STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Springs at Minnetonka	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)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review the facility failed to submit accurate data for staffing information, including agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 1 2026) to the centers for Medicare and Medicaid (CMS) according to specifications established by CMS. This had the potential to affect all 21 residents living in the facility.Findings include:Review of the Payroll Based Journal (PBJ) [NAME] Report 1705D for quarter 1 2026 (October 1st through December 31st), identified the metric for excessively low weekend staffing, and failure to have licensed nursing coverage for 24/hours a day had been triggered for the facility on the following days: 10/1/25, 10/11/25, 11/28/25, 11/29/25, 12/28/25, 12/29/25.Review of the facility's schedule and nursing staff census sheets for quarter 1 2026, indicated the facility did in fact have appropriate coverage on the weekends and 24 hours licensed coverage, however, indicated incorrect data had been reported for the PBJ to CMS. On 6/4/26 at 1026 a.m., the bookkeeper (BK) confirmed they were responsible for reporting the PBJ data for the facility. BK stated they did not have access to the schedule, and they would use the bills from the agency staffing companies as the source for their data. Due to being unable to view/access the schedule they couldn't navigate the data and see when the agency staff had been scheduled or working and had therefore been entering incorrect data based on what they had available to them.On 6/3/26 at 2:30 p.m., the administrator confirmed the BK did not have access to the facility schedule and based the reporting data off of the payroll invoices and not the schedule.A policy for staff reporting was requested and none was provided.

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

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

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview the facility failed to ensure Quality Assurance Performance Improvement (QAPI) meetings were held on a quarterly basis. This had the potential to affect all 21 residents residing at the facility.Findings include:On 6/3/26 at 9:17a.m., The last 3 meeting minutes for QAPI had been requested via email, one of the three requested was provided for April 6th. The other two meeting minutes requested were requested again on 6/3/26 at 12:30 p.m., 6/3/26 at 3:45 p.m., and 6/4/26 at 8:40a.m., Neither were provided.On 6/4/26 at 12:38 p.m., the Director of nursing (DON) stated the facility had not conducted their QAPI meeting in January, had planned to reschedule the meeting, however, were unable to. Furthermore, the DON stated they had met in the fall, however, were unable to open the notes. The opportunity was presented for them to resend them or send in another format. The document was never provided.The Quality Assurance and Performance Improvement Plan last updated 6/19/2024, indicated the QAPI concerns, updates, or changes are to be reviewed and discussed at the quarterly meetings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to obtain informed consents including risk and benefit for 1 of 5 residents (R11) reviewed for psychotropic medications.Findings include:R11's quarterly minimum data set (MDS) dated [DATE], indicated R11 was admitted [DATE], was severely cognitively impaired and had the following diagnoses: Hyperlipidemia (HLD) (high levels of fat in the blood), Alzheimer's Disease, non-Alzheimer's Dementia, anxiety, and schizophrenia. R11's Order Summary Report dated 6/3/26, indicated R11 was currently prescribed Clozaril (anti-psychotic) start date 10/20/25, Lexapro (anti-depressant) start date 5/7/2018, lorazepam (antianxiety) start date 8/19/2026, and Olanzapine (anti-psychotic) start date 10/20/25.R11's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed.On 6/3/26 at 11:42 a.m., the director of nursing (DON) stated they were responsible for completing the consents for psychotropics. The DON stated they did not have R11 sign the consent because they felt that R11 was unable to do so cognitively. The DON stated R11 has windows of lucidity, and confusion, and was their own decision maker. The DON stated they had been working to get R11 guardianship in place, however, had been thus far unsuccessful. The DON confirmed they made the decision for R11 to not sign themselves without speaking to R11 and did not include any other interdisciplinary members in the decision and could have included other interdisciplinary members of the care team however, they did not.The facility Psychotropic Medications policy last reviewed 7/2023, indicated nursing will document discussion with the resident and/or responsible party regarding the risk versus benefits of the use of these medications including in the discussion and written consent will be obtained.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to obtain diagnostic testing related to recommendations from a speech language pathology (SLP) evaluation for 1 of 1 resident (R11) reviewed for SLP recommendations.Findings include:R11's quarterly minimum data set (MDS) dated [DATE], indicated R11 was admitted [DATE], was severely cognitively impaired and had the following diagnoses: Hyperlipidemia (HLD) (high levels of fat in the blood), Alzheimer's Disease, non-Alzheimer's Dementia, anxiety, and schizophrenia. The Speech Language Pathology Initial Evaluation and Treatment Telehealth visit dated 12/11/25, indicated a referral had been made by R11's primary care provider (PCP) to SLP for evaluation. The report indicated R11 had the diagnosis of dysphagia (difficulty swallowing) and the need for instrumental imaging of swallow and was required to provide intervention for decreased aspiration and choking risk, and improve the residents quality of life.The Speech Language Pathology discharge report dated 12-29-26, indicated the SLP's evaluation recommended swallowing imaging, either a modified barium swallow study, or flexible endoscopic evaluation of swallow to assess impaired structures or musculature, as well as to determine the safest, least restrictive diet. Furthermore, the document indicated R11 was being discharged from SLP and stated Nursing director (DON) and SLP agree to discharge the speech orders for ongoing treatment to obtain new orders if the swallowing imaging assessment indicated the need for further speech dysphagia intervention.R11's chart lacked any evidence of the above listed diagnostic testing ever being completed.On 6/3/26 at 11:10 a.m. the speech language pathologist (SLP)-A stated they remember evaluating R11 and diagnostic imaging was needed to assess the resident's further speech needs. SLP-A stated they spoke to the DON, and the DON would inform the provider and obtain the orders and imaging. SLP-A stated they never heard back from the DON regarding the diagnostic testing, and they typically don't follow up unless further evaluations are ordered.The Appointment referral dated 1/21/26, indicated the provider had signed an order to continue SLP treatment.On 6/3/26 at 11:42 a.m. DON confirmed R11 was discharged from SLP services to pursue diagnostic testing in December. The DON confirmed they were responsible for completing those updates to the provider, and ensuring the diagnostic testing was conducted. However, the DON confirmed the diagnostic testing was never performed, and speech was never continued as per provider orders. The DON stated the orders were missed and never passed on and spoke to the importance of completing referral orders because they should have been completed as ordered.A policy for following physician orders was requested and none was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and interview, the facility failed to report a COVID-19 outbreak in their facility. This had the potential to affect all 21 residents in the facility, staff, and visitors.Findings include:According to the Minnesota Department of Health website (MDH) https://www.health.state.mn.us/diseases/coronavirus/hcp/report.html, SARS-CoV-2 Infection (COVID-19) must be reported to MDH within one working day.The Quarterly infection Control Log undated, indicated one staff member (LPN-A) tested positive for COVID-19 on 5/2/25 and one resident R7 tested positive for COVID-19 on 5/3/26. The facility provided evidence that the staff was sent home and R7 was put on precautions. However, no evidence was provided to show the outbreak was reported to state officials per regulations.On 6/3/26 at 2:28 p.m., the Director of Nursing (DON) confirmed the facility had a COVID-19 outbreak of one staff and 1 resident, and furthermore, it was never reported to MDH. The DON stated the task of reporting was previously done by a recently retired staff member, and the task of reporting had not been passed on to anyone else. The DON stated the importance of reporting outbreaks to aid tracking of the disease.The facility Public Health and Reportable Disease Reporting procedure reviewed 6/4/26, indicated when urgent reporting is required, make the initial public-health notification as soon as practicable and supplement additional information when it becomes available.