DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2026

Administrator
Hilltop Health Care Center
410 LUELLA STREET
WATKINS, MN 55389

RE: CCN:245358
Cycle Start Date: May 12, 2026

Dear Administrator:

On May 12, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section

above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 12, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 12, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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May 21, 2026

Administrator
Hilltop Health Care Center
410 LUELLA STREET
WATKINS, MN 55389

Re: Event ID: 230F6C-H1

Dear Administrator:

The above facility survey was completed on May 12, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 5/12/2026. At the time of this survey, Hilltop Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/29/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245358	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hilltop Care Center Building 01 was constructed in 1978, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/29/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K0353	1. Corrective action taken or planned to correct the deficiency: The facility will ensure the required sprinkler	07/01/2026

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K0353 SS = F Bldg. 01	Continued from page 2 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2 and 5.2.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 5/12/2026 between 09:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire sprinkler was inspected during the fourth quarter of 2025. On 5/12/2026 at 11:09 AM, it was revealed by observation that a sprinkler in the soiled utility room 127 had paint on it. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353	Continued from page 2 inspection is completed during the fourth quarter going forward, including the fourth quarter of 2026. The painted sprinkler head identified in soiled utility room 127 will be replaced. 2. Measures put into place to ensure the deficiency does not reoccur: The Administrator or designee will verify and sign off that required quarterly sprinkler inspections are completed as scheduled. In addition, all sprinkler heads throughout the facility will be inspected to ensure they are free from paint or damage and replaced if necessary. 3. Monitoring plan to ensure continued compliance: Documentation of quarterly sprinkler inspections will be reviewed and signed off by the Administrator and Maintenance Director or designee to ensure compliance. Findings and compliance monitoring will be reviewed through the facility's QAPI process. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1st, 2026.	07/01/2026

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K0901 SS = F Bldg. 01	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 5/12/2026 between 9:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey that at the time of the survey the facility could not provide a risk assessment of the facility being completed using chapters 10 and 11 of NFPA 99 (2012 edition), Health Care Facilities Code. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0901	1. Corrective action taken or planned to correct the deficiency: No residents were identified as being negatively affected by the deficient practice. Upon notification of the survey findings, facility administration initiated a review of NFPA 99 Chapters 10 and 11 requirements. The facility will complete and maintain a documented risk assessment in accordance with NFPA 99 requirements. Any deficiencies identified during the review process will be corrected. 2. Measures put into place to ensure the deficiency does not reoccur: The facility will conduct a comprehensive review of applicable systems, equipment, policies, procedures, and documentation related to NFPA 99 Chapters 10 and 11 to ensure ongoing compliance. The required risk assessment documentation will be maintained and readily available for review. 3. Monitoring plan to ensure continued compliance: The facility will consult with qualified life safety/code compliance personnel regarding applicable NFPA 99 Chapter 10 and 11 requirements and ongoing compliance expectations. The Maintenance Director or designee will conduct periodic audits to verify required documentation remains current and compliant. Findings will be reviewed through the facility's QAPI process for ongoing oversight. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1, 2026.	07/01/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current,	K0921	1. Corrective action taken or planned to correct the deficiency: No residents were identified as being negatively affected by the deficient practice. The facility utilizes MNMedical to perform inspection and testing of patient care-related electrical appliances and equipment (PCREE). Following the survey, the facility	07/01/2026

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K0921 SS = F Bldg. 01	Continued from page 4 and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 5/12/2026 between 9:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0921	Continued from page 4 obtained and organized the required testing documentation that was not readily available at the time of survey. 2. Measures put into place to ensure the deficiency does not reoccur: The facility reviewed all patient care-related electrical equipment records to verify current inspection and testing documentation is available for all applicable equipment. A centralized log and organized recordkeeping system will be maintained for all PCREE inspection, testing, maintenance, repair, and modification documentation. The Maintenance Director or designee will ensure all future reports are retained and readily accessible for survey review. Related policies and procedures will be reviewed and updated as needed. 3. Monitoring plan to ensure continued compliance: The Maintenance Director and/or Administrator will conduct monthly audits for three months to verify required testing documentation remains current, complete, and readily accessible. Findings will be reviewed through the facility's QAPI process, and corrective action will be taken as needed to ensure sustained compliance. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1, 2026.	07/01/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K0321	1. Corrective action taken or planned to correct the deficiency: The device being used to hold open the soiled utility room door (311B) was removed. The door now remains closed and functions as intended in	07/01/2026

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K0321 SS = E Bldg. 01	Continued from page 5 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 5/12/2026 at 11:17 AM, it was revealed by observation that the door to the soiled utility room 311B was being held open with a device that does not drop the door when the fire alarm is activated.	K0321	Continued from page 5 accordance with Life Safety Code requirements. 2. Measures put into place to ensure the deficiency does not reoccur: Staff were instructed that hazardous area doors must remain closed unless equipped with an approved automatic release device. 3. Monitoring plan to ensure continued compliance: The Maintenance Director or designee will conduct weekly audits of hazardous area/fire doors for one month to ensure doors are not improperly held open. Following the initial monitoring period, audits will continue on a random basis. Audit findings will be reviewed through the facility's QAPI process for ongoing compliance monitoring. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1, 2026.	07/01/2026

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K0321 SS = E Bldg. 01	Continued from page 6 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		07/01/2026
K0363 SS = E Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility.	K0363	1. Corrective action taken or planned to correct the deficiency: Doors to resident room 218, storage room 308, the medical supplies room across from resident room 324, and resident room 332 were inspected and repaired to ensure proper closing and positive latching. The rubber wedge used to hold open the door to resident room 332 was removed. 2. Measures put into place to ensure the deficiency does not reoccur: An audit of corridor and latch-equipped doors throughout the facility will be conducted to ensure doors properly close and latch in accordance with Life Safety Code requirements. Staff were educated not to use wedges or other unapproved devices to hold doors open. 3. Monitoring plan to ensure continued compliance: The Maintenance Director or designee will complete monthly audits of corridor doors for three months to verify proper operation, closing, and latching. Findings will be reviewed through the facility's QAPI process to ensure ongoing compliance and sustained corrective action. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1, 2026.	07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245358	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0363 SS = E Bldg. 01	Continued from page 7 Findings include: 1. On 5/12/2026 at 11:11 AM, it was revealed by observation that the latch on the door to resident room 218 was sticking, causing the door to not latch. 2. On 5/12/2026 at 11:15 AM, it was revealed by observation that the door to storage room 308 would not latch. 3. On 5/12/2026 at 11:19 AM, it was revealed by observation that the door to the medical supplies room across from resident room 324 would not latch it appeared that the latch was cut. 4. On 5/12/2026 at 11:22 AM, it was revealed by observation that the door to resident room 332 was held open with a rubber wedge. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0363		07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING **02 - 410 LUELLA...** B. WING	**05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 5/12/2026. At the time of this survey, Hilltop Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/29/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245358	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - 410 LUELLA...** B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hilltop Care Center Building 02 is a 6 bed addition that was constructed in 2021, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245358	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - 410 LUELLA...** B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353 SS = F Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 5/12/2026 between 09:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire sprinkler was inspected during the fourth quarter of 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	1. Corrective action taken or planned to correct the deficiency: The facility will ensure the required sprinkler inspection is completed during the fourth quarter going forward, including the fourth quarter of 2026. The painted sprinkler head identified in soiled utility room 127 will be replaced. 2. Measures put into place to ensure the deficiency does not reoccur: The Administrator or designee will verify and sign off that required quarterly sprinkler inspections are completed as scheduled. In addition, all sprinkler heads throughout the facility will be inspected to ensure they are free from paint or damage and replaced if necessary. 3. Monitoring plan to ensure continued compliance: Documentation of quarterly sprinkler inspections will be reviewed and signed off by the Administrator and Maintenance Director or designee to ensure compliance. Findings and compliance monitoring will be reviewed through the facility's QAPI process. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1st, 2026.	07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245358	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - 410 LUELLA...** B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0901 SS = F Bldg. 02	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 5/12/2026 between 9:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey that at the time of the survey the facility could not provide a risk assessment of the facility being completed using chapters 10 and 11 of NFPA 99 (2012 edition), Health Care Facilities Code. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0901	1. Corrective action taken or planned to correct the deficiency: No residents were identified as being negatively affected by the deficient practice. Upon notification of the survey findings, facility administration initiated a review of NFPA 99 Chapters 10 and 11 requirements. The facility will complete and maintain a documented risk assessment in accordance with NFPA 99 requirements. Any deficiencies identified during the review process will be corrected. 2. Measures put into place to ensure the deficiency does not reoccur: The facility will conduct a comprehensive review of applicable systems, equipment, policies, procedures, and documentation related to NFPA 99 Chapters 10 and 11 to ensure ongoing compliance. The required risk assessment documentation will be maintained and readily available for review. 3. Monitoring plan to ensure continued compliance: The facility will consult with qualified life safety/code compliance personnel regarding applicable NFPA 99 Chapter 10 and 11 requirements and ongoing compliance expectations. The Maintenance Director or designee will conduct periodic audits to verify required documentation remains current and compliant. Findings will be reviewed through the facility's QAPI process for ongoing oversight. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1, 2026.	07/01/2026
K0921 SS = F Bldg. 02	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current,	K0921	1. Corrective action taken or planned to correct the deficiency: No residents were identified as being negatively affected by the deficient practice. The facility utilizes MNMedical to perform inspection and testing of patient care-related electrical appliances and equipment (PCREE). Following the survey, the facility	07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245358	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - 410 LUELLA...** B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

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K0921 SS = F Bldg. 02	Continued from page 4 and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 5/12/2026 between 9:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0921	Continued from page 4 obtained and organized the required testing documentation that was not readily available at the time of survey. 2. Measures put into place to ensure the deficiency does not reoccur: The facility reviewed all patient care-related electrical equipment records to verify current inspection and testing documentation is available for all applicable equipment. A centralized log and organized recordkeeping system will be maintained for all PCREE inspection, testing, maintenance, repair, and modification documentation. The Maintenance Director or designee will ensure all future reports are retained and readily accessible for survey review. Related policies and procedures will be reviewed and updated as needed. 3. Monitoring plan to ensure continued compliance: The Maintenance Director and/or Administrator will conduct monthly audits for three months to verify required testing documentation remains current, complete, and readily accessible. Findings will be reviewed through the facility's QAPI process, and corrective action will be taken as needed to ensure sustained compliance. 4. Person(s) responsible for corrective action and monitoring: Maintenance Director or designee. 5. Date of completion: July 1, 2026.	07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING B. WING	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	410 LUELLA STREET , WATKINS, Minnesota, 55389

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E0000	Initial Comments On 5/11/26 through 5/12/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 5/11/26 through 5/12/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53583041C (2709162). NO deficiencies were cited. The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health Care Center	**410 LUELLA STREET , WATKINS, Minnesota, 55389**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/11/26 through 5/12/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Nursing Home Licensure. NO licensing orders were issued. The following complaints were reviewed: H53583041C (2709162).	20000		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/12/2026**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 17, 2026

Administrator
HILLTOP HEALTH CARE CENTER
410 LUELLA STREET
WATKINS, MN 55389

RE: CCN: 245358
Cycle Start Date: May 12, 2026

Dear Administrator:

On July 9, 2026, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112