 a.m., nursing assistant (NA)-A stated they notified a nurse if they found a resident on the floor, and the nurse completed an assessment and obtained vital signs. Staff asked the resident what happened and what they were trying to do before the fall and assisted the resident back into a wheelchair, recliner, or bathroom. NA-A was unsure of fall interventions for R8. NA-A stated R8 was found on the ground before, and the facility found R8 placed themselves on the floor by reviewing the facility camera footage. NA-A stated R8 had previous falls, and staff helped R8 when needed.</p> <p>During interview on 2/12/25 at 2:53 p.m., NA-B stated fall interventions for R8 were to set up anything they need around them, ensure walker and call light were close by, check on R8 frequently, and remind R8 to use their call light and keep walker close to themselves.</p> <p>During interview on 2/13/25 at 11:55 a.m., licensed practical nurse (LPN)-A stated they have a fall tracker sheet which listed interventions to prevent future falls. LPN-A stated they take vitals, assessed for injury, asked the resident what happened, and completed neurological checks for unwitnessed falls.</p> <p>During interview on 2/13/25 at 3:13 p.m., the director of nursing (DON) stated nurses updated resident care plans with new interventions after a fall. DON brought fall information to QA (quality assurance) to discuss. DON stated R8 had two or three falls at night when first admitted and were recliner related. DON stated R8 knew they slept better in bed and talked about sleeping in bed at care conferences. DON reviewed R8's care plan and confirmed R8's fall care plan was not updated after R8's fall on 1/28/25. DON stated the fall interventions were repeated for R8 as they were unsure if the previous fall interventions were followed. DON thought they educated staff on R8's fall interventions or placed a note in their Homebase app (app used by businesses to assist with scheduling, payroll, communication) but did not provide documentation of such. DON stated if staff captured all the needed fall information in the progress notes and fall book, they would not have to write a four-page fall report. DON stated they have a fall book which they have not implemented yet to further analyze resident falls. DON stated creating and implementing fall interventions were important to prevent R8 from future falls and injury.</p> <p>The facility policy Falls/Incident dated 8/2021, directed staff to complete the Fall/Incident report and a progress note detailing the fall/incident, vital signs, and who was notified. The policy directed staff to chart under Fall Risk Assessments and in the fall tracking book about what type of fall occurred and the intervention implemented to prevent further falls/incidents. The policy directed staff to chart the date of the fall/incident and implemented intervention in the care plan.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on observation, interview and document review the facility failed to comprehensively assess pain and attempt non-pharmacological pain interventions for 1 of 1 resident (R11) receiving multiple medications for pain.</p> <p>Findings include:</p> <p>R11's quarterly Minimum Data Set (MDS), dated [DATE], indicated R11 was cognitively intact and had pain almost constantly that frequently effected sleep and day to day activities. The MDS further indicated R11 had received pain medication during the look back period however had not received any non-pharmacological pain interventions.</p> <p>R11's Orders, printed on 2/13/25, indicated R11 received several medications for pain including Ajovy (used to prevent migraine headaches) 225 milligram (mg)/1.5 milliliters (ml) inject subcutaneously once a month for intractable migraines, alpha-lipoic acid (used in alternative medicine to aide treating nerve pain) 300mg by mouth two times a day for polyneuropathy (a condition where multiple peripheral nerves throughout the body become damaged or malfunction which may cause numbness, tingling, burning or stabbing pain), Gabapentin (commonly used medication for the treatment of neuropathic pain) 1200 mg by mouth three times a day for polyneuropathy, diclofenac sodium gel 1% (a medication used to relieve pain and inflammation associated with arthritis, sprains, and other musculoskeletal conditions) apply to neck, shoulders and arms as needed for pain (self-administered), Humira 40 mg/0.4 ml (a medication used to treat arthritis) inject 80mg subcutaneously one time a day every 14 days for arthropathic psoriasis (chronic inflammatory condition that affects the joints causing joint pain, stiffness and swelling), and Nurtec (a medication used to treat migraines) 75 mg sublingually daily as needed for migraine (received on 2/10/25).</p> <p>R11's care plan, dated 6/26/24, indicated R11 was on pain medication therapy related to neuropathy, bladder spasms, muscle tendon pain and migraines and R11 had chronic pain related to psoriatic arthritis, depression, neuropathy and migraines. The care plan lacked resident specific non-pharmacological pain interventions.</p> <p>R11's electronic medical record (EMR), including the medication administration record (MAR) lacked any pain assessment in the past seven months to include pain goal, what makes pain better or worse and non-pharmacological interventions that were tried and successful or unsuccessful.</p> <p>During an interview on 2/10/25 at 6:00 p.m., R11 stated she had pain almost constantly but did not want to take more medication. R11 denies staff attempting to use non-pharmacological pain interventions and stated staff do not ask her about her pain levels or what makes it better or worse.</p> <p>During an interview on 2/13/25 at 8:21 a.m., licensed practical nurse (LPN)-A stated pain assessments should be conducted at least quarterly but also anytime a resident received a pain medication, the MAR would prompt staff to record the resident's pain level. LPN-A stated R11 had an implanted pain device in her neck and was working with a pain clinic, but they did not use any non-pharmacological pain interventions with her. LPN-A stated they would only implement non-pharmacological pain interventions if it was ordered by the doctor.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 8:27 a.m., nursing assistant (NA)-C stated R11 had complaints of stomach pains and migraines, and most recently had been complaining of pain a lot stating she believed it to be behavioral. NA-C stated she had not been told about any non-pharmacological pain intervention for R11 and had not tried anything herself for R11's pain.</p> <p>During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) confirmed that there were no non-pharmacological pain interventions for R11. The DON stated when staff were administering R11's diclofenac sodium gel the nurses were prompted by the medication administration record (MAR) to ask about R11's pain level but since R11 was self-administering the medication the pain assessment piece had fallen off.</p> <p>A facility on pain management was requested and not available at the time of survey.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure alternate interventions were assessed and/or attempted, risks and benefits of bed assist devices were reviewed, and consent was obtained for 1 of 2 residents (R9) reviewed for bed assist devices. Furthermore, the facility failed to remove a bed assist device or re-evaluate its use after an assessment indicated the bed assist device was not needed for 1 of 2 residents (R14) reviewed for bed assist devices.</p> <p>Findings include:</p> <p>R9</p> <p>R9's quarterly minimum data set (MDS) dated [DATE], indicated R9 had moderately impaired cognition, inattention, disorganized thinking, hallucinations, delusions, verbal and other behaviors, and rejected cares. R9 had no upper or lower extremity impairments and used a walker. R9 required partial and/or moderate assistance for dressing and supervision for footwear application and removal, toileting, personal and oral hygiene, and ambulation. The MDS indicated R9 had arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). The MDS indicated bed rails were not in use.</p> <p>R9's care plan dated 11/13/24, did not indicate use of a bed assist device.</p> <p>R9's admission Bedrails Risk Assessment Flow Chart dated 6/7/24, indicated R9 did not need bed rails.</p> <p>A progress note dated 6/2/24 at 01:35 [1:35 a.m.], indicated staff tied R9's call light to their left siderail.</p> <p>A progress note dated 6/15/24 at 07:27 [7:27 a.m.], indicated staff tied R9's call light to their side rail.</p> <p>A progress note dated 7/15/24 at 06:38 [6:38 a.m.], indicated R9 detached the call light attached to their bed siderail twice.</p> <p>R9's medical chart did not mention anything further on bed assist device use, education of risks and benefits, consent, or attempted alternatives prior to installation of the bed rail.</p> <p>During observation and interview on 2/10/25 at 2:45 p.m., the left side of R9's bed was against the wall, and a bed assist device was on the right-hand side of R9's bed. R9 stated they did not use the device, did not have to sign anything for the device in place, and the device was in place when they admitted .</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R14</p> <p>R14's annual MDS dated [DATE], indicated R14 had intact cognition, had no behaviors, and was independent for most activities of daily living. R14 had diagnoses of diabetes mellitus (condition when blood sugar is too high), anxiety, depression, and schizophrenia. The MDS indicated bed rails were not in use.</p> <p>R14's care plan dated 1/8/25, did not indicate use of bed assist device.</p> <p>R14's Bedrails Risk Assessment Flow Chart Tool dated 12/29/21, indicated use of bed rails was beneficial for R14.</p> <p>R14's Bed Rails Risk Assessment Decision to Use form dated 12/30/21, indicated R14 used bed rail for repositioning and easy access to bed controls and personal care items. The form indicated R14 was educated how to use the bed rail, about the need for bed rails, and its use.</p> <p>R14's quarterly Bedrails Risk Assessment Flow Chart dated 6/11/23, indicated bed rails were not needed.</p> <p>R14's chart did not contain any other bed assist device assessments.</p> <p>R14's progress note dated 7/30/24 at 17:51 [5:51 p.m.], indicated staff placed call light to R14's siderail.</p> <p>R14's progress note dated 11/6/24 at 02:48 [2:48 a.m.], indicated staff secured call light to grab bar.</p> <p>During observation and interview on 2/10/25 at 5:28 p.m., R14 had a bed assist device on the right side of their bed. R14 stated they did not use the device and did not remember if anyone educated them about the risks and benefits and obtained consent for use.</p> <p>During an interview on 2/12/25 at 10:37 a.m., nursing assistant (NA)-A stated R9 required supervision to limited assistance with morning activities of daily living. NA-A they were not sure how often R9 used their bed assistive device and saw R9 grab the device to lift out of bed and then grab their walker. NA-A stated R14 required more assistance after a fall but moved back to their original room on the first floor once their strength returned and they were more independent again.</p> <p>During an interview on 2/12/25 at 2:32 p.m., registered nurse (RN)-A stated they did not complete bed rail assessments and was unsure about other nursing staff.</p> <p>During an interview on 2/12/25 at 2:45 p.m., NA-B stated R9 used the device on their bed to get out of bed. NA-B stated R14 was independent.</p> <p>During an interview on 2/13/25 at 2:20 p.m., the administrator stated they installed bed assist devices when the director of nursing (DON) communicated the need to them.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 3:31 p.m., DON stated bed rail assessments were completed upon admission and quarterly. DON stated other nursing staff were able to complete bed rail assessments and told DON what residents needed bed assist devices applied. DON expected notification if any assessment indicated a change in bed assist device use. DON stated they thought they were told R9 needed a bed assist device and verified R9 did not have a consent or education of risks and benefits in their chart. DON stated R14's bed assist device was part of a fall intervention after R14 got out of the right side of bed, slipped, and fell . DON was not aware of R14's bed rail assessment which indicated R14 did not need bed rails.</p> <p>The facility policy Bed Rails Assessment and Use Policy dated 6/2023, directed staff to use the Bed Rails Risk Assessment form to determine if bed rails were appropriate upon admission, quarterly, and as change in resident's health condition. The assessment may result in bed rail removal if determined resident's condition has improved for which the bed rail was installed. The policy directed staff to discuss the need for bed rails, risks and benefits, and obtain an informed consent prior to installation.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>51577</p> <p>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 21 residents who resided in the facility.</p> <p>Findings include:</p> <p>The PBJ (Payroll Based Journal) Staffing Data Report triggered for no continuous 8-hour RN coverage in 24-hour period for four or more days within 4th quarter. Infraction dates were 7/17/24, 7/18/24, 7/24/24, 7/26/24, 9/21/24 and 9/22/24.</p> <p>Document review of the schedule from 10/1/24 - 2/9/25, identified the facility failed to have RN coverage for the dates of: 11/9/24, 11/10/24, 11/28/24, 11/29/24, 12/21/24, 12/25/24, 1/1/25, 1/18/25 and 1/20/25.</p> <p>During interview on 2/10/25 at 9:37 a.m., R12 stated no concerns were reported in resident council. R12 stated the facility was staffed very well with knowledgeable and well-established staff.</p> <p>During interview on 2/13/25 at 1:03 p.m., director of nursing (DON) indicated they were responsible for staffing the facility and submitting the PBJ reports. They confirmed the facility did not have eight hours of continuous RN coverage daily, however, stated there was proper coverage with regularly scheduled competent staff, and stressed the importance of continuity of care of licensed staff for the residents outweighing the title of RN over LPN (licensed practical nurse), and the skill set to care for these residents was met with an LPN. The focus of individual care plans for residents was important, as important to survey to individual care of facilities.</p> <p>A facility' policy on staffing was requested, not received.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</p> <p>Based on observation, interview and document review the facility failed to ensure the appropriate, modified diet was given, and risks versus benefits of refusing a modified diet were discussed with 1 of 2 residents (R18) who had difficulty swallowing and recent coughing episodes after meals.</p> <p>Findings include:</p> <p>R18's quarterly [NAME] Data Set (MDS), dated [DATE], indicated R18 was admitted to the care facility on 11/8/23, and was cognitively intact. The MDS further indicated R18 had coughing/choking episodes during meals.</p> <p>R18's Diagnoses, dated 11/7/23, indicated R18 had several medical diagnoses including dysphagia (difficulty swallowing) and moderate protein-calorie malnutrition.</p> <p>R18's Orders, dated 7/15/24, indicated an order for mechanical soft texture, regular consistency, easy to chew texture.</p> <p>R18's Care Plan, dated 11/24/23, and revised on 2/10/25, indicated R18 was able to feed himself and staff was to provide soft food and ground meat, indicating at times R18 would ask that his meat not be ground. The care plan further indicated R18 had been offered, and declined, a pureed diet on 5/28/24.</p> <p>R18's Kardex, printed 2/14/25, indicated R18 was to receive soft foods and ground meat, however, would sometimes ask that meat not be ground up.</p> <p>The Resident's Diets book, utilized by the cooks in the kitchen to ensure the residents received the correct diet and food texture, indicated R18 should have food cut into small, bite sized pieces.</p> <p>R18's progress notes, dated 1/14/25 - 2/14/25, indicated R18 had 11 coughing episodes during meals in the past 30 days.</p> <p>On 1/14/25, it was documented R18 consumed 100% of his meal (soup and grilled cheese) and did have some coughing during and after his meal.</p> <p>On 1/15/25, it was documented R18 attended dinner and did cough a little while eating. He eats a mechanical soft diet.</p> <p>On 1/31/25, it was documented R18 appeared to have a cough.</p> <p>On 2/1/25, it was documented R18 was coughing during his supper meal again and had chili, consumed most of it including a corn muffin.</p> <p>On 2/2/25, it was documented R18 only ate his soup for supper, coughed & sneezed off & on and then once he got to the elevator to go back upstairs, he started coughing quite hard again.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/2/25, it was documented R18 was asked if he was having difficulty at mealtime in swallowing his food and/or fluids evidenced by his increased coughing spells that nursing (and some concerned residents) have observed. [R18] [NAME][ed] having any swallowing difficulties and offered no other information.</p> <p>On 2/3/25, it was documented R18 was heard by writer coughing as he was entering his room after lunch. Writer was 2 rooms down and could hear the resident cough x2 hard to the point where he almost vomited.</p> <p>On 2/4/25, it was documented R18 was coughing a little at dinner.</p> <p>On 2/5/25, it was documented R18 ate a hamburger for supper and had coughing during his meal per usual. He [was] supposed to have mechanical soft texture, but resident chooses not to per his request. He denied any difficulty chewing or swallowing his hamburger meat.</p> <p>On 2/6/25, it was documented R18 requested the crispy chicken sandwich for dinner and stated No when asked if he wanted to ground up for easy chewing/swallowing. R18 was documented as coughing while eating his crispy chicken sandwich.</p> <p>On 2/12/25, it was documented R18 ate grilled cheese and tomato soup with some coughing noted.</p> <p>During observation on 02/12/25 at 8:13 a.m., R18 was sitting at the breakfast table eating a bowl of corn flakes, eggs, raisin toast and bacon.</p> <p>During an interview on 2/12/25 at 8:30 a.m., nursing assistant (NA)-A stated the nursing assistants utilized the Kardex to now how to care for residents, how they transfer, level of assistance needed, their diet, etc. NA-A stated R18 was on a regular diet and staff cut up his food into bite sized pieces.</p> <p>During an interview on 2/12/25 at 8:51 a.m., R18 stated he should be eating his food cut up into bite sized pieces but did not always receive it that way. R18 stated he had not had any discussions with staff on the risks versus benefits of his food choices, including the risks of aspiration or choking.</p> <p>During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated R18 received his medications crushed in applesauce and was supposed to receive a soft diet but she was not down in the dining room during mealtimes so could not confirm what type of diet staff were providing R18, stating R18 would eat whatever was put in front of him.</p> <p>During observation and interview on 2/12/25 at 12:08 p.m., R18 was given a plate of potato wedges, broccoli salad and barbeque ribs, nothing on the plate was cut into bit sized pieces. R18 attempted to cut a few bites of meat but was unsuccessful and sat and stared at his food after eating a few bites until NA-A removed his full plate of food without offer to help cut up his food. NA-A stated his meat should have been cut up into bite sized pieces, stating she did not offer to cut it up because even if it was, he wouldn't eat it.</p> <p>(continued on next page)</p>		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) stated the expectation was for R18 to receive minced meat however she had found out last week that he was refusing at times. The DON confirmed she had not discussed risks versus benefits of refusing his prescribed diet, stating she needed to have a discussion with R18 to address his food choices and the risks of refusing to have his meat minced. A facility policy regarding modified diets was requested but not received.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure cups were completely dry before storing and stacked bowls stayed dry to prevent bacterial growth. In addition, the facility failed to ensure food items were properly labeled and dated, failed to ensure staff covered their hair, assess food temperature during food prep, and to ensure staff followed appropriate infection control technique during food service. This had potential to affect all 21 residents who were served food from the kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour on [DATE] at 12:26 p.m., a refrigerator in the main kitchen had sliced cheese with no opened date or expiration date and half of Smithfield boneless ham wrapped in plastic with expiration date of February 26, 2025 and no opened date. The freezer in the main kitchen area had a few packages of bratwurst unlabeled and not dated, multiple packaged tortillas with no label or date, and a packaged cheese omelet with white flakes with no date on them. The clean dish area had four stacks of clean cups, and multiple cups had condensation between them. Clean bowls were stacked upright, and condensation was observed in the first, second, and third bowl.</p> <p>During an interview on [DATE] at 12:45 p.m., dietary aid (DA)-A, who also cooked, confirmed the observations and stated the ham was used on Saturday, two days prior, and was not sure how long the brats, omelet, or tortillas were in the freezer. DA-A stated dishes needed to be dry before stacking.</p> <p>During observation on [DATE] at 11:51 a.m., DA-A wore a headband with two long loose braids halfway down their back and no hair net. DA-A had gloves on and used a knife to cut celery on a cutting board. DA-A removed gloves and stirred the beef in a pan on the stove. DA-A applied gloves and placed the celery in the pan with the beef. DA-A placed the cutting board and knife in the dirty area of the dish machine area, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A prepped one plate with spaghetti and broccoli and gave to staff to serve. DA-A removed gloves, did not perform hand hygiene, applied new gloves, and placed cooked spaghetti noodles in the pan with the beef. DA-A plated multiple plates of the noodles and beef and broccoli and some plates with small pizza circles using tongs and utensils. One pizza circle fell on to the table, and DA-A used utensil to throw the pizza away. DA-A placed broccoli onto the plates of pizza, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A gave plates of food to staff to serve in the dining area, cut pizza in half, continued meal service, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A placed dish soap onto dishes and scrubbed some dishes, rinsed, and placed in dish machine. DA-A removed gloves and placed dirty pan into the dirty area of the dish machine area. DA-A grabbed a package of a small pizza circle from the freezer and placed on the counter by the microwave. DA-A did not perform hand hygiene, applied gloves, put the pizza in the microwave, grabbed a blender from the dish machine, blended and plated the food, placed the blender into the dirty area of the dish room, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A removed the pizza from the microwave, plated the pizza and broccoli, and served.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on [DATE] at 12:23 p.m., DA-A stated they checked the broccoli temperature but did not take the temperature of the beef served with the meal or the one pizza circle cooked in the microwave. DA-A stated they cooked the pizza in the microwave based on the time frames listed on the package and had prepped the beef for a long enough time for it to be cooked. DA-A verified they had not worn a hair net today or the day prior and did not know where the hair nets were until the previous day. DA-A verified they had not washed their hands and were supposed to wash their hands with every glove change, but indicated they did not unless they touched a food item or had dirty hands for time management purposes.</p> <p>During observation on [DATE] at 11:45 a.m., DA-B, who also cooked, temped the food, washed their hand, applied gloves, and dished up salad and barbeque pork. DA-B wore a stocking cap and had a beard. A longer loose hair dangled from DA-B's chin as they scooped salad onto plates. DA-B continued plating food and gave to staff to serve without a beard net.</p> <p>During interview on [DATE] at 12:23 p.m., DA-B stated they took the temperature of food before they served. DA-B stated they labeled food when opened and when taken out of its original package, and food was rotated daily so new food was towards the back and older stock would be used first. DA-B stated they changed gloves and wash hands when changing tasks or anytime there was a chance of cross contamination. DA-B stated they had hairnets and needed to wear them, or a hat, when in the kitchen to keep their hair covered. DA-B stated a quarter inch of hair was okay without a beard net and thought the hair on their chin and sides of face was an okay length, but agreed their mustache needed to be covered.</p> <p>During interview on [DATE] at 2:27 p.m., the administrator expected staff to check the temperature of served food to ensure the food was at appropriate to prevent sickness for those who consumed the food. The administrator expected items to be thrown when expired and products to be labeled when opened and taken out of the original box. Staff was expected to cover their hair in the kitchen, including facial hair. It was also expected dishes would air dry before stacking to ensure no contamination. The administrator expected staff to wash their hands between gloves changes, especially after completion of dirty tasks and before clean tasks with food.</p> <p>The facility policy Food Receiving and Storage dated ,d+[DATE], indicated all food stored in the refrigerator or freezer would be covered, labeled, and dated with use by date. The policy indicated all dishes, silverware, pots, and pans were air-dried.</p> <p>The facility policy Dietary Areas- Cleanliness, Safety, Organization, and Regulations dated 2023, directed staff with significant facial beard and/or mustache to wear facial beard nets and hairnets or hats were to be used by all dietary personnel or hair pulled back into secure pony. The policy directed staff to label food with the date it was opened.</p> <p>The facility policy Dietary Gloves and Handwashing dated ,d+[DATE], directed staff to remove gloves, wash hands, and apply new gloves after contact with items such as refrigerator, stove, freezer, and dirty dishes.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>47495</p> <p>Based on interview and document review the facility failed to maintain documentation and demonstrate evidence of a comprehensive, data-driven quality assurance and performance improvement (QAPI) program. These findings had potential to affect all 21 residents residing within the facility.</p> <p>Findings include:</p> <p>During an interview on 2/13/25 at 2:49 the director of nursing (DON) stated the QA committee, consisting of herself, the administrator and the medical director, met quarterly to review adverse events. However, the committee did not have a system to identify, collect and use data from all departments and had not identified any opportunities for improvement or performance improvement projects to implement. The DON further stated the facility did not record any meeting minutes or documentation of their ongoing QA meetings.</p> <p>A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, QA [quality assurance] and PI [performance improvement] combine to form QAPI, a comprehensive approach to ensuring high quality care. QAPI concerns, updates, or changes are reviewed and discussed at the quarterly QAA meeting.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>47495</p> <p>Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee identified and implement performance improvement projects to address any identified concerns. These findings had potential to affect all 21 residents residing within the facility.</p> <p>Findings include:</p> <p>During an interview on 2/13/25 at 2:49 the director of nursing (DON) stated the QA committee, consisting of herself, the administrator and the medical director, met quarterly to review adverse events. However, the committee did not have a system to identify, collect and use data from all departments and had not identified any opportunities for improvement or performance improvement projects to implement.</p> <p>A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, a Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>47495</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and document review the facility failed to ensure the Quality Assurance (QA) committee consisted of the minimum required members. These findings had potential to affect all 21 residents residing within the facility.</p> <p>Findings include:</p> <p>During an interview on 2/13/25 at 2:49 p.m., the director of nursing (DON) stated the committee, consisting of herself (also the infection preventionist), the administrator and the medical director, met quarterly to review adverse events. The DON confirmed the QA did not consist of at least two additional staff members to meet the required members however, they had discussed having a nursing assistant join the committee.</p> <p>A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, members of the team will include the Administrator and Director of Nursing (DON), the medical director and other key staff members from other departments, along with a designated resident as designated by the Resident Council if they wish to participate, and family or guardians if they wish to participate.</p>		