



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 17, 2026

Administrator

Hope Springs at Minnetonka

16913 Highway 7

Minnetonka, MN 55345

RE: CCN: 245606

Cycle Start Date: June 4, 2026

Dear Administrator:

On June 17, 2026, we informed you that we may impose enforcement remedies.

On August 13, 2026, the Minnesota Department of Public Safety completed a revisit, and it has been determined that your facility is not in substantial compliance.

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

The deficiencies not corrected are as follows:

- K0918: Electrical Systems - Essential Electric Systems
- K0921: Electrical Equipment - Testing and Maintenance

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 4, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 4, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective [Deny Pay for New Admits 04B - 3 mo. Effective Date()].

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 4, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, HOPE SPRINGS AT MINNETONKA will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 4, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2026

Administrator
Hope Springs at Minnetonka
16913 HIGHWAY 7
MINNETONKA, MN 55345

RE: CCN: 245606

Cycle Start Date: June 4, 2026

Dear Administrator:

On June 4, 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 **September 4, 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 **December 4, 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,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0000	Initial Comments On 6/1/26 through 6/4/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.			E0000			06/26/2026
F0000	INITIAL COMMENTS On 6/1/26 through 6/4/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. The facility is enrolled in ePOC and therefore a			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: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0000	Continued from page 1 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		06/26/2026
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).	F0851	F0851 It is the practice of Hope Springs to submit complete and accurate payroll-based staffing information, including agency and contract staffing, using verifiable and auditable source records. Consistent with this practice, the following has been completed: 1.) The staffing data for the cited dates was reviewed against payroll records, timecards, schedules, census sheets, and agency invoices, and a reconciliation was completed on June 10, 2026. 2.) While no residents were harmed and facility review showed actual staffing levels were in place, all residents have the potential to be affected by inaccurate PBJ reporting; therefore, the facility reviewed the past quarter for accuracy of licensed nursing and agency reporting. 3.) The Book keeper has been given all access to all systems and will maintain accurate reporting. The facility revised its PBJ submission process so that when the Bookkeeper enters data from complete source documents and the administrator will validate the submission before transmission. Staff responsible for payroll, scheduling, and PBJ submission were educated on the revised process on June 4, 2026. 4.) The Administrator or designee will audit PBJ source documentation and submission accuracy monthly for three months. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated.	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
F0851 SS = F	Continued from page 2 §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: 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) Casper 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			F0851			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0851 SS = F	Continued from page 3 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.	F0851		07/30/2026
F0868 SS = F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee.	F0868	The facility acknowledges the alleged deficient practice of not holding and/or maintaining documentation for quarterly QAPI meetings as required. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Because quarterly QAPI meetings were not held and/or documented as required, all 21 residents had the potential to be affected by this deficient practice. No specific resident harm was identified. The Administrator, Director of Nursing, Infection Preventionist, Medical Director/designee, and designated QAPI committee members will meet on July 13th, our regularly scheduled meeting, to complete a QAPI meeting, review current facility concerns, review infection prevention and control updates, and address performance improvement needs. Current QAPI records were organized and placed in a designated location for ongoing access and review. How the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents, census 21, were identified as having the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur: The facility will review and update its QAPI policy on July 10th. The updated process includes:	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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	
F0868 SS = F	Continued from page 4 The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: 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.		F0868	Continued from page 4 QAPI meetings will be held at least quarterly and as needed. Required members, including the Director of Nursing, Medical Director/designee, Administrator, Infection Preventionist, and additional staff as required, will be included in QAPI meetings. QAPI meeting minutes, attendance, and supporting documentation will be completed and maintained after each meeting. QAPI records will be kept in a designated electronic folder and/or binder for easy access. If a scheduled QAPI meeting is missed or canceled, it will be rescheduled and held within 14 days. A 12-month QAPI calendar will be created on July 10th to schedule meetings in advance. How the corrective actions will be monitored to ensure the deficient practice will not recur: On July 13, 2026, the Administrator will educate the Director of Nursing, Infection Preventionist, Medical Director/designee, and designated QAPI committee members on QAPI meeting requirements, required committee participation, documentation expectations, and the process for rescheduling missed meetings. The Administrator or designee will complete a monthly audit for 6 months to verify: QAPI meetings are scheduled and held as required Required committee members, including the Infection Preventionist, are included Meeting minutes, attendance records, and related documents are completed and maintained Items discussed in QAPI are followed through as needed		07/30/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0868 SS = F		F0868	Continued from page 5	07/30/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: 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 5/8/26, indicated R11 was admitted 9/1/2009, 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,	F0552	Audit results will be reviewed by the QAPI Committee and Governing Body monthly for 3 months, then quarterly thereafter. Any areas identified as needing correction will be addressed promptly. Date of completion: July 15, 2026 F0552- It is the practice of Hope Springs to ensure residents or their authorized representatives are informed of the risks, benefits, and alternatives related to treatment decisions, including psychotropic medications, and that informed consent is documented in the medical record. Consistent with this practice, the following has been completed: 1.) For resident R11, the facility has instructed R!! on the risks, benefits, and alternatives related to his prescribed treatment including his psychotropic medication on 6/24/26 and he has signed the informed consent document for Psychoactive medications . 2.) Other residents receiving psychotropic medications had the potential to be affected; therefore, the facility audited all charts in the facility for current informed consent, decision-maker documentation, and risk/benefit discussion. 3.) The psychotropic consent process was revised to require documentation at initiation, significant medication change, and any change in resident decision-making status. Nursing, social services, and applicable providers will be educated on the revised process by 7/30/26. 4.) The DON or designee will audit psychotropic consent documentation for all new admission ensuring that this is completed . Results will be reviewed in QAPI and additional corrective action will be taken as needed.	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0552 SS = D	Continued from page 6 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.	F0552		07/30/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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.	F0684	F0684 - It is the practice of Hope Springs to ensure physician orders, consult recommendations, and diagnostic follow-up are completed timely and in accordance with professional standards of practice. Consistent with this practice, the following has been completed: 1.) For resident R11, the facility requested the primary physician enter an order in EPIC for R11 to have a video swallow evaluation on 6/4/26. 2.) Other residents with open orders, consults, referrals, or diagnostic follow-up had the potential to be affected; therefore, the facility audited all charts from the last 60 days of appointments to identify overdue items. 3.) The facility implemented an order and referral tracking log, defined escalation steps for missed or delayed orders. Licensed nursing and interdisciplinary staff will be educated on the revised process by 7/30/26. 4.) The DON or designee will review the order/referral tracking log weekly and report results through QAPI for ongoing oversight. A video swallow exam will be set up for R11 by 7/30/26	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0684 SS = D	Continued from page 7 Findings include: R11's quarterly minimum data set (MDS) dated 5/8/26, indicated R11 was admitted 9/1/2009, 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	F0684		07/30/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345		
(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	
F0684 SS = D	Continued from page 8 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.	F0684		07/30/2026	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	F0880- It is the practice of Hope Springs to maintain an infection prevention and control program that includes timely reporting of communicable disease events in accordance with applicable public health requirements. Consistent with this practice, the following has been completed: 1.) The facility reported the positive resident COVID case on 6/9/26. 2.) All residents, staff, and visitors had the potential to be affected by this practice; therefore, the facility reviewed all infections since 1/1/26 to determine whether other reportable events required follow-up. 3.) The outbreak-reporting process was revised to identify reporting triggers, responsible staff, backup coverage, timelines, and storage of submission confirmation. The DON, Infection Preventionist, charge nurses, and backup staff will be educated on reporting requirements for NHSN by 7/30/26. 4.) The Infection Preventionist or designee will audit infection-event reporting Monthly and present results to QAPI for ongoing monitoring.	07/30/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0880 SS = D	Continued from page 9 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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	F0880		07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345	
(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
F0880 SS = D	Continued from page 10 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.	F0880		07/30/2026
E0004	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program	E0004	It is the practice of Hope Springs to review and update its emergency preparedness plan at least annually. Consistent with this practice, the following has been completed: 1.) The emergency preparedness plan will be reviewed and updated on July 17, 2026 including updating the information . 2.) All residents, staff, and visitors had the potential to be affected by failure to maintain a current plan; therefore, the facility reviewed the emergency preparedness program for continued compliance, supporting policies and related data and information pertinent to the emergency preparedness plan. 3.) A process was implemented to ensure annual review is scheduled, assigned, and documented, and the responsible leadership staff will be educated by July 30, by virtue of the updated plan being posted and staff will sign having read the updated plan. 4.) The Administrator or designee will verify completion of annual emergency preparedness review requirements semi-annually with results reviewed in QAPI. 4.) The policy for EPP will be updated, reviewed and any new information will be educated by July 30, 2026.	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0004	Continued from page 11 that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure their emergency preparedness plan (EPP) was updated annually. This had the potential to affect all 21 residents, staff, and visitors to the facility. Findings include: Review of the facility's EPP, identified it was last revised/updated in 6/2023. On 6/4/26 at 12:38p.m., the Director of nursing (DON) stated their expectation was it should have been updated annually in order to focus on new topics each year, and confirmed it had not been updated since 2023. A policy related to EPP was requested, and none was provided.			E0004			07/30/2026
E0026	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			E0026	E0026 It is the practice of Hope Springs to maintain emergency preparedness policies and procedures that address the facility's role under an 1135 waiver and care at an alternate site when applicable. Consistent with this practice, the following has been completed: 1.) The emergency preparedness plan/policy will be revised on Jul 17, 2026 to include the facility's role under an 1135 waiver, including updated information relevant to keeping the plan current and viable. 2.) All residents had the potential to be affected by incomplete emergency preparedness procedures; therefore, the facility reviewed the emergency preparedness policies for required waiver and alternate-site content. 3.)		07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0026	Continued from page 12 section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included policies and procedures to address and identify the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act (a waiver designed to waive specific regulatory requirements in order to more easily provide needed care in an emergency situation) in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 21 residents currently residing in the facility. Findings include: Review of the facility's EPP lacked a policy or procedure for addressing the facility's role under a 1135 waiver declared by the Secretary during an emergency to provide services at an alternate site for their residents. On 6/4/26 at 12:38p.m., the Director of nursing (DON) confirmed the 1135 waiver was not included in the facility's EPP and relayed the importance of including the waiver in case of an emergency. A policy related to EPP was requested, and none was provided.			E0026	Continued from page 12 Leadership staff will be educated on the revised procedure and the facility's emergency role by July 30, 2026. 4.) The Administrator or designee will audit the emergency preparedness policy set semi-annually to ensure required elements remain current, with findings reported through QAPI. 5.) The policy for EPP will be updated, reviewed and any new information will be educated by July 30, 2026.		07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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	
E0037	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to		E0037	E0037 It is the practice of Hope Springs to maintain properly train all employees on emergency preparedness policies and procedures. Consistent with this practice, the following has been completed: 1.) The emergency preparedness plan/policy will be revised by July 30, 2026 to include the facility's training program for all employees to ensure proper knowledge of emergency procedures. 2.) All residents had the potential to be affected by incomplete emergency preparedness procedures; therefore, the facility reviewed the emergency preparedness policies for employee training. 3.) Leadership staff will be educated on the revised procedure and the facility's emergency role by July 30, 2026 4.) The Administrator or designee will audit the emergency preparedness policy set semi-annually to ensure required elements remain current, with findings reported through QAPI.		07/30/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0037	Continued from page 14 protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must			E0037			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0037	Continued from page 15 conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where			E0037			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0037	Continued from page 16 necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain an emergency preparedness plan (EPP) training program which was based on the emergency plan, risk assessment, policies, and procedures. This had the potential to affect all 21 residents residing at the facility and staff members. Findings include: During review of the facility's EP program last revised 6/2023, lacked any evidence of a training program for employees. On 6/4/26 at 12:38p.m., the Director of nursing (DON) stated they had a training program but was unsure of its informational content. The DON stated the importance of completing EPP training as required so their staff are ready in case of an emergency.			E0037			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345		
(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	
E0037	Continued from page 17 The above discussed EPP training program for staff was requested and was not provided. A policy related to EPP was requested, and none was provided.	E0037		07/30/2026	
E0039	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a	E0039	E0039 It is the practice of Hope Springs to complete and document required emergency preparedness testing and after-action follow-up. Consistent with this practice, the following has been completed: 1.) The facility has scheduled a tabletop drill to be completed by September 30, 2026 . 2.) All residents had the potential to be affected by incomplete emergency preparedness testing; therefore, the facility reviewed emergency preparedness exercise documentation and testing requirements for the past year. 3.) The emergency preparedness testing calendar and documentation process will be revised, and responsible leadership staff will be educated on by July 30, 2026. 4.) The Administrator or designee will audit completion and documentation of emergency preparedness testing semi-annually with findings reviewed through QAPI.	07/30/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 18 facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 19 the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 20 exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 21 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 22 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 23 (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
E0039	Continued from page 24 emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain an emergency preparedness plan (EPP) training and testing program which was based on the emergency plan, risk assessment, policies, and procedures. This had the potential to affect all 21 residents residing at the facility. Findings include: During review of the facility's EP program last revised 6/2023, it was revealed the EPP lacked evidence of the required tabletop exercises and full-scale community-based exercise. On 6/4/26 at 12:38p.m., the Director of nursing (DON) confirmed if the required exercises had not been provided, then they had not been completed. The DON stated the importance of completing these trainings as required so their staff are ready in case of an emergency. A policy related to EPP was requested, and none was provided.			E0039			07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/03/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Hope Springs at M			K0000			08/04/2026
K0345 SS = F Bldg. 02	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.4.1, 9.6.1.3, and 9.6.1.5, NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2, 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2026 at 10:53 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of smoke detector sensitivity testing. An interview with the Administrative Assistant verified this deficient finding at the time of discovery.			K0345	K0345 It is the practice of Hope Springs to submit complete and accurate fire alarm testing and maintenance. Consistent with this practice, the following has been completed: Fire inspection completed by Brothers Fire and Security on 2/3/2026. While no residents were harmed and facility review showed, actual inspection was completed; therefore, the facility reviewed the past year for accuracy of fire inspection reports. 3. The Administrator or designee will audit fire inspection reports annually. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated.		06/04/2026

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: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0712 SS = F Bldg. 02	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 18.7.1.4, 18.7.1.6, 18.7.1.7, 4.7.4, and 4.6.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/03/2026 at 10:27 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 a fire drill was conducted during the second shift during the first quarter of 2026. 2. On 06/03/2026 at 10:29 AM, it was revealed by a review of available documentation that the times that second shift fire drills were being completed were not varied. An interview with the Administrative Assistant verified these deficient findings at the time of discovery.			K0712	It is the practice of Hope Springs to submit complete and accurate fire drills. Consistent with this practice, the following has been completed: Fire drill was completed by Administrator on 6/22/26 for the 2nd shift. While no residents were harmed and facility completed the fire drill, all residents have the potential to be affected by incomplete fire drills; therefore, the facility reviewed the past year for accuracy of fire dill reports. The emergency preparedness testing calendar and documentation process will be revised, and responsible leadership staff will be educated on by July 30, 2026. The Administrator or designee will audit fire drill reports bi-annually. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated.		07/30/2026
K0741 SS = F Bldg. 02	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: 1. Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other			K0741	It is the practice of Hope Springs to submit complete policies and procedures at the time of survey. Consistent with this practice, the following has been completed: The Smoking policy has been reviewed and updated as of 7/30/2026. While no residents were harmed and facility		07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0741 SS = F Bldg. 02	Continued from page 2 hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. 2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. 3. Smoking by patients classified as not responsible shall be prohibited. 4. The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. 5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. 6. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, observation, and staff interview, failed to have a smoking policy in accordance with the requirements of NFPA 101 - 2000 edition, Section 18.7.4 and 18.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2026 at 10:25 Am, it was revealed by observation and a review of available documentation that there was no smoking policy available at the time of the survey. An interview with the Administrative Assistant verified this deficient finding at the time of discovery.			K0741	Continued from page 2 completed the review of the policy, all residents have the potential to be affected by incomplete policies and procedures; therefore, the facility reviewed and updated the policy for accuracy. The Smoking policy was revised and responsible leadership staff will be educated by July 30, 2026. The Administrator or designee will audit the Smoking policy annually. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated.		07/30/2026
K0918 SS = F Bldg. 02	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion			K0918	It is the practice of Hope Springs to complete load bank testing It is the practice of Hope Springs to complete load bank testing every 36 months for the emergency generator. Consistent with this practice, the following will be completed:		08/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0918 SS = F Bldg. 02	Continued from page 3 is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.5.1, 8.4.9.5.2. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 06/03/2026 at 10:55 AM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation for a 36- month load bank test for the emergency generator. An interview with the Administrative Assistant verified these deficient findings at the time of discovery.			K0918	Continued from page 3 The 36-month load bank testing While no residents were harmed and facility completed the 36-month load bank testing, all residents have the potential to be affected by incomplete testing; therefore, the facility reviewed and updated the policy for accuracy. The facility has scheduled a load bank test with Advance Power Services that will be completed by August 12, 2026. Documentation of the test will be provided to the facility and the facility will forward the documentation to the Fire Marshall's office. The facility will then schedule this to be done every 36 months thereafter. The Administrator or designee will audit the Emergency Generator testing monthly. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated.		08/12/2026
K0921 SS = F Bldg. 02	Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101			K0921	It is the practice of Hope Springs to complete PCREE testing as required. Consistent with this practice, the following has been		08/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0921 SS = F Bldg. 02	Continued from page 4 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, 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 06/03/2026 at 10:51 Am, it was revealed by a review of the 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 Administrative Assistant verified this deficient finding at the time of discovery.			K0921	Continued from page 4 completed: The facility immediately initiated a full inventory of all patient-care related electrical equipment (PCREE) used within resident care areas. Any patient care equipment found in use without documented electrical safety testing was removed from service until proper inspection and testing were completed. All PCREE was evaluated for physical integrity, resistance, leakage current, and touch current in accordance with NFPA 99 (2012) Sections 10.2, 10.3, and 10.5.2.1.1. Documentation of completed testing was recorded and filed. While no residents were harmed and facility completed The PCREE evaluation, all residents have the potential to be affected by incomplete testing; therefore, the facility developed a centralized tracking log to record all electrical safety tests, repairs, and modifications The Maintenance Department and Administrative Assistant received re-training on NFPA 99 requirements, documentation retention, and proper testing procedures. No PCREE will be placed into service without documented electrical safety testing. The facility will commence with a PCREE program by August 12, 2026 so that there is a centralized logging system and documentation that shows all resident rooms have been checked and monitored for every piece of electrical equipment used in patient care in the room. The facility will develop or obtain a log system so that all resident rooms and patient care equipment is covered under the program. The Administrator or designee will audit the Tracking log monthly. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated.		08/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0324 SS = E Bldg. 02	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect their kitchen hood and maintain kitchen doors per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.5.1, 18.3.2.5.5, and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.5 and 11.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/03/2026 at 10:49 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide inspection reports for the kitchen hood suppression system. An interview with the Administrative Assistant verified this deficient finding at the time of discovery.			K0324	It is the practice of Hope Springs to submit complete and accurate hood inspection testing and maintenance. Consistent with this practice, the following has been completed: Hood inspection completed by Summit Fire Protection on 5/13/2026. While no residents were harmed and facility review showed, actual inspection was completed; therefore, the facility reviewed the past year for accuracy of hood inspection reports. The Administrator or designee will audit hood inspection reports annually. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated		06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0355 SS = D Bldg. 02	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 18.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2026 at 10:52 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide an annual inspection report of the portable fire extinguishers. An interview with the Administrative Assistant verified these deficient findings at the time of discovery.			K0355	It is the practice of Hope Springs to submit complete and accurate Fire Extinguisher inspection testing and maintenance. Consistent with this practice, the following has been completed: Fire Extinguisher inspection completed by Summit Fire Protection on 5/13/2026. While no residents were harmed and facility review showed, actual inspection was completed; therefore, the facility reviewed the past year for accuracy of Fire extinguisher inspection reports. The Administrator or designee will audit fire extinguisher inspection reports annually. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated		06/04/2026
K0920 SS = D Bldg. 02	Electrical Equipment - Power Cords and Extension Cords CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed			K0920	It is the practice of Hope Springs to follow all regulations and safety expectations in the kitchen. Consistent with this practice, the following has been completed: The toaster was immediately unplugged from the power strip; and the power strip was removed from the kitchen area. While no residents were harmed by the use of a power strip, power strips are not allowed to be used in our kitchen; therefore, the facility completed a kitchen inspection to ensure compliance. The facility reviewed and revised its electrical safety policy to address appropriate use of power strip and electrical appliances.		08/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDI... B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA				STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 , MINNETONKA, Minnesota, 55345			
(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
K0920 SS = D Bldg. 02	Continued from page 7 and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, sections 400.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2026 at 11:20 AM, it was revealed by observation that an toaster was plugged into a power strip in the kitchen. Toaster was unplugged at the time of the survey. An interview with the Administrative Assistant verified this deficient finding at the time of discovery.			K0920	Continued from page 7 By August 12, 2026 the facility will write a policy for the safe use or non-use of electrical power strips in the facility, including which ones are approved for use in a residential living facility. The Administrator or designee will review and monitor compliance annually. Audit results will be reviewed in QAPI and additional corrective action will be taken as indicated		08/12/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2026

Administrator
HOPE SPRINGS AT MINNETONKA
16913 HIGHWAY 7
MINNETONKA, MN 55345

RE: CCN: 245606

Cycle Start Date: June 4, 2026

Dear Administrator:

On August 17, 2026, we notified you a remedy was imposed. On September 8, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 31, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 4, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 17, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 4, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 31, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us