



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 5, 2025

Administrator
Hope Springs At Minnetonka
16913 Highway 7
Minnetonka, MN 55345

RE: CCN: 245606
Cycle Start Date: February 11, 2025

Dear Administrator:

On February 14, 2025, 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.

Hope Springs At Minnetonka

March 5, 2025

Page 2

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:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 May 14, 2025 (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 August 14, 2025 (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>

Hope Springs At Minnetonka

March 5, 2025

Page 4

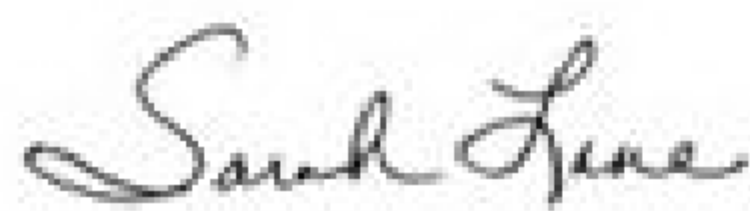
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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



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



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March 5, 2025

Administrator
Hope Springs At Minnetonka
16913 Highway 7
Minnetonka, MN 55345

Re: State Nursing Home Licensing Orders
Event ID: 24D311

Dear Administrator:

The above facility was surveyed on February 10, 2025 through February 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

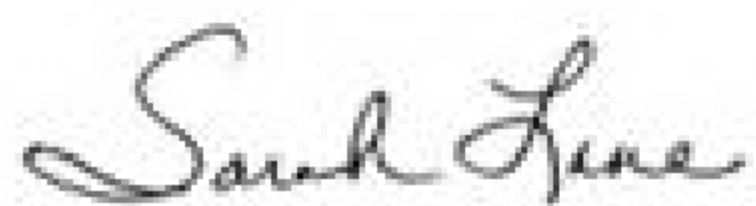
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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

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

PRINTED: 04/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 MINNETONKA, MN 55345		
(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
E 000	Initial Comments	E 000			
	On 2/10/25 - 2/14/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 2/10/25 to 2/14/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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. 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.				
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554			4/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/19/2025

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

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F 554	Continued From page 1 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents who self-administered topical medications creams were assessed for safe and appropriate use for 2 of 3 residents (R11 and R15) reviewed for self-administration of medications. Findings include: R11: R11's quarterly Minimum Data Set (MDS) dated 1/7/25, indicated R11 was admitted to the care facility on 4/6/23 and was cognitively intact. R11's Orders, indicated R11 had an order for Betamethasone Valerate External Cream 0.1% (a steroid cream used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), apply to affected skin as needed for rash unsupervised self-administration. Apply to affected skin twice daily PRN [as needed] for rash up to five days a month and two times a day for rash for two weeks. R11's care plan, dated 6/26/24, indicated for staff to provide medications as ordered, including Betamethasone cream PRN for rash outbreaks. R11's electronic medical record (EMR) indicated R11's last skin observation by a licensed nurse was 11/8/24.	F 554	Residents 11 and 15 will have a medication self-administration assessment completed for any medications kept at bedside as ordered by MD. The MAR for all residents will be assessed for any other medications that doctors may have written an order for that they may be kept at bedside and a SAM will be completed on them also. For any resident that has a completed SAM assessment that has determined that they are capable of having certain medications at bedside - they will have a ¿SAM completed quarterly with MDS and with any change in condition or change in ordered of the medication covered by the SAM. The consulting pharmacist will be asked to monitor for completed Quarterly assessments with their monthly audits and will be completed by April 4, 2025. Compliance with Sams Assessment will be brought to QAPI committee.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 554	Continued From page 2 R11's EMR lacked evidence that R11 had been assessed for safe self-administration of medication including how to use it, where, and how often. During an interview on 2/13/25 at 10:57 a.m., licensed practical nurse (LPN)-A stated that she did not believe R11 should be able to administer her own medicated cream as she had recently self-declared blindness. LPN-A stated nursing staff should be doing an assessment to ensure residents are visually and cognitively able to self-administer medications. LPN-A further stated it was "questionable" whether R11 had a [neck] rash and although R11 kept the cream in her room, she should be asking staff to assist her with applying the cream. During an interview on 2/13/25 at 11:09 a.m., R11 stated she kept the medicated cream in her bathroom. R11 stated she had been using the cream on her neck twice a day and the rash had cleared up but now she was using it for a rash on her right thigh. R11 stated nursing staff were not assessing her skin and were not offering, or asking, if she needed help applying the cream. She was doing it on her own. During an interview on 2/13/25 at 12:32 p.m., the consultant pharmacist (CP) stated Betamethasone Valerate External Cream 0.1% can cause thinning of the skin which is why it is generally prescribed with a time limit. The CP stated she would want to ensure R11 had the same rash on her thigh the cream was prescribed for on her neck before she used it on the rash on her thigh. During an interview on 2/13/25 at 12:59 p.m., the	F 554			

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F 554	Continued From page 3 director of nursing (DON) confirmed R11 had not been assessed for self-administration of her medicated cream. The DON stated she believed R11 had been fine to self-administer medications when they were prescribed but was "not as reliable" now and was unsure if R11 could safely self-administer medications at this time. The DON stated she was unaware of a rash on R11's thigh and she should be assessed for safe and proper use. R15: R15's annual MDS dated 12/4/24, indicated R15 was admitted to the care facility on 12/17/20 and was cognitively intact. R15's Order Summary Report printed 2/14/25, indicated: -Hydrocortisone External Cream 1% (Hydrocortisone (Topical)) (topical corticosteroid which treats skin conditions). Apply to lower extremities and/or [abdomen] topically as needed for pruritus (itching) unsupervised self-administration apply to lower extremities bid prn (twice daily as needed) for leg rash- may keep at bedside. -Micotrin AP External Powder 2% (Miconazole Nitrate (Topical)) (antifungal medicine used to treat certain kinds of fungal or yeast infections of the skin). Apply to areas of irritation. Apply to under breasts and between skin fold when irritation is present as needed BID. -Terbinafine HCl External Cream 1% (Terbinafine HCl (Topical)) (an antifungal medication which treats fungal infections of the skin). Apply to rash on abdomen topically two times a day for rash unsupervised self-administration. Apply BID until clear. Ok to keep at bedside. -Voltaren Gel 1% (Diclofenac Sodium)	F 554			

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F 554	Continued From page 4 (nonsteroidal anti-inflammatory drug which treats joint pain caused by arthritis). Apply to [bilateral] wrists and hands topically every six hours as needed for pain- moderate unsupervised self-administration. Apply 4 grams every six hours prn. May keep at bedside. R15's care plan, indicated the following interventions: -1/29/21, administer analgesia (refers to the relief or absence of pain) as per orders. Give half hour before treatments or care. -8/29/24, R15 self-administered clotrimazole cream under abdominal fold for rash and has as needed for cortisone cream. R15's progress note dated 8/27/24 at 12:23 [12:23 p.m.], indicated R15's providers saw R15 for a continued rash around their abdomen and lower legs and ordered clotrimazole cream twice daily to waist area until rash healed and may keep clotrimazole and hydrocortisone at bedside to use until healed. R15's progress note dated 11/22/24 at 14:47 [2:47 p.m.], indicated R15's providers saw R15 and ordered micotin antifungal powder to apply under breasts and between skin folds when irritation was present as needed twice daily. R15's EMR lacked evidence that R15 had been assessed for safe self-administration of medication including how to use it, where, and how often. During an interview on 2/13/25 at 11:45 a.m., licensed practical nurse (LPN)-A stated they did not complete self-administration assessments since they were an LPN. LPN-A stated residents	F 554			

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F 554	Continued From page 5 were assessed for self-administration when medications first ordered, and R15 cleaned their own skin folds and self-applied needed creams. LPN-A checked with R15 daily to ensure areas cleaned or if R15 had concerns. During observation and interview on 2/13/25 at 12:55 p.m., R15 stated the use voltaren gel once or twice a day for their knees, thumbs joints, and wrists and keep the gel in their room. R15 stated they kept hydrocortisone in their room and used when their skin folds were irritated. R15 stated they also had an antifungal powder in their bathroom which R15 used when they had a rash. R15 stated the doctor ordered the powder, and staff provided R15 the powder and knew about it too. R15 stated they asked the doctor to write they may keep the powder and other treatments at bedside. R15 went to the bathroom to grab their powder, and the powder was miconazole nitrate 2% antifungal powder with a pharmacy label. During an interview on 2/13/25 at 3:35 p.m., the director of nursing (DON), verified R15 did not have a self-administration assessment and needed an assessment rather than only the doctor's orders. A facility policy titled Self-Administration of Medications Assessments, dated 8/2023, indicated if a resident wished to self-administer medications "the interdisciplinary team must assess the resident's cognitive, physical, visual ability to carry out/administer medications. If resident wishes to self-administer medications/treatments such as insulin's, eye drops, lotions and/or wish medications left for self-administration, resident will be instructed in	F 554			

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F 554	Continued From page 6	F 554			
F 561 SS=D	proper technique and then monitored for 10 days for correct task completion. Staff will document on MAR." Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food	F 561			4/4/25
			Hope Springs makes every effort to affirm each resident's right to		

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F 561	Continued From page 7 preferences were honored for 1 of 1 resident (R4) reviewed for choices related to food. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/30/24, indicated R4 had intact cognition, disorganized thinking, verbal behavioral symptoms directed towards others, and did not reject cares. R4 required supervision or touching assistance with eating and was independent with most activities of daily living. R4 had diagnoses of orthostatic hypotension (condition where blood pressure drops when standing up from a sitting or lying position), dementia and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R4's oral intake care plan revised 12/13/24, indicated R4 had potential for inadequate oral intakes related to history of varying appetite secondary to mental health and had been hospitalized for not eating and weight loss. Care plan interventions indicated R4 liked Mexican food, soups, desserts, macaroni and cheese, carrot cake, chicken wrap, pizza, tuna, and hot cereal. R4 disliked Chinese food, liver, gizzards and hearts, and red met. R4's Kardex Report printed 2/14/25, indicated R4 was independent with eating, may need encouragement to come to meals, and offer strawberry ensure if R4 did not want to eat. R4's progress note dated 12/13/24 at 10:19 [10:19 a.m.], indicated R4 was semi-vegetarian and tried to avoid red meats but liked ham and sometimes pork. R4 liked chicken, fish, tuna,	F 561	self-determination and choices about aspects of their life that are significant to them, including dietary choices. ¿Due to the nature of the facility many of the residents are not always consistent or dependable in their expression of preferences, especially as it relates to dietary. ¿Every effort will be made to accommodate and understand their requests. ¿The nursing assistants and dietary personnel will be instructed as to resident R4's dietary preferences and how to best meet each of the individual requests identified in the deficiency. ¿Other residents will have their dietary choices examined regularly by the Dietitian who will communicate with the dietary and nursing assistant staff either in person or via email to identify any residents whose dietary choices are not being addressed by the staff. ¿In addition, at the quarterly care conferences for each resident they will be asked if their choices are being met. ¿This information will be given to the Dietitian, if they do not already have it from these quarterly care conferences so that the Dietitian can follow up with the staff if there are any choices not being met. ¿The Dietitian will be responsible for overseeing that the dietary choices of residents are met and can be met by the dietary and nursing staff, in addition to making changes as needed to the therapeutic diets, substitutionary policies and overall menu of the residents. ¿This citation will be given to the QA committee for inclusion as needed in the overall QAPI program.		

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

PRINTED: 04/28/2025
FORM APPROVED
OMB NO. 0938-0391

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F 561	Continued From page 8 eggs, dairy, and hot cereal. R4 triggered for weight loss related to decreased intakes and agreed to try to eat more. During an interview on 2/10/25 at 3:19 p.m., R4 stated the facility did not have enough vegetarian options. R4 stated they ate chicken, ham, and turkey but did not like other types of meat. R4 stated the facility had alternative options but got the regular entrée if they did not sign up for another option before the set time. R4 stated they spoke with the dietician about their food preferences, and R4 believed they would live longer if they cut out certain types of meat. During an interview on 2/11/25 at 12:23 p.m., dietary aid (DA)-A, who also cooked, stated they had a book and white board which listed residents' food preferences. DA-A stated they offer alternative options for meals, and residents had to sign up for the alternative option before a certain time. During observation on 2/11/25 at 1:03 p.m., the white board in the kitchen dish machine room did not indicate any food preferences for R4. The dietary book undated, indicated R4 had "No special beverage or food instructions". During an interview on 2/12/25 at 10:40 a.m., nursing assistant (NA)-A stated R4 had a fasting behavior and was not a "huge meat person". NA-A stated the facility tried to give R4 smaller portions, or R4 signed up for a meal alternative or wrote "no meat". NA-A stated they encouraged R4 to eat what they wanted and leave what they did not want to eat. NA-A stated they have cleared the meat off R4's plate before, so then R4 ate everything else on the plate.	F 561			

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

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F 561	Continued From page 9 During observation on 2/12/25 at 12:06 p.m., R4 was given the barbequed pork with potatoes and an apple, broccoli salad. At 12:10 p.m., R4 was eating the potatoes and salad but not the barbequed pork. At 12:13 p.m., R4 ate a dessert and had eaten everything on their plate but the barbequed pork. The life enrichment director (ACT)-A took R4's plate and threw the meat away. During an interview on 2/12/25 at 12:23 p.m., DA-B, who also cooked, stated they knew residents' food preferences through verbal interactions. DA-B stated R4 wavered and had different preferences. DA-B stated R4 requested no meat at times and other times wanted the meat portion of the meal or a hot dog. During an interview on 2/12/25 at 2:21 p.m., registered nurse (RN)-A stated R4 refused to eat or drink at times. RN-A stated they were not able to leave the second floor to assist in the dining room for meals on the first floor, so the nursing assistants and dietary staff knew residents' food preferences. During an interview on 2/13/25 at 12:35 p.m., NA-C stated R4 fasted at times and encouraged R4 to drink when they did not eat. NA-C stated R4 will pace back and forth from the meal table and make statements such as "I can't, I can't". NA-C stated R4 looked ahead at the menu themselves and signed up for an alternative entrée if they wanted. NA-C stated R4 ate meat sometimes and other times did not. NA-C stated they "let [R4] be" when they did not eat the meat portion of their meal and took R4's plate when R4 stated they were done.	F 561			

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

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F 561	Continued From page 10 During an interview on 2/13/25 at 12:32 p.m., ACT-A stated they took R4's plate on 2/12/24, because R4 stated they were finished. ACT-A stated R4 had a "thing" about meat, such as R4 did not eat the soup for lunch because it had beef in it. ACT-A stated R4 went on fasts sometimes when their weight got higher than what they wanted. ACT-A stated the kitchen offered alternative options, so most residents and staff were good at knowing what food they liked or did not like. ACT-A stated they did not check with R4 if they were full or wanted anything else before taking R4's plate and throwing away the untouched barbeque pork. During an interview on 2/13/25 at 4:03 p.m., the director of nursing (DON) stated the dietician asked residents about their likes and dislikes related to food, and the cook talked to the residents, so they knew about residents' food preferences. DON stated R4's mental illness was not stable and conflicted from hearing negative thoughts related to eating. DON stated R4 requested more vegetables, and R4 was not consistent with what they wanted. DON thought NA-A talked to people who got up late in the day or didn't look at the menu to ask what they wanted to eat before meals. DON stated they observed R4 looking at the menu prior to meals and was able to sign up for alternative entrees. DON stated staff made sure R4 drank enough to avoid weight loss, weakness, and hospitalization. DON stated residents had little control over themselves, so it was important for them to get food they liked. The facility policy New Admission Dietary Assessment dated 1/2023, directed the cook to			F 561			

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

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FORM APPROVED
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F 561	Continued From page 11 interview each new resident for likes and dislikes, and the dietician to meet with residents for a nutrition related physical exam and initial assessment. The dietician updated resident assessments, progress notes, MDS, and care plan on a quarterly basis.	F 561			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578			4/4/25

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

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F 578	Continued From page 12 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure provider orders code status [e.g. full code or do not resuscitate (DNR)] were updated, consistent, and accurate throughout the resident's medical record for 1 of 4 residents (R4) reviewed for advance directives. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/30/24, indicated R4 was admitted to the care facility on 6/21/23. The MDS indicated R4 had intact cognition, disorganized thinking, verbal behavioral symptoms directed toward others, and diagnoses including orthostatic hypotension (condition where blood pressure drops when standing up from a sitting or lying position), dementia and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R4's care plan dated 1/31/25, lacked documentation of code status. R4's Health Care Directive dated 12/30/19, indicated they did not want CPR			F 578	R4s care plan will be updated to show code status and information obtained from Advance Directives. At next primary visit a POLST, will be completed with providers signature to reflect Resident's wishes. All resident charts will be audited for completed POLSTS and if not found their primary will be contacted to complete one. POLSTS will be completed upon Admission and discussed Quarterly at care conference or a change in condition. Staff will be educated to alert DON if POLST is not found for any resident. Compliance with POLST will be addressed with QAPI committee.		

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F 578	Continued From page 13 (cardiopulmonary resuscitation; emergency procedure which combined chest compressions and rescue breathing to help someone who is not breathing or whose heart is not beating) attempted if their heart and breathing stopped. R4 wanted a natural death. R4 understood if they chose this option, they would see their health care provider about writing a DNR order. R4's Transfer Orders from Regions Hospital signed 4/11/23, indicated R4's code status was full code. R4's Discharge Orders from Regions Hospital signed 6/21/23, indicated R4's code status was full code. R4's Care Conference note dated 10/18/24, indicated R4, the social workers, and director of nursing attended the care conference. The note indicated R4 wanted CPR in the past and now changed their mind. R4's Admission Record printed 2/14/25, indicated R4 did not want resuscitation and did not want intubation. R4's orders printed 2/14/25, did not indicate R4's code status. During interview on 2/12/25 at 2:13 p.m., registered nurse (RN)-A stated code statuses were reviewed at care conferences and during admission by the director of nursing (DON). RN-A knew residents' code statuses from the face sheet binder. The face sheet binder had a copy of R4's Admission Record and Health Care Directive, both which did not have a provider signature.	F 578			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 578	Continued From page 14 During interview on 2/13/25 at 3:31 p.m., the director of nursing (DON) confirmed there was no provider order or involvement in R4's DNR status. The DON preferred everyone to have a POLST and stated not everyone had one, which included R4. The DON stated provider involvement was important to ensure residents were educated about DNR status by a professional with a higher degree. The DON stated they reviewed code status at each care conference. The facility's POLST policy dated 10/2021, directed staff to assist the resident or resident's guardian/representative with completing a Providers Orders for Life Sustaining Treatment (POLST) form. If the resident or guardian/representative chooses to decline CPR, intubation, etc., HSM staff documented on the POLST, and two staff members witnessed the POLST to become effective. The POLST was then faxed to the primary physician for signature. The facility's Advanced Directives/CPR policy dated 1/2023, reflected the same process as the POLST policy. The policy indicated the care plan reflected resident wishes and whether an advance directive existed. The policy directed staff to reference the Facesheet binder in the event a resident was found without a pulse.	F 578			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584			4/4/25

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F 584	Continued From page 15 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a process for missing clothing was followed and residents received			F 584	Hope Springs makes every effort to label all resident clothing with the resident's initials for identification of resident		

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F 584	Continued From page 16 appropriate follow up after reporting concerns of missing clothing for 3 of 5 residents (R1, R4, and R9) reviewed for personal property. Findings include: R1: R1's quarterly Minimum Data Set (MDS) dated 12/26/24, indicated R1 was admitted to the care facility 7/24/23 and was cognitively intact. During an interview on 2/11/25 at 8:41 a.m., R1 stated missing clothing was a common occurrence in the facility and she was currently missing a blue hoody. R1 confirmed she had let the facility nursing assistants (NA) know but had not received any follow up. R5: R5's quarterly MDS dated 1/8/25, indicated R5 was admitted to the care facility 10/1/24 and was cognitively intact. During an interview on 2/12/25 at 8:54 a.m., R5 stated she had not been getting all of her clothing back after getting it washed and was currently missing a pair of jeans, socks, and underwear. R5 stated she had told the NA who distributed the laundry and the director of nursing (DON). R5 further stated it had been approximately 1 month and she had not received any follow up. The facility's Missing Item Report, kept in a three-ring binder at the nursing station, dated 9/2/24 - 2/10/25, lacked evidence of R1's and R5's reported missing clothing.			F 584	clothing. ¿The one person who does the facility laundry has been ¿instructed at an in person meeting on March 14th on the importance of ensuring all clothing items of every individual resident will be identified and returned to the resident. ¿Understanding that not all of our residents are accurate historians or can equally recall what clothing items they have or do not have, the missing clothing log will be updated as needed, when an item of clothing is said to be missing. ¿An inventory of the residents outerwear clothes (not underwear) will be made for each resident to verify any claims of missing laundry. ¿Laundry net bags will be implemented for smaller clothing items including socks, underwear and bras, so that they will not adhere to other clothing items and become lost in the facility by sticking to other residents¿ clothing items. ¿Larger items will be identified with resident¿s initials and if not identified will be placed in a separate bin for identification later by the nursing assistant staff. ¿The administrator will be responsible for ensuring that the processes and systems implemented will ensure that no resident¿s personal clothing items are lost. ¿This citation will be given to the QA committee for inclusion as needed in the overall QAPI program.		

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F 584	Continued From page 17 During observation on 2/12/25 at 10:30 a.m., a pair of unmarked resident jeans were laying on a chair near the nursing station. Facility staff were unable to confirm who they belonged to. During an interview on 2/12/25 at 11:55 a.m., NA-A stated she was aware R1 was missing a blue hoody and R5 was missing clothing items including a pair of jeans. NA-A stated the process for missing laundry was when an item was reported missing, staff would check the laundry room, laundry cart and other resident rooms for the item. If it could not be found that it should be written on the missing items report kept at the nursing station. NA-A stated R1's and R5's missing clothing was reported off to her by another NA so she did not look for the clothing herself or write it in the missing item report. During an interview on 2/13/25 at 12:59 p.m., the DON stated she was aware of R5's missing clothing but was not aware R1 was missing clothing. The DON stated since there was only one NA and one nurse working at a time, the staff could not be expected to leave the floor and search for missing items every time it was reported. The DON stated she encouraged all staff to use the missing items report, however confirmed the facility lacked follow up on the report and with missing items. The DON also stated clothing was labeled with a sharpie that would wash off after a few washes creating issues of clothing items not being labeled with resident identifying information. R9: R9's quarterly MDS dated 11/15/24, indicated R9 had moderately impaired cognition, inattention,	F 584			

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F 584	Continued From page 18 disorganized thinking, hallucinations, delusions, verbal and other behaviors, and rejected cares. R9 had no upper or lower extremity impairments and used a walker. R9 required partial and/or moderate assistance for dressing and supervision for footwear application and removal, toileting, personal and oral hygiene, and ambulation. The MDS indicated R9 had arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety, and schizophrenia. R9's progress note dated 11/14/24 at 8:17 a.m., indicated R9 had a history of paranoia with staff and/or people taking clothes, or R9 reported missing possessions from their room. During an interview on 2/10/25 at 2:39 p.m., R9 stated they were missing an expensive jacket, and the facility was not able to locate it. During an interview on 2/12/25 at 10:37 a.m., nursing assistant (NA)-A stated they looked in the laundry area, looked downstairs, and in every room when a resident reported a missing item. NA-A stated the facility had a missing item binder where they wrote down a description of the missing item. NA-A stated clothes were initialed and clean clothes were kept behind a label with resident information, so staff knew whose clean clothes were hanging on the rack. NA-A stated they were unaware of a missing jacket for R9. During an interview on 2/12/25 at 12:17 p.m., anonymous resident stated they lost clothes every wash and were missing black pants, jeans, bras, socks, and shirts. Resident stated their clothes had their initials on them, and nursing assistants told resident they looked for their			F 584			

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

PRINTED: 04/28/2025
FORM APPROVED
OMB NO. 0938-0391

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F 584	Continued From page 19 clothes. Resident stated missing clothes was a "serious problem" and cost the resident a lot of money. During observation review on 2/12/25 at 1:22 p.m., the missing items log did not have an entry for R9's jacket. During an interview on 2/12/25 at 2:10 p.m., RN-A stated the nursing assistants took care of any missing laundry or missing items. RN-A stated the facility had a grievance and missing items log and they were aware R9's family reported a missing jacket. RN-A stated R9 had gained weight and some clothes which were too small for R9 were packed away, so R9 could believe they were missing clothes they were not. RN-A was not sure if the jacket was found or not and knew the family talked to the DON. During an interview on 2/12/25 at 2:43 p.m., NA-B stated they wrote a note or verbally reported to housekeeping when residents brought up concerns of missing laundry. NA-B stated they should get a list started related to missing items. NA-B was not aware of R9's missing jacket. During an interview on 2/13/25 at 3:09 p.m., the director of nursing (DON) stated they thought the life enrichment director checked the missing items log but was not sure if there was a misunderstanding. DON stated the facility had seen R9 wear the jacket which was described as missing. DON stated R9 threw items away at times and outgrew some of their clothes, so staff packed clothes which were too small for R9 outside of their room. DON stated R9's parents went through R9's items weekly and got R9 agitated when they reported items as missing and	F 584			

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

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F 584	Continued From page 20 stolen. DON stated the facility did not find the jacket and talked to the family, and the family was unhappy it was missing. A facility policy related to resident missing items was requested and not available at the time of survey.	F 584			
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure completed Minimum Data Set (MDS) assessments were accurately coded to reflect correct medication use for 5 of 5 residents (R1, R3, R6, R9, and R15). Findings include: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual), dated 10/2024, indicated medications are to be indicated as taken by a resident based on pharmacological classification, not how it is used. The RAI Manual further indicated "herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin)."	F 641	The MDS of R1, R3, R6, R9, R15 have been modified to accurately code medications. The pharmacy consultant has been notified that Melatonin should not be coded as a hypnotic as it is not FDA regulated and is considered a supplement. The current worksheet used to complete MDS's will be updated to reflect medications being monitored on the MDS. An audit will be completed on each residents' current MDS to determine if an error has been made and if an error was made, the MDS will be modified. Audits will be discussed at QAPI for compliance.		4/4/25

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

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F 641	Continued From page 21 R1 R1's quarterly Minimum Data Set (MDS) dated 12/26/24, indicated R1 was admitted to the care facility 7/24/23 and was cognitively intact. The MDS further indicated R1 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication and lacked mention of R1 receiving a anticonvulsant medication despite receiving two different anticonvulsant medications during the look back period. R1's Diagnoses list, printed 2/13/25, indicated R1 had several medical and mental health diagnoses including major depressive disorder, anxiety disorder, dementia, and bipolar disorder. R1's Orders indicated R1 was on several medications including Melatonin (a dietary supplement) 6 milligrams (mg) by mouth one time a day at bedtime, dated 7/24/23; Gabapentin (an anticonvulsant medication) 200 mg by mouth three times a day, dated 7/24/23; and Lamotrigine (an anticonvulsant medication) 25 mg by mouth one time a day, dated 7/25/23. R3 R3's quarterly MDS, dated 12/19/24, indicated R3 was admitted to the care facility on 9/21/09 and was cognitively intact. The MDS lacked mention of R3 receiving anticoagulant and anticonvulsant medication despite being prescribed both medications. R3's Diagnoses list, printed 2/13/25, indicated R3 had several medical and mental health diagnoses including bipolar disorder, major depressive disorder, anxiety disorder.	F 641			

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

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F 641	Continued From page 22 R3's Orders indicated R3 was several medications including Lamotrigine (an anticonvulsant medication) 75 mg by mouth one time a day at bedtime, dated 5/22/24 and Eliquis (an anticoagulant medication) 5 mg by mouth two times a day, dated 2/25/22. During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) stated she was also responsible for completing the MDS. The DON confirmed both R1 and R3 had inaccuracies coded on their MDS, stating it would be expected that each medication is coded as the medication drug class and not what the medication is given for. The DON stated she believed Melatonin should have been classified as a hypnotic, despite the RAI manual stating otherwise. R6 R6's significant change MDS dated 11/7/24, indicated R6 was admitted to the care facility on 10/28/24 and was cognitively intact. The MDS indicated R6 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication, and lacked identification of R6 receiving an anticoagulant medication despite receiving an anticoagulant during the look back period. R6's Diagnoses list, printed 2/11/25, indicated R6 had several medical diagnoses including chronic embolism (blockage in a blood vessel) and thrombosis (occurs when blood clots block blood vessels) of other specified veins and other specified veins, peripheral vascular disease (slow and progressive circulation disorder cause by narrowing, blockage, or spasms in a blood	F 641			

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

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F 641	Continued From page 23 vessel), and insomnia. R6's Medication Administration record dated 11/1/24 to 11/30/24, indicated R6 received Eliquis (an anticoagulant medication) 2.5 mg by mouth two times a day and Melatonin (a dietary supplement to promote sleep) 5 mg by mouth at bedtime. R9 R9's quarterly MDS dated 11/15/24, indicated R9 had a reentry to the care facility on 11/4/24, and moderately impaired cognition. The MDS indicated R9 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication. R9's Admission Record, printed 2/11/25, indicated R9 had diagnoses including insomnia, schizoaffective disorder (chronic mental health condition characterized by symptoms such as hallucinations, delusions, mania, and depression), catatonic schizophrenia (type of schizophrenia which involves a syndrome where the brain does not manage muscle movement signals as it should), and generalized anxiety disorder. R9's Orders indicated R9 was on medications which included Melatonin 6 mg by mouth at bedtime, dated 5/22/24. R15 R15's annual MDS dated 12/4/24, indicated R15 was cognitively intact, and lacked identification of R6 receiving an anticonvulsant medication despite receiving an anticoagulant during the look back period.	F 641			

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

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F 641	Continued From page 24 R15's Diagnoses list, printed 2/14/25, indicated R15's diagnoses included major depressive disorder, anxiety disorder, and attention-deficit hyperactivity disorder. R15's Orders indicated R15 was on several medications including Gabapentin (an anticonvulsant medication) 100 mg by mouth two times a day and 300 mg by mouth at bedtime, dated 6/13/24. During an interview on 2/13/25 at 3:09 p.m., the DON confirmed R6, R9, and R15 had inaccuracies coded on their MDS. The facility provided MDS policy dated 10/23, indicated staff chart in the electronic medical record on resident's care, behaviors, needs, eating, and activities. A licensed practical nurse assisted the DON with interviewing residents and floor staff completed assessments for annual and quarterly MDS. The DON completed significant change and discharge MDS.	F 641			
F 684 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 observation, interview, and document	F 684			4/4/25
			A UA/UC was obtained for R3 and she		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 25 review, the facility failed to assess and monitor skin alterations for 1 of 2 residents (R8) reviewed for skin integrity. Furthermore, the facility failed to follow up with urology after several urinary tract infection and failed to comprehensively monitor and assess (i.e bladder scanning to assess for urine retention, proactive UTI assessments or assessing if R3 required more assistance with toileting or bathing) to timely treat, if needed, and prevent hospitalization for 1 of 1 resident (R3) reviewed for hospitalization. Findings include: R3's quarterly Minimum Data Set (MDS), dated 12/19/24, indicated R3 was cognitively intact and was independent with most activities of daily living and required set up assistance with bathing. R3's progress notes dated 8/6/24 - 2/12/25, indicated R3 had three UTIs in the past six months resulting in two hospitalizations and was displaying current UTI symptoms. On 8/6/24 it was documented R3 had complaints of "strong smelling/cloudy urine" and reported "falling to her knees last week." Reportedly the director of nursing (DON) was notified. On 8/7 24 it was documented R3 reported feeling weak with ambulation and having intermittent "burning pain" with urination and "odorous urine." R3 further stated she felt like she had a UTI. The note indicated, "will updated DON." On 8/29/24 it was documented R3 had a change in condition with increased confusion and inability to stand. R3 was hospitalized, On 8/29/24 it was confirmed R3 was being treated at the hospital for a UTI, 23 days after symptoms started, 23 days after first documented			F 684	was treated with antibiotics appropriately. A urology appt was also made for her to investigate ongoing UTIs. R8 had a skin assessment completed by an RN and will have weekly monitoring completed on bath day.¿ A skin assessment form is kept in the Spa room and Personal Care room and also at the nurses station for staff to fill out whenever a skin alteration such as an open area rash, bruise or redness is noted during cares and/or during bathing. The skin assessment will be completed by the NAR whenever there is a skin alteration, and the nurse will do a skin assessment after checking and documenting the alteration. The paper skin assessment will then be given to the DON who will ensure completion of documentation. Primary MD will be notified by fax to determine if the skin alteration requires a referral to a wound care team. All charting for March has been reviewed and if Resident complained of UTI symptoms or had a similar medical change of condition, they were tested for UTI. All staff will be educated on criteria for obtaining UA/UC and what symptoms to look for. For residents two or more UTI's in a year, a referral for urology will be obtained to see if a cause/prevention can be determined. Staff will be educated to relay and sign and symptoms to charge nurse/DON for determination if UA/UC is needed. Results of monitoring will be discussed at QAPI.		

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

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F 684	Continued From page 26 symptoms. On 9/15/24 it was documented R3 had complaints of cloudy and odorous urine, stating she felt weak. It was documented R3 "did not appear weak when ambulating" and was reminded to drink water. Per progress note next shift notified. On 9/16/24 it was documented R3 denied painful urination but had complaints of feeling weak with ambulation and odorous urine. On 9/25/24 it was documented that R3 had a care conference and voiced concerns about her cloudy urine, stating she "feared" she may have another UTI. R3 agreed to drink more water. DON was to consult R3's physician. On 9/30/24 it was documented in a pharmacy note that R3 had been referred to urology. On 10/2/24 it was documented the physician wrote an order for a urine culture, 17 days after symptoms started. The physician also increased R3's Mirabegron (a medication used to treat overactive bladder) and discontinued R3's Tamsulosin (a medication to treat urine retention). On 11/6/24 it was documented R3 requested staff visualize her urine which was documented as yellow, "slightly" cloudy, and odorous, stating she "thinks" she had pain with urination and felt weak with ambulation. On 11/7/24 it was documented R3 was hospitalized for increased weakness after a fall and was diagnoses at the hospital with acute cystitis (inflammation of the bladder) and had a urine culture pending. On 1/14/25 it was documented R3 stated she wanted a urine culture because she thought she had a UTI again. R3 reported burning with	F 684			

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

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F 684	Continued From page 27 urination, cloudy urine and feeling weak for a "couple of weeks." R3 was encouraged to drink water and R3's concerns were passed on at shift change. On 1/18/25 it was documented R3 reported "symptoms of a UTI for the past few weeks." The DON recommended R3 to drink more water and to take tub baths and showers. On 2/12/25 it was documented R3 continued to report burning with urination, cloudy urine and feeling weak, 29 days after first reporting symptoms. R3 did not have a fever. The DON was aware and instructed R3 to drink water, which R3 "did not like to do." R3's electronic medical record (EMR) lacked documentation of ongoing, comprehensive assessments or updated interventions (i.e bladder scanning to assess for urine retention, proactive UTI assessments or assessing if R3 required more assistance with toileting or bathing) to help prevent and/or timely treat UTIs and hospitalizations. R3's care plan indicated R3 had "had an increased risk for Urinary Tract Infection AEB [as evidenced by] acute polynephritis and urinary incontinence. The care plan lacked intervention updates since 9/3/24 despite continued UTIs and current UTI symptoms. During an interview on 2/12/25 at 8:30 a.m., nursing assistant (NA)-A stated R3 was able to let staff know when she felt like she had a UTI, stating it was obvious because R3 would become very weak. NA-A stated R3 was incontinent of bladder but changed her own brief and toileted herself.	F 684			

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

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F 684	Continued From page 28 During an interview on 2/12/25 at 8:45 a.m., R3 stated she felt like she had another UTI and felt weak. R3 stated she wished the facility would treat her for UTIs at the facility instead of sending her to the hospital. During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated staff try to encourage R3 to drink water but R3 preferred to drink soda. RN-A stated R3 could often tell staff when she thought she had a UTI but was "not always correct." During an interview on 2/13/25 at 12:59 p.m., the DON stated R3 was on a prophylactic antibiotic in the past. At the time it was discovered she had infected kidney stones, and they were removed and R3 had ureter stents placed in March of 2024. R3 saw the urologist on 4/17/24, which was when the prophylactic antibiotic was stopped, and an order was given for R3 to follow up with urology if she started have UTIs again. The DON confirmed R3 had not been back to see the urologist despite multiple UTIs since that time. The DON stated staff would encourage R3 to drink water however R3 preferred soda. The DON confirmed the care planed lacked updated interventions to prevent UTIs stating the facility could not afford a bladder scanner. The DON stated the medical director had not been notified of R3's recurring UTIs but she would notify them and would inquire about getting a urine culture for R3 due to her current UTI symptoms. A facility policy on UTIs was not available at the time of survey.			F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 684	Continued From page 29 R8 R8's quarterly Minimum Data Set (MDS) dated 1/10/25, indicated R8 had intact cognition and no delirium. R8 had delusions, verbal behaviors towards others, wandered one to three days, and did not reject cares. R8 had diagnoses of hypertension (high blood pressure), diabetes mellitus (chronic disease which affects how the body uses sugar for energy), arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety disorder, depression, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R8 had no upper or lower extremity impairments and used a walker. R8 required substantial and/or maximal assistance with shower/bathing. R8 required partial and/or moderate assistance with toileting hygiene, toilet transfers, tub/shower transfers, and dressing. R8 was independent with footwear application and removal, rolling left and right, sit to lying and lying to sitting on side of bed, and with chair and/or bed-to-chair transfers. R8 was occasionally incontinent of urine. R8 took antipsychotic, antianxiety, antidepressant, hypoglycemic, and anticonvulsant medication, was not at risk for pressure ulcers, had moisture associated skin damage, and applications of ointments/medications other than to feet. R8's Care Assessment Area (CAA) worksheet dated 7/16/24, indicated R8 required supervision or touching assistance for sit to lying and lying to sitting on the side of the bed, and R8 was at risk for skin alterations, infection, sepsis, increased dependence on staff, decreased leisure, isolation, and further decline.	F 684			

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

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FORM APPROVED
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F 684	Continued From page 30 R8's pressure ulcer care plan revised 10/14/24, indicated R8 was at risk for pressure ulcer development related to compression stockings. Interventions dated 5/13/24, directed staff to inform R8/family/caregivers of any new area of skin breakdown and remove compression stockings each evening, wash and hang to dry, and apply clean stockings each morning. R8's incontinence care plan dated 5/13/24, indicated R8 had mixed bladder incontinence related to confusion, impaired mobility, inability to communicate needs at times of confusion. The care plan goal dated 5/13/24, indicated R8 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions dated 5/13/24, directed staff to ensure R8 had unobstructed path to the bathroom, and R8 used "Depends" for occasional urinary incontinence. R8's Kardex Report printed 2/12/25, indicated R8 received transfer assistance in and/or out of tub/shower and limited to extensive assistance for bathing and more assistance if confused. R8's Order Summary Report printed 2/12/25, indicated an order for miconazole powder with instructions to apply to abdomen, breasts, peri-area as needed twice daily for "redness/rash skin irritation (yeast areas) with date of 10/2/24. R8's Skin Observation Tool dated 7/29/24, indicated R8 had a "cyst type sore" to their posterior right thigh and was tender to touch. R8's Skin Observation Tool dated 1/3/25, indicated R8 had a superficial "scratch-like"	F 684			

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

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F 684	Continued From page 31 abrasion to their left abdominal fold. No other Skin Observation Tool assessments were recorded from 7/29/24 to 2/13/25. R8's Point of Care Response History had "No Data Found" for Skin Observation in the past 30 days. R8's progress note dated 1/31/25 at 08:39 [8:39 a.m.], indicated R8's skin was intact. During an interview on 2/10/25 at 4:07 p.m., R8 stated they have a "sore" in the crack of their butt. R8 stated staff they had the spot for "a while", and staff placed cream on the area which helped. During observation and interview on 2/12/25 at 8:23 a.m., registered nurse (RN)-A stated R8 brought themselves to the bathroom and walked into R8's bathroom. R8 had their pants and incontinent product pulled down and bent over by waist with buttocks pulled apart. There was an open spot of skin approximately a quarter to half inch in length and width at the top area of R8's butt crack. R8 was placing their fingernails in the spot and stated the area was sore. RN-A looked closely at the area, looked around R8's bathroom, and stated there were no washcloths in R8's bathroom to wash the area. R8 pointed to the green tube of calmoseptine by their bathroom sink and stated the tube was the cream which helped. RN-A assisted R8 to sit on the toilet and left R8's room. R8 stated they had the spot for a "long time", the area hurt when they wiped themselves, and cream helped the pain. R8 was provided privacy to use the bathroom. During observation and interview on 2/12/25 at	F 684			

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

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F 684	Continued From page 32 8:36 a.m., RN-A entered R8's room. R8 was on their bed with their pants pulled up, and R8 stated they were "exhausted". RN-A exited R8's room and stated they could tell someone had taken care of the area previously and had to look at the chart to see if the area was noted before. RN-A stated the area looked like a skin "split" approximately half to three quarters of an inch. During an interview on 2/12/25 at 8:48 a.m., nursing assistant (NA)-A stated they reported new skin concerns to nursing staff, so they could assess if the area needed barrier cream, nystatin powder, or be left open to air. NA-A stated nurses completed weekly skin checks. NA-A stated R8 was independent most of the time and was already up by the time they got to work in the morning. NA-A stated the night shift reported they placed barrier cream on R8's bottom more than weeks ago, because the area looked red and for comfort. During an interview on 2/12/25 at 2:32 p.m., RN-A stated they did not return to R8 to look at their bottom and still needed to check R8's chart to see if the area was a change in condition. RN-A stated there was not a schedule to complete skin checks, and they facility had a lot of independent residents. RN-A stated the shower aid or other staff would tell them if there were any skin concerns, and then RN-A would check the resident's skin. During an interview on 2/12/25 at 2:53 p.m., NA-B stated R8 did not need help in the bathroom unless they had a bowel movement. NA-B stated they applied barrier cream to a lot of residents, including R8. NA-B stated R8's "crack" bothered R8, and NA-B applied cream to a red area on			F 684			

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

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F 684	Continued From page 33 R8's bottom after R8 had a shower the week prior. NA-B stated they did not need to let the nurse know, because the area on R8's butt crack was "just a little pink". NA-B stated they alerted the nurse when residents had skin changes, such as an open tear. During an interview on 2/13/25 at 3:13 p.m., the DON expected staff to alert nursing staff about any skin alterations, and the nurses documented on resident's skin after a skin assessment. DON stated R8 was independent with toileting during the day and needed more assistance at night. DON stated they were not aware of any open skin area or shearing on R8. DON stated they wanted to ensure R8 had the right treatment to decrease risk for infection and worsening of the area. The facility's Skin Monitoring policy dated 10/2021, directed the nursing assistants to check the residents' skin during each shower and notify the nurse of any skin alterations and any possible explanation. The policy directed staff to complete a "Skin Observation Tool" assessment for any skin alteration, such as a bruise, rash, open area, skin tear, blister, or any other skin alteration. Staff were to schedule a weekly assessment by a registered nurse as well as a treatment plan for healing when a skin alteration was found. Staff were to notify the DON of any skin issue for follow-up.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689			4/4/25

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

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F 689	Continued From page 34 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who wished to smoke off facility grounds was properly assessed for safety, and risks of unsupervised smoking were discussed for 1 of 1 resident (R5) reviewed for smoking. The facility further failed to ensure residents at risk for falls were assessed for a root cause and new interventions were put in place to prevent falls for 2 of 3 residents (R10 and R8) reviewed for falls. Findings include: R5 R5's quarterly Minimum Data Set (MDS) dated 1/8/25, indicated R5 was cognitively intact. The MDS further indicated R5 utilized a walker for locomotion and was independent with most activities of daily living (ADLs) except bathing. R5's progress note, dated 1/6/25, indicated R5 asked staff if it was okay for her to go outside and walk down the trail. Staff assured R5 it was okay as long as staff knew where she was. That afternoon R5 came back to facility smelling of smoke. R5 confirmed she was aware the care facility was a non-smoking facility but she would like to smoke off property. R5 was also informed that if her decision was to continue smoking, she would need to find alternative placement. R5 verbalized feeling overwhelmed and it was suggested that she take some time to think about what she wanted to do.	F 689	Hope Springs at Minnetonka is a smoke free facility. Prior to admission, one of the screening questions asked by our DON is if the referral is a smoker. We do not admit smoking residents. We were told R5 was not a smoker. A smoking assessment was offered to R5 but she declined stating that she no longer wished to smoke. HSM will have R5 sign documentation that they have refused a smoking assessment. In the future, if the any other residents who wish to smoke when they are off of facility grounds a smoking assessment will be completed and documented accordingly. R10's Kardex lacked mentioning that R10 was a fall risk and interventions were in place to prevent further falls. R10's care plan and Kardex was updated to reflect interventions for fall prevention. An audit of all care plans and Kardex will be completed and updated by 4/4/25. Staff will be re-educated on the fall intervention book and what needs to be completed. An audit assessment will be discussed at QAPI committee meeting.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 35 R5's electronic medical record (EMR) lacked evidence a safe smoking assessment was completed on R5, risks of smoking unsupervised were discussed with R5, and any interventions were care planned to ensure R5's decision to occasionally smoke off campus was as safe as possible (i.e. ensuring staff knew when she was leaving campus, monitoring clothes for burn holes, etc). During an interview on 2/12/25 at 8:54 a.m., R5 stated she wanted to have the right to smoke off campus occasionally but did not want to leave the facility as she liked living there. R5 stated she had gone off campus by walking up the path off the parking lot twice to smoke. R5 stated when she came back the second time the aide had noticed she smelled like smoke and notified the director of nursing (DON). R5 stated she still had a pack of cigarettes and a lighter in her room but had not smoked since. R5 further stated staff had not assessed her for safe smoking, just told her she could not smoke as it was a non-smoking facility. During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated she was aware R5 had, and wanted to continue to smoke off campus, stating the facility had put up signs to indicate there was no smoking on the facility grounds. RN-A stated R5 was "talked to" by the DON and administrator but that a safe smoking assessment was not completed because "they [residents] are not supposed to smoke." RN-A further stated R5 was asked about starting a nicotine patch but was not sure if she wanted one and had not been followed up with. During an interview on 2/13/25 at 12:59 p.m., the	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 36 DON stated they held a meeting with the ombudsman and R5 had stated she did not want to smoke, however a few days ago she had informed the administrative assistant she did want to smoke. The DON confirmed they had not completed a safe smoking assessment for R5 or put any interventions into place to ensure R5 was as safe as possible if she chose to smoke off campus because they were a non-smoking facility, and she "did not admit smokers". A facility policy on smoking assessments was requested but not received. R10 R10's quarterly MDS dated 12/9/24, indicated R10 had moderate cognitive impairment, was independent with ambulation, and had one fall without injury since last assessment. R10's last two fall assessments, dated 9/10/24 and 11/5/24, both indicated that R10 was at risk for falls. R10's progress notes, dated 8/2/24 - 9/14/24, indicated R10 had three falls in the past 6 months, two out of three of them happening on a Thursday. On 8/2/24, it was documented R10 was found on the floor in her room. On 9/13/24, it was documented R10 was hospitalized after a fall in her bathroom while standing at her sink, resulting in a head strike and laceration above her left eye. On 11/5/24, it was documented R10 was found on the floor in her room and reported hitting her	F 689			

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

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F 689	Continued From page 37 head. R10's care plan, printed 2/14/25, indicated R10 had a history of falls, most current on 11/5/24. R10's care plan indicated several fall interventions dated 2/23/24, and 9/17/24, including monitoring orthostatic blood pressure monthly (checking for blood pressure changes with position changes which may cause dizziness), using a wheelchair while at her bathroom sink and reminding R10 to always have her walker with her. The care plan lacked intervention updates for R10's falls in August and November. R10's Kardex, printed 2/14/25, was utilized by the facility nursing assistants (NA) to know what cares to provide a resident and any special instructions. The Kardex lacked any mention of R10 being a fall risk or any fall interventions. R10's electronic medical record (EMR) indicated the last 2 orthostatic blood pressure that were taken or recorded was on 6/13/24 and 9/9/24. The facility's Fall Tracking Book lacked any mention of the fall on 8/2/24. R10's EMR identified that R10 was weak after receiving weekly ETC (Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions) on Wednesdays, however failed to implement new, care planned interventions for falls and post ECT monitoring despite R10 almost always falling on	F 689			

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

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F 689	Continued From page 38 the Thursday after ECT. During an interview on 2/15/25 at 8:30 a.m., NA-A stated R10 was independent with most ADLs, including grooming and ambulation. NA-A stated when R10 came back from ECT she was weak and staff would offer her a wheelchair to go to lunch or watch her close at lunch if she refused her wheelchair. NA-A was unaware of any other fall interventions or post ECT monitoring. During an interview on 2/12/25 at 10:30 am, registered nurse (RN)-A stated R10 had ECT every Wednesdays and she would have the NAs keep her in her wheelchair when she arrived back to the facility. RN-A stated that was the only fall intervention or post ECT monitoring she was aware. During an interview on 2/13/25 at 12:59 p.m., the DON stated it would be expected that will each fall the nurse would be implementing a new intervention and writing the fall, root cause and interventions on the fall log. The DON stated at times she would be included in the conversation to help "think outside the box" to ensure a new intervention was always implemented. The DON confirmed R10's care plan and Kardex lacked interventions for post ECT monitoring and while staff were monitoring R10 closer when she returned to the community from ECT, the weakness continued into Thursday when most falls were happening. The DON further confirmed it would be expected that orthostatic blood pressures were monitored monthly as stated in R10's care plan. A facility policy titled Falls/Incidents, dated 8/2021, indicated nursing staff should determine	F 689			

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

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F 689	Continued From page 39 the cause of the fall after each fall and implement and record what new intervention was being implemented to help prevent future falls. R8 R8's quarterly Minimum Data Set (MDS) dated 1/10/25, indicated R8 had intact cognition and no delirium. R8 had delusions, verbal behaviors towards others and wandered one to three days, and did not reject cares. R8 had diagnoses of hypertension (high blood pressure), diabetes mellitus (chronic disease which affects how the body uses sugar for energy), arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety disorder, depression, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R8 had no upper or lower extremity impairments and used a walker. R8 required partial and/or moderate assistance with toileting hygiene, toilet transfers, and dressing. R8 was independent with footwear application and removal, rolling left and right, and with chair and/or bed-to-chair transfers. R8 was occasionally incontinent of urine. The MDS indicated R8 had one fall with no injury since the last assessment. R8 took antipsychotic, antianxiety, antidepressant, hypoglycemic, and anticonvulsant medication. R8's Care Area Assessment (CAA) worksheet for falls dated 7/16/24, indicated R8 was at risk for falls related to fall history and antianxiety and antidepressant medication use. The CAA noted R8 had a history of falls in their room when getting up from their recliner and using their	F 689			

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

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F 689	Continued From page 40 walker. R8 was at risk for falls, injury, discomfort, increased dependence on staff, decreased leisure, isolation, and further decline. R8's Fall Risk Assessment dated 1/4/25, indicated R8 had one to two falls in the past three months, was ambulatory and continent, had intermittent confusion and/or forgets limitations, required use of assistive device, had systolic blood pressure drop less than 20 mmHg (millimeters of mercury) between lying and standing in three minutes, took three to four of medications the medication classes listed within the past seven days, and had three or more present predisposing conditions or diseases. R8 was "at risk" for falls. R8's Fall Risk Assessment dated 1/28/25, indicated R8 had one to two falls in the past three months, was ambulatory and incontinent, was alert, had normal gait and/or balance, did not have a drop in systolic blood pressure between lying and standing, did not take psychoactive or other listed medication classes in the past seven days, and did not have predisposing conditions or diseases. The assessment indicated R8 was not "at risk" for falls. R8's fall care plan revised 11/13/24, indicated R8 was at moderate risk for falls related to confusion, gait and/or balance problems, incontinence, poor communication and/or comprehension, psychoactive drug use, and unaware of safety needs. The fall care plan indicated R8's last fall was on 11/13/24. Fall interventions included: -11/13/24, be sure R8's call light within reach and encourage to use call light for assistance as needed. R8 needed prompt response to all requests for assistance.	F 689			

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

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F 689	Continued From page 41 -11/13/24, encourage appropriate use of assistive device. -7/4/24, encourage R8 to sleep in bed and not recliner to promote good sleep and to prevent falls from R8 trying to get out of chair with the footrest up when R8 was confused. -4/13/24, ensure R8 wore appropriate footwear non-skid socks when ambulating or mobilizing in wheelchair. R8's Kardex Report printed 2/12/25, directed staff to keep R8's call light within reach, encourage R8 to use for assistance as needed, and provide prompt response to R8's requests for assistance. Staff were to ensure R8 had an unobstructed path to the bathroom, wore appropriate footwear non-skid socks when ambulating or mobilizing in wheelchair, and encourage R8 to use assistive device. R8's progress note on 1/28/25 at 3:55 a.m., indicated R8 pushed their call light and was found sitting on the floor in front of their recliner in their apartment. The note indicated R8 stated they slid out of the recliner when trying to pick up a blanket which was on the floor. Range of motion of upper and lower extremities were intact and equal, vital signs were stable, and no injuries or pain were noted or reported. R8 used the bathroom and sat in their recliner covered with blankets. The director of nursing was notified. The facility fall book indicated R8 had an unwitnessed fall from their recliner in their room on 1/28/25. The note indicated R8 tried to reach their blankets which were on the floor. Interventions included to remind R8 to use call light all the time to get assistance from staff and encourage R8 to sleep in bed instead of recliner.	F 689			

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

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F 689	Continued From page 42 R8's medical record lacked evidence of fall prevention interventions based on a root cause analysis after the fall on 1/28/25. During interview on 2/12/25 at 10:52 a.m., nursing assistant (NA)-A stated they notified a nurse if they found a resident on the floor, and the nurse completed an assessment and obtained vital signs. Staff asked the resident what happened and what they were trying to do before the fall and assisted the resident back into a wheelchair, recliner, or bathroom. NA-A was unsure of fall interventions for R8. NA-A stated R8 was found on the ground before, and the facility found R8 placed themselves on the floor by reviewing the facility camera footage. NA-A stated R8 had previous falls, and staff helped R8 when needed. During interview on 2/12/25 at 2:53 p.m., NA-B stated fall interventions for R8 were to set up anything they need around them, ensure walker and call light were close by, check on R8 frequently, and remind R8 to use their call light and keep walker close to themselves. During interview on 2/13/25 at 11:55 a.m., licensed practical nurse (LPN)-A stated they have a fall tracker sheet which listed interventions to prevent future falls. LPN-A stated they take vitals, assessed for injury, asked the resident what happened, and completed neurological checks for unwitnessed falls. During interview on 2/13/25 at 3:13 p.m., the director of nursing (DON) stated nurses updated resident care plans with new interventions after a fall. DON brought fall information to QA (quality			F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 43 assurance) to discuss. DON stated R8 had two or three falls at night when first admitted and were recliner related. DON stated R8 knew they slept better in bed and talked about sleeping in bed at care conferences. DON reviewed R8's care plan and confirmed R8's fall care plan was not updated after R8's fall on 1/28/25. DON stated the fall interventions were repeated for R8 as they were unsure if the previous fall interventions were followed. DON thought they educated staff on R8's fall interventions or placed a note in their Homebase app (app used by businesses to assist with scheduling, payroll, communication) but did not provide documentation of such. DON stated if staff captured all the needed fall information in the progress notes and fall book, they would not have to write a four-page fall report. DON stated they have a fall book which they have not implemented yet to further analyze resident falls. DON stated creating and implementing fall interventions were important to prevent R8 from future falls and injury. The facility policy Falls/Incident dated 8/2021, directed staff to complete the Fall/Incident report and a progress note detailing the fall/incident, vital signs, and who was notified. The policy directed staff to chart under "Fall Risk Assessments" and in the fall tracking book about what type of fall occurred and the intervention implemented to prevent further falls/incidents. The policy directed staff to chart the date of the fall/incident and implemented intervention in the care plan.	F 689			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697			4/4/25

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F 697	Continued From page 44 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess pain and attempt non-pharmacological pain interventions for 1 of 1 resident (R11) receiving multiple medications for pain. Findings include: R11's quarterly Minimum Data Set (MDS), dated 1/7/25, indicated R11 was cognitively intact and had pain "almost constantly" that frequently effected sleep and day to day activities. The MDS further indicated R11 had received pain medication during the look back period however had not received any non-pharmacological pain interventions. R11's Orders, printed on 2/13/25, indicated R11 received several medications for pain including Ajovy (used to prevent migraine headaches) 225 milligram (mg)/1.5 milliliters (ml) inject subcutaneously once a month for intractable migraines, alpha-lipoic acid (used in alternative medicine to aide treating nerve pain) 300mg by mouth two times a day for polyneuropathy (a condition where multiple peripheral nerves throughout the body become damaged or malfunction which may cause numbness, tingling, burning or stabbing pain), Gabapentin (commonly used medication for the treatment of neuropathic pain) 1200 mg by mouth three times a day for polyneuropathy, diclofenac sodium gel 1% (a	F 697	R11's care plan does not list non-pharmacological pain interventions. Non-pharmacological interventions will be listed on R11's care plan and staff will be educated on offering interventions from this list and documenting with a follow-up or refusal. R11's scheduled pain medication also does not prompt the nurse to ask R11 to rate her pain level which it now does. A chart audit will be completed on all residents to make sure that any scheduled or PM analgesics ask for a pain rating. Upon admission, quarterly and with a change in condition or a change in PRN or scheduled pain management, a comprehensive pain assessment will be completed. A new pain policy will established and reviewed at the next quarterly QAA meeting in April.		

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

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F 697	Continued From page 45 medication used to relieve pain and inflammation associated with arthritis, sprains, and other musculoskeletal conditions) apply to neck, shoulders and arms as needed for pain (self-administered), Humira 40 mg/0.4 ml (a medication used to treat arthritis) inject 80mg subcutaneously one time a day every 14 days for arthropathic psoriasis (chronic inflammatory condition that affects the joints causing joint pain, stiffness and swelling), and Nurtec (a medication used to treat migraines) 75 mg sublingually daily as needed for migraine (received on 2/10/25). R11's care plan, dated 6/26/24, indicated R11 was on pain medication therapy related to neuropathy, bladder spasms, muscle tendon pain and migraines and R11 had chronic pain related to psoriatic arthritis, depression, neuropathy and migraines. The care plan lacked resident specific non-pharmacological pain interventions. R11's electronic medical record (EMR), including the medication administration record (MAR) lacked any pain assessment in the past seven months to include pain goal, what makes pain better or worse and non-pharmacological interventions that were tried and successful or unsuccessful. During an interview on 2/10/25 at 6:00 p.m., R11 stated she had pain almost constantly but did not want to take more medication. R11 denies staff attempting to use non-pharmacological pain interventions and stated staff do not ask her about her pain levels or what makes it better or worse. During an interview on 2/13/25 at 8:21 a.m., licensed practical nurse (LPN)-A stated pain	F 697			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 697	Continued From page 46 assessments should be conducted at least quarterly but also anytime a resident received a pain medication, the MAR would prompt staff to record the resident's pain level. LPN-A stated R11 had an implanted pain device in her neck and was working with a pain clinic, but they did not use any non-pharmacological pain interventions with her. LPN-A stated they would only implement non-pharmacological pain interventions if it was ordered by the doctor. During an interview on 2/13/25 at 8:27 a.m., nursing assistant (NA)-C stated R11 had complaints of stomach pains and migraines, and most recently had been "complaining of pain a lot" stating she believed it to be behavioral. NA-C stated she had not been told about any non-pharmacological pain intervention for R11 and had not tried anything herself for R11's pain. During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) confirmed that there were no non-pharmacological pain interventions for R11. The DON stated when staff were administering R11's diclofenac sodium gel the nurses were prompted by the medication administration record (MAR) to ask about R11's pain level but since R11 was self-administering the medication the pain assessment piece had "fallen off."	F 697			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate	F 700			4/4/25

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F 700	Continued From page 47 alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure alternate interventions were assessed and/or attempted, risks and benefits of bed assist devices were reviewed, and consent was obtained for 1 of 2 residents (R9) reviewed for bed assist devices. Furthermore, the facility failed to remove a bed assist device or re-evaluate its use after an assessment indicated the bed assist device was not needed for 1 of 2 residents (R14) reviewed for bed assist devices. Findings include: R9 R9's quarterly minimum data set (MDS) dated	F 700	An audit will be completed on all the resident beds in the facility to determine if bedrails are being used. If a bedrail is on a resident bed, their chart will be audited to see if an assessment has been completed in the last quarter. If it was not done in the last quarter, an assessment will be completed and added to their chart. Education will be provided for all nurses to know that a bedrail assessment should be completed quarterly and their MDS with and with a change in condition. If a bedrail is no longer needed after the assessment, it will be removed. Audits will be discussed at the QAPI meeting. The bed rails have been removed from		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 700	Continued From page 48 11/15/24, indicated R9 had moderately impaired cognition, inattention, disorganized thinking, hallucinations, delusions, verbal and other behaviors, and rejected cares. R9 had no upper or lower extremity impairments and used a walker. R9 required partial and/or moderate assistance for dressing and supervision for footwear application and removal, toileting, personal and oral hygiene, and ambulation. The MDS indicated R9 had arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). The MDS indicated bed rails were not in use. R9's care plan dated 11/13/24, did not indicate use of a bed assist device. R9's admission Bedrails Risk Assessment Flow Chart dated 6/7/24, indicated R9 did not need bed rails. A progress note dated 6/2/24 at 01:35 [1:35 a.m.], indicated staff tied R9's call light to their left "siderail". A progress note dated 6/15/24 at 07:27 [7:27 a.m.], indicated staff tied R9's call light to their "side rail". A progress note dated 7/15/24 at 06:38 [6:38 a.m.], indicated R9 detached the call light attached to their "bed siderail" twice. R9's medical chart did not mention anything further on bed assist device use, education of risks and benefits, consent, or attempted			F 700	R9 and R14's bed.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 700	Continued From page 49 alternatives prior to installation of the bed rail. During observation and interview on 2/10/25 at 2:45 p.m., the left side of R9's bed was against the wall, and a bed assist device was on the right-hand side of R9's bed. R9 stated they did not use the device, did not have to sign anything for the device in place, and the device was in place when they admitted. R14 R14's annual MDS dated 11/20/24, indicated R14 had intact cognition, had no behaviors, and was independent for most activities of daily living. R14 had diagnoses of diabetes mellitus (condition when blood sugar is too high), anxiety, depression, and schizophrenia. The MDS indicated bed rails were not in use. R14's care plan dated 1/8/25, did not indicate use of bed assist device. R14's Bedrails Risk Assessment Flow Chart Tool dated 12/29/21, indicated use of bed rails was beneficial for R14. R14's Bed Rails Risk Assessment Decision to Use form dated 12/30/21, indicated R14 used bed rail for repositioning and easy access to bed controls and personal care items. The form indicated R14 was educated how to use the bed rail, about the need for bed rails, and its use. R14's quarterly Bedrails Risk Assessment Flow Chart dated 6/11/23, indicated bed rails were not needed. R14's chart did not contain any other bed assist	F 700			

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F 700	Continued From page 50 device assessments. R14's progress note dated 7/30/24 at 17:51 [5:51 p.m.], indicated staff placed call light to R14's "siderail". R14's progress note dated 11/6/24 at 02:48 [2:48 a.m.], indicated staff secured call light to "grab bar". During observation and interview on 2/10/25 at 5:28 p.m., R14 had a bed assist device on the right side of their bed. R14 stated they did not use the device and did not remember if anyone educated them about the risks and benefits and obtained consent for use. During an interview on 2/12/25 at 10:37 a.m., nursing assistant (NA)-A stated R9 required supervision to limited assistance with morning activities of daily living. NA-A they were not sure how often R9 used their bed assistive device and saw R9 grab the device to lift out of bed and then grab their walker. NA-A stated R14 required more assistance after a fall but moved back to their original room on the first floor once their strength returned and they were more independent again. During an interview on 2/12/25 at 2:32 p.m., registered nurse (RN)-A stated they did not complete bed rail assessments and was unsure about other nursing staff. During an interview on 2/12/25 at 2:45 p.m., NA-B stated R9 used the device on their bed to get out of bed. NA-B stated R14 was independent. During an interview on 2/13/25 at 2:20 p.m., the administrator stated they installed bed assist			F 700			

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F 700	Continued From page 51 devices when the director of nursing (DON) communicated the need to them. During an interview on 2/13/25 at 3:31 p.m., DON stated bed rail assessments were completed upon admission and quarterly. DON stated other nursing staff were able to complete bed rail assessments and told DON what residents needed bed assist devices applied. DON expected notification if any assessment indicated a change in bed assist device use. DON stated they thought they were told R9 needed a bed assist device and verified R9 did not have a consent or education of risks and benefits in their chart. DON stated R14's bed assist device was part of a fall intervention after R14 got out of the right side of bed, slipped, and fell. DON was not aware of R14's bed rail assessment which indicated R14 did not need bed rails. The facility policy Bed Rails Assessment and Use Policy dated 6/2023, directed staff to use the Bed Rails Risk Assessment form to determine if bed rails were appropriate upon admission, quarterly, and as change in resident's health condition. The assessment may result in bed rail removal if determined resident's condition has improved for which the bed rail was installed. The policy directed staff to discuss the need for bed rails, risks and benefits, and obtain an informed consent prior to installation.	F 700			
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at	F 727			4/4/25

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F 727	Continued From page 52 least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight consecutive hours per day. This deficient practice had the potential to affect all 21 residents who resided in the facility. Findings include: The PBJ (Payroll Based Journal) Staffing Data Report triggered for no continuous 8-hour RN coverage in 24-hour period for four or more days within 4th quarter. Infraction dates were 7/17/24, 7/18/24, 7/24/24, 7/26/24, 9/21/24 and 9/22/24. Document review of the schedule from 10/1/24 - 2/9/25, identified the facility failed to have RN coverage for the dates of: 11/9/24, 11/10/24, 11/28/24, 11/29/24, 12/21/24, 12/25/24, 1/1/25, 1/18/25 and 1/20/25. During interview on 2/10/25 at 9:37 a.m., R12 stated no concerns were reported in resident council. R12 stated the facility was staffed very well with knowledgeable and well-established staff.			F 727	Hope Springs has regularly scheduled RN staffing 7 days a week for 8 hours a day. ¿The failures to achieve this requirement occur when there are call ins or scheduled vacations. ¿Every effort is made to replace a regularly scheduled RN shift with another RN but due to our small staff size this is not always possible. ¿It is the understanding that this requirement is made to ensure that the regular availability of an RN with a higher degree of medical training is made available to all the residents on a daily basis. ¿In the Administrators opinion staffing these rare occurrences, when our own RNs are not available because of a staffing change, with one of the facilitys own LPNs, who are tenured employees with exceptional knowledge of our residents provides a better continuity of care, and is a safer and more effective alternative than staffing with a staffing pool agencys RN, who does not know our residents but fulfills the rigid RN staffing requirements of CMS. ¿In this day in age when simply staffing all shifts is a challenge for most facilities, Hope Springs has done a		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 727	Continued From page 53 During interview on 2/13/25 at 1:03 p.m., director of nursing (DON) indicated they were responsible for staffing the facility and submitting the PBJ reports. They confirmed the facility did not have eight hours of continuous RN coverage daily, however, stated there was proper coverage with regularly scheduled competent staff, and stressed the importance of continuity of care of licensed staff for the residents outweighing the title of RN over LPN (licensed practical nurse), and the skill set to care for these residents was met with an LPN. The focus of individual care plans for residents was important, as important to survey to individual care of facilities. A facility' policy on staffing was requested, not received.	F 727	remarkable job staffing all nursing shifts with dependable and qualified employees to care for our residents, especially when compared most other nursing homes in the state. ¿Larger facilities have multiple RNs on duty on many shifts, making it easier for them to comply with this requirement. Hope Springs contracts with Clipboard Health for our nuring pool options. ¿The administrator and DON will make every effort to staff the facility with RN coverage 7 days a week for 8 hours a day. Nursing pool will be scheduled as needed to fill in when our own staff are not available. ¿The QA committee will review RN coverage as needed in the overall QAPI program.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758			4/4/25

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F 758	Continued From page 54 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure orthostatic hypotension (characterized by a sudden drop in blood pressure that may lead to dizziness, lightheadedness, or fainting) was communicated the physician to ensure psychotropic medications (which can commonly cause orthostatic hypotension due to their effect on the body's blood vessels) did not need to be reduced to	F 758	R3's psych provider was not notified of her orthostatic hypotension that was obtained on 12/18/2024. The covering provider at Behavioral Care Solutions has since been notified. A chart audit will be completed to determine if any other residents have had assessments completed that have had a drop in blood pressure noted in their orthostatic BP		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 55 prevent falls, over sedation or complications for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R3's quarterly Minimum Data Set (MDS), dated 12/19/24, indicated R3 was admitted to the care facility on 9/21/09 and was cognitively intact. R3's Diagnoses, printed 2/13/25, indicated R3 had several medical and mental health diagnoses including bipolar disorder, major depressive disorder and anxiety disorder. R3's Orders indicated R3 was receiving several medications including Venlafaxine (an antidepressant medication which may cause orthostatic hypotension) 225 milligrams (mg) by mouth one time a day for major depressive disorder, dated 5/4/22; Risperdal (an antipsychotic medication which may cause orthostatic hypotension) 0.75 mg by mouth one time a day at bedtime for bipolar disorder, dated 4/10/22; Citalopram (an antidepressant medication) 20 mg by mouth one time a day at bedtime for bipolar disorder, dated 12/21/21; Clonazepam (an antianxiety medication which may cause orthostatic hypotension, especially in older adults) 0.5 mg by mouth one time a day at bedtime for anxiety or agitation, dated 12/21/21; and Lamotrigine (an anticonvulsant medication that may cause orthostatic hypotension) 75 mg by mouth one time a day at bedtime for bipolar disorder. R3's last orthostatic blood pressure reading (blood pressure taken while a person is laying, then sitting, then standing to monitor for changes.			F 758	assessments and the covering provider will be notified by April 4th 2025.¿ Orthostatic blood pressures will be completed monthly for any resident on psychotropic medication and that psych provider will receive a copy of the assessments during her monthly visit.¿ A monthly Audit¿ will be completed by the DON to make sure that orthostatic BPs were completed and given to the psych provider.¿ The audit of monthly orthostatic BPs will be discussed at the QAPI meeting.		

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F 758	Continued From page 56 Orthostatic hypotension is defined as a decrease in systolic blood pressure of at least 20 mmHg or diastolic blood pressure of at least 10 mmHg within 3 minutes of standing up) was recorded on 12/18/24 as 155/90 (lay) and 112/80 (sit) indicating orthostatic hypotension. R3's care plan indicated R3 was at low risk for falls related to psychotropic medication use initiated in 6/30/15 and revised on 8/1/24. During an interview on 2/13/25 at 12:32 p.m., the consultant pharmacist (CP) stated that any drop in blood pressure readings should be reported to the physician for medication review as the resident may need a change or decrease in their medication. The CP stated the conversation should be documented and the resident should have closer fall monitoring initiated. During an interview on 2/13/25 at 12:43 p.m., licensed practical nurse (LPN)-A stated when assessing a residents' orthostatic blood pressure reading, if there was more than a 20-point difference it should be reported to the director of nursing (DON) or directly to the physician if it was more significant. During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) stated she would expect that psychiatric provider be notified if there were changes in a residents' orthostatic blood pressure readings. The DON stated she generally reviews the orthostatic blood pressure readings when she completes the MDS but was unaware of R3's drop in blood pressure readings, confirming the physician and/or psychiatric provider was also not notified to assess the resident's medications.			F 758			

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F 758	Continued From page 57	F 758			
F 805 SS=D	A facility policy on psychotropic medication use was requested but not received. Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the appropriate, modified diet was given, and risks versus benefits of refusing a modified diet were discussed with 1 of 2 residents (R18) who had difficulty swallowing and recent coughing episodes after meals. Findings include: R18's quarterly Minium Data Set (MDS), dated 1/16/25, indicated R18 was admitted to the care facility on 11/8/23, and was cognitively intact. The MDS further indicated R18 had coughing/choking episodes during meals. R18's Diagnoses, dated 11/7/23, indicated R18 had several medical diagnoses including dysphagia (difficulty swallowing) and moderate protein-calorie malnutrition. R18's Orders, dated 7/15/24, indicated an order for "mechanical soft texture, regular consistency, easy to chew texture." R18's Care Plan, dated 11/24/23, and revised on	F 805			4/4/25
			R18 will have a risks versus benefits discussion/assessment with the nursing staff and/or Dietitian to ensure that the resident understands both the risks and benefits of having a mechanically altered diet and its impact upon aspiration and choking. ¿After the discussion R18's care plan will be updated to indicate any choices/determinations that are made. ¿In addition the dietary Kardex will be updated so that the dietary staff and nursing assistants are consistent in their application of the choices and decisions that R18 made regarding their diet. ¿It will be clear as to whether the resident has their food cut up into smaller pieces, or needs to be mechanically soft or pureed. ¿If the resident chooses to continue with a liberal diet that choice will be documented in their care plan and the dietary Kardex. ¿The Dietitian will be responsible to ensure that the risk/benefits discussion/assessment is conducted and documented consistently in both the care plan and dietary Kardex. ¿The Dietitian		

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F 805	Continued From page 58 2/10/25, indicated R18 was able to feed himself and staff was to provide "soft food and ground meat", indicating at times R18 would "ask that his meat not be ground." The care plan further indicated R18 had been offered, and declined, a pureed diet on 5/28/24. R18's Kardex, printed 2/14/25, indicated R18 was to receive soft foods and ground meat, however, would sometimes ask that meat not be ground up. The "Resident's Diets" book, utilized by the cooks in the kitchen to ensure the residents received the correct diet and food texture, indicated R18 should have "food cut into small, bite sized pieces." R18's progress notes, dated 1/14/25 - 2/14/25, indicated R18 had 11 coughing episodes during meals in the past 30 days. On 1/14/25, it was documented R18 consumed 100% of his meal (soup and grilled cheese) and "did have some coughing during and after his meal." On 1/15/25, it was documented R18 attended dinner and "did cough a little while eating. He eats a mechanical soft diet." On 1/31/25, it was documented R18 "appeared to have a cough." On 2/1/25, it was documented R18 was "coughing during his supper meal again" and "had chili, consumed most of it including a corn muffin."	F 805	will also review all other residents who may need to have a risks versus benefits discussion with nursing staff and Dietitian to ensure that they are kept safe in their eating choices. ¿ The Administrator will ensure that this is done on as needed for new residents and ones that have a change in eating status. The QAPI committee will review and discuss the dietary assessments. ¿		

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F 805	Continued From page 59 On 2/2/25, it was documented R18 "only ate his soup for supper, coughed & sneezed off & on and then once he got to the elevator to go back upstairs, he started coughing quite hard again." On 2/2/25, it was documented R18 was asked if he was "having difficulty at mealtime in swallowing his food and/or fluids evidenced by his increased coughing spells that nursing (and some concerned residents) have observed. [R18] deni[ed] having any swallowing difficulties and offered no other information." On 2/3/25, it was documented R18 was "heard by writer coughing as he was entering his room after lunch. Writer was 2 rooms down and could hear the resident cough x2 hard to the point where he almost vomited." On 2/4/25, it was documented R18 was "coughing a little at dinner." On 2/5/25, it was documented R18 "ate a hamburger for supper and had coughing during his meal per usual. He [was] supposed to have mechanical soft texture, but resident chooses not to per his request. He denied any difficulty chewing or swallowing his hamburger meat." On 2/6/25, it was documented R18 requested the crispy chicken sandwich for dinner and stated "No" when asked if he wanted to "ground up for easy chewing/swallowing." R18 was documented as coughing while eating his crispy chicken sandwich. On 2/12/25, it was documented R18 ate grilled cheese and tomato soup "with some coughing noted."	F 805			

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F 805	Continued From page 60 During observation on 02/12/25 at 8:13 a.m., R18 was sitting at the breakfast table eating a bowl of corn flakes, eggs, raisin toast and bacon. During an interview on 2/12/25 at 8:30 a.m., nursing assistant (NA)-A stated the nursing assistants utilized the Kardex to now how to care for residents, how they transfer, level of assistance needed, their diet, etc. NA-A stated R18 was on a regular diet and staff cut up his food into bite sized pieces. During an interview on 2/12/25 at 8:51 a.m., R18 stated he should be eating his food cut up into bite sized pieces but did not always receive it that way. R18 stated he had not had any discussions with staff on the risks versus benefits of his food choices, including the risks of aspiration or choking. During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated R18 received his medications crushed in applesauce and was supposed to receive a soft diet but she was not down in the dining room during mealtimes so could not confirm what type of diet staff were providing R18, stating R18 would eat whatever was put in front of him. During observation and interview on 2/12/25 at 12:08 p.m., R18 was given a plate of potato wedges, broccoli salad and barbeque ribs, nothing on the plate was cut into bit sized pieces. R18 attempted to cut a few bites of meat but was unsuccessful and sat and stared at his food after eating a few bites until NA-A removed his full plate of food without offer to help cut up his food. NA-A stated his meat should have been cut up			F 805			

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F 805	Continued From page 61 into bite sized pieces, stating she did not offer to cut it up because "even if it was, he wouldn't eat it." During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) stated the expectation was for R18 to receive "minced meat" however she had found out last week that he was refusing at times. The DON confirmed she had not discussed risks versus benefits of refusing his prescribed diet, stating she needed to have a discussion with R18 to address his food choices and the risks of refusing to have his meat minced.	F 805			
F 812 SS=F	A facility policy regarding modified diets was requested but not received. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812			4/4/25

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F 812	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure cups were completely dry before storing and stacked bowls stayed dry to prevent bacterial growth. In addition, the facility failed to ensure food items were properly labeled and dated, failed to ensure staff covered their hair, assess food temperature during food prep, and to ensure staff followed appropriate infection control technique during food service. This had potential to affect all 21 residents who were served food from the kitchen. Findings include: During the initial kitchen tour on 2/10/25 at 12:26 p.m., a refrigerator in the main kitchen had sliced cheese with no opened date or expiration date and half of Smithfield boneless ham wrapped in plastic with expiration date of February 26, 2025 and no opened date. The freezer in the main kitchen area had a few packages of bratwurst unlabeled and not dated, multiple packaged tortillas with no label or date, and a packaged cheese omelet with white flakes with no date on them. The clean dish area had four stacks of clean cups, and multiple cups had condensation between them. Clean bowls were stacked upright, and condensation was observed in the first, second, and third bowl. During an interview on 2/10/25 at 12:45 p.m., dietary aid (DA)-A, who also cooked, confirmed the observations and stated the ham was used on Saturday, two days prior, and was not sure how long the brats, omelet, or tortillas were in the freezer. DA-A stated dishes needed to be dry before stacking.	F 812	The Dietary staff have been instructed at a dietary meeting on March 12th that 1) all dishware ¿ must be completely dry before returning to shelving; 2) all items that are opened must be labelled and dated. ¿(A food expiration dating guide will be displayed in the kitchen.) ¿ The staff were also instructed that all hair, including facial hair, must be covered. In addition dietary staff were instructed that all hot food must be temped with a thermometer before serving any food to the residents. ¿ The facility has adopted food temp logs to ensure that the taking of the food temps will continue on an ongoing basis. ¿ The Food Service manager will regularly check the cooler and freezer for labelled and dated food and that no expired food is stored in either of these. ¿ All staff have been empowered to remove any unlabeled or outdated food from the freezer, cooler or dry good storage room so that we have multiple individuals able to check the dating and labelling of food. ¿ The dietitian will perform spot checks during her visits to ensure that the above items are being completed. ¿ The administrator will ensure that compliance with all of these food safety items will be done. ¿ This citation will be given to the QA committee for inclusion as needed in the overall QAPI program.		

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F 812	Continued From page 63 During observation on 2/11/25 at 11:51 a.m., DA-A wore a headband with two long loose braids halfway down their back and no hair net. DA-A had gloves on and used a knife to cut celery on a cutting board. DA-A removed gloves and stirred the beef in a pan on the stove. DA-A applied gloves and placed the celery in the pan with the beef. DA-A placed the cutting board and knife in the dirty area of the dish machine area, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A prepped one plate with spaghetti and broccoli and gave to staff to serve. DA-A removed gloves, did not perform hand hygiene, applied new gloves, and placed cooked spaghetti noodles in the pan with the beef. DA-A plated multiple plates of the noodles and beef and broccoli and some plates with small pizza circles using tongs and utensils. One pizza circle fell onto the table, and DA-A used utensil to throw the pizza away. DA-A placed broccoli onto the plates of pizza, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A gave plates of food to staff to serve in the dining area, cut pizza in half, continued meal service, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A placed dish soap onto dishes and scrubbed some dishes, rinsed, and placed in dish machine. DA-A removed gloves and placed dirty pan into the dirty area of the dish machine area. DA-A grabbed a package of a small pizza circle from the freezer and placed on the counter by the microwave. DA-A did not perform hand hygiene, applied gloves, put the pizza in the microwave, grabbed a blender from the dish machine, blended and plated the food, placed the blender into the dirty area of the dish room, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A removed			F 812			

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

PRINTED: 04/28/2025
FORM APPROVED
OMB NO. 0938-0391

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F 812	Continued From page 64 the pizza from the microwave, plated the pizza and broccoli, and served. During interview on 2/11/25 at 12:23 p.m., DA-A stated they checked the broccoli temperature but did not take the temperature of the beef served with the meal or the one pizza circle cooked in the microwave. DA-A stated they cooked the pizza in the microwave based on the time frames listed on the package and had prepped the beef for a long enough time for it to be cooked. DA-A verified they had not worn a hair net today or the day prior and did not know where the hair nets were until the previous day. DA-A verified they had not washed their hands and were supposed to wash their hands with every glove change, but indicated they did not unless they touched a food item or had dirty hands for time management purposes. During observation on 2/12/25 at 11:45 a.m., DA-B, who also cooked, temped the food, washed their hand, applied gloves, and dished up salad and barbeque pork. DA-B wore a stocking cap and had a beard. A longer loose hair dangled from DA-B's chin as they scooped salad onto plates. DA-B continued plating food and gave to staff to serve without a beard net. During interview on 2/12/25 at 12:23 p.m., DA-B stated they took the temperature of food before they served. DA-B stated they labeled food when opened and when taken out of its original package, and food was rotated daily so new food was towards the back and older stock would be used first. DA-B stated they changed gloves and wash hands when changing tasks or anytime there was a chance of cross contamination. DA-B stated they had hairnets and needed to wear	F 812			

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

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FORM APPROVED
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F 812	Continued From page 65 them, or a hat, when in the kitchen to keep their hair covered. DA-B stated a quarter inch of hair was okay without a beard net and thought the hair on their chin and sides of face was an okay length, but agreed their mustache needed to be covered. During interview on 2/13/25 at 2:27 p.m., the administrator expected staff to check the temperature of served food to ensure the food was at appropriate to prevent sickness for those who consumed the food. The administrator expected items to be thrown when expired and products to be labeled when opened and taken out of the original box. Staff was expected to cover their hair in the kitchen, including facial hair. It was also expected dishes would air dry before stacking to ensure no contamination. The administrator expected staff to wash their hands between gloves changes, especially after completion of dirty tasks and before clean tasks with food. The facility policy Food Receiving and Storage dated 1/2023, indicated all food stored in the refrigerator or freezer would be covered, labeled, and dated with "use by" date. The policy indicated all dishes, silverware, pots, and pans were air-dried. The facility policy Dietary Areas- Cleanliness, Safety, Organization, and Regulations dated 2023, directed staff with significant facial beard and/or mustache to wear facial beard nets and hairnets or hats were to be used by all dietary personnel or hair pulled back into secure pony. The policy directed staff to label food with the date it was opened.			F 812			

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

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F 812	Continued From page 66	F 812			
F 865 SS=F	The facility policy Dietary Gloves and Handwashing dated 1/2023, directed staff to remove gloves, wash hands, and apply new gloves after contact with items such as refrigerator, stove, freezer, and dirty dishes. QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 865			4/4/25

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

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F 865	Continued From page 67 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.			F 865			

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

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F 865	Continued From page 68 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to maintain documentation and demonstrate evidence of a comprehensive, data-driven quality assurance and performance improvement (QAPI) program. These findings had potential to affect all 21 residents residing			F 865	The facility has and does hold quarterly Quality Assurance meetings, and records minutes for these meetings, which are sent to all of the members of the committee, including the Medical Director, Director of Nursing, Dietitian, Pharmacist		

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

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F 865	Continued From page 69 within the facility. Findings include: During an interview on 2/13/25 at 2:49 the director of nursing (DON) stated the QA committee, consisting of herself, the administrator and the medical director, met quarterly to review adverse events. However, the committee did not have a system to identify, collect and use data from all departments and had not identified any opportunities for improvement or performance improvement projects to implement. The DON further stated the facility did not record any meeting minutes or documentation of their ongoing QA meetings. A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, "QA [quality assurance] and PI [performance improvement] combine to form QAPI, a comprehensive approach to ensuring high quality care. QAPI concerns, updates, or changes are reviewed and discussed at the quarterly QAA meeting."	F 865	and Administrator. ¿ The QA meetings focus on addressing specific issues affecting the quality of life for residents by seeking to find ways that will help improve all areas of their life while living at the facility. ¿ Data will be used from the facility's ERM (Electronic Record Management) system to produce reports based upon input received by any member of the committee of a quality issue needing to be addressed. ¿ In a small facility like ours it is difficult to obtain statistically accurate information as demonstrated by the facility's inability to obtain enough information from the patient satisfaction surveys of DHS that are done each year by an outside agency. ¿ In our small facility trends and issues by observation. ¿ All staff has been and is encouraged to share with the leadership. The facility will develop and maintain an effective, comprehensive data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. ¿ The plan and appropriate documentation will be available for review by State and Federal Agencies for their review and assessment. ¿ The plan will collect and review data from all departments and identify opportunities for improvement within the facility. ¿ The administrator will be responsible for the implementation of the QAPI plan and see that it is completed.		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	F 867			4/4/25

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

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F 867	Continued From page 70 monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and	F 867			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 867	Continued From page 71 systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.			F 867			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 867	Continued From page 72 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee identified and implement performance improvement projects to address any identified concerns. These findings had potential to affect all 21 residents residing within the facility.	F 867	Hope Springs Quality Assurance committee will identify and implement performance projects to address any concerns at its next regularly scheduled quarterly meeting in April. ¿A Performance Improvement Project (PIP) will be a concentrated effort on a		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 867	Continued From page 73 Findings include: During an interview on 2/13/25 at 2:49 the director of nursing (DON) stated the QA committee, consisting of herself, the administrator and the medical director, met quarterly to review adverse events. However, the committee did not have a system to identify, collect and use data from all departments and had not identified any opportunities for improvement or performance improvement projects to implement. A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, "a Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention."			F 867	particular problem within the facility. ¿ The administrator will be responsible for the implementing and following through with the completion of a PIP effort as part of the overall QAPI program and maintain its overall working for the facility.		
F 868 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			F 868			4/4/25

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

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F 868	Continued From page 74 (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. 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 interview and document review the facility failed to ensure the Quality Assurance (QA) committee consisted of the minimum required members. These findings had potential to affect all 21 residents residing within the facility. Findings include: During an interview on 2/13/25 at 2:49 p.m., the director of nursing (DON) stated the committee, consisting of herself (also the infection preventionist), the administrator and the medical			F 868	Hope Springs does maintain a Quality Assessment and Assurance committee consisting of the Medical Director, the Director of Nursing Services, the Consultant Pharmacist, the Consultant Dietitian, the Administrator and the Infection Preventionist (DON). ¿The administrator will recruit two additional nursing staff to the quarterly meetings to ensure compliance with the F 868 tag. The QAA committee does meet quarterly and does have written minutes of each of its meetings which are given/available to		

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

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F 868	Continued From page 75 director, met quarterly to review adverse events. The DON confirmed the QA did not consist of at least two additional staff members to meet the required members however, they had discussed having a nursing assistant join the committee. A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, "members of the team will include the Administrator and Director of Nursing (DON), the medical director and other key staff members from other departments, along with a designated resident as designated by the Resident Council if they wish to participate, and family or guardians if they wish to participate."			F 868	the governing body and sent to each member after each meeting. ¿Due to the facility's size as the smallest nursing home in the state of Minnesota, having additional staff present at these meetings is problematic as there are limited staff available for extra responsibilities such as these types of committees. ¿Again, CMS's rules for requirements do not seem to allow for any flexibility in the enforcement of their rules based upon a facility's size which is unfortunate, as Hope Springs has probably one of the highest percentage of staff participation on its QA committee as compared to other nursing homes. ¿ The administrator will continue to maintain this committee, recruit two new nursing members and its goal of increasing the quality of various areas within the facility as it has in the past		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/10/25 - 2/14/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and		2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

03/19/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee identified and implement performance improvement projects to address any identified concerns. These findings had potential to affect all 21 residents residing within the facility. Findings include: During an interview on 2/13/25 at 2:49 the director of nursing (DON) stated the QA committee, consisting of herself, the	2 255	Corrected.		3/31/25

Minnesota Department of Health

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2 255	Continued From page 3 administrator and the medical director, met quarterly to review adverse events. However, the committee did not have a system to identify, collect and use data from all departments and had not identified any opportunities for improvement or performance improvement projects to implement. A facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 6/19/24, indicated, "a Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention." SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administration will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255			
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each	2 540			3/31/25

Minnesota Department of Health

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2 540	Continued From page 4 resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure completed Minimum Data Set (MDS) assessments were accurately coded to reflect correct medication use for 5 of 5 residents (R1, R3, R6, R9, and R15). Findings include:	2 540	Corrected.		

Minnesota Department of Health

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2 540	Continued From page 5 The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual), dated 10/2024, indicated medications are to be indicated as taken by a resident based on pharmacological classification, not how it is used. The RAI Manual further indicated "herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin)." R1 R1's quarterly Minimum Data Set (MDS) dated 12/26/24, indicated R1 was admitted to the care facility 7/24/23 and was cognitively intact. The MDS further indicated R1 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication and lacked mention of R1 receiving a anticonvulsant medication despite receiving two different anticonvulsant medications during the look back period. R1's Diagnoses list, printed 2/13/25, indicated R1 had several medical and mental health diagnoses including major depressive disorder, anxiety disorder, dementia, and bipolar disorder. R1's Orders indicated R1 was on several medications including Melatonin (a dietary supplement) 6 milligrams (mg) by mouth one time a day at bedtime, dated 7/24/23; Gabapentin (an anticonvulsant medication) 200 mg by mouth three times a day, dated 7/24/23; and Lamotrigine (an anticonvulsant medication) 25 mg by mouth	2 540			

Minnesota Department of Health

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2 540	Continued From page 6 one time a day, dated 7/25/23. R3 R3's quarterly MDS, dated 12/19/24, indicated R3 was admitted to the care facility on 9/21/09 and was cognitively intact. The MDS lacked mention of R3 receiving anticoagulant and anticonvulsant medication despite being prescribed both medications. R3's Diagnoses list, printed 2/13/25, indicated R3 had several medical and mental health diagnoses including bipolar disorder, major depressive disorder, anxiety disorder. R3's Orders indicated R3 was several medications including Lamotrigine (an anticonvulsant medication) 75 mg by mouth one time a day at bedtime, dated 5/22/24 and Eliquis (an anticoagulant medication) 5 mg by mouth two times a day, dated 2/25/22. During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) stated she was also responsible for completing the MDS. The DON confirmed both R1 and R3 had inaccuracies coded on their MDS, stating it would be expected that each medication is coded as the medication drug class and not what the medication is given for. The DON stated she believed Melatonin should have been classified as a hypnotic, despite the RAI manual stating otherwise. R6 R6's significant change MDS dated 11/7/24, indicated R6 was admitted to the care facility on 10/28/24 and was cognitively intact. The MDS indicated R6 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication, and lacked	2 540			

Minnesota Department of Health

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2 540	Continued From page 7 identification of R6 receiving an anticoagulant medication despite receiving an anticoagulant during the look back period. R6's Diagnoses list, printed 2/11/25, indicated R6 had several medical diagnoses including chronic embolism (blockage in a blood vessel) and thrombosis (occurs when blood clots block blood vessels) of other specified veins and other specified veins, peripheral vascular disease (slow and progressive circulation disorder cause by narrowing, blockage, or spasms in a blood vessel), and insomnia. R6's Medication Administration record dated 11/1/24 to 11/30/24, indicated R6 received Eliquis (an anticoagulant medication) 2.5 mg by mouth two times a day and Melatonin (a dietary supplement to promote sleep) 5 mg by mouth at bedtime. R9 R9's quarterly MDS dated 11/15/24, indicated R9 had a reentry to the care facility on 11/4/24, and moderately impaired cognition. The MDS indicated R9 had taken a hypnotic medication during the look back period despite not being prescribed a hypnotic medication. R9's Admission Record, printed 2/11/25, indicated R9 had diagnoses including insomnia, schizoaffective disorder (chronic mental health condition characterized by symptoms such as hallucinations, delusions, mania, and depression), catatonic schizophrenia (type of schizophrenia which involves a syndrome where the brain does not manage muscle movement signals as it should), and generalized anxiety disorder.	2 540			

Minnesota Department of Health

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2 540	Continued From page 8 R9's Orders indicated R9 was on medications which included Melatonin 6 mg by mouth at bedtime, dated 5/22/24. R15 R15's annual MDS dated 12/4/24, indicated R15 was cognitively intact, and lacked identification of R6 receiving an anticonvulsant medication despite receiving an anticoagulant during the look back period. R15's Diagnoses list, printed 2/14/25, indicated R15's diagnoses included major depressive disorder, anxiety disorder, and attention-deficit hyperactivity disorder. R15's Orders indicated R15 was on several medications including Gabapentin (an anticonvulsant medication) 100 mg by mouth two times a day and 300 mg by mouth at bedtime, dated 6/13/24. During an interview on 2/13/25 at 3:09 p.m., the DON confirmed R6, R9, and R15 had inaccuracies coded on their MDS. The facility provided MDS policy dated 10/23, indicated staff chart in the electronic medical record on resident's care, behaviors, needs, eating, and activities. A licensed practical nurse assisted the DON with interviewing residents and floor staff completed assessments for annual and quarterly MDS. The DON completed significant change and discharge MDS. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related	2 540			

Minnesota Department of Health

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2 540	Continued From page 9 to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540			
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight consecutive hours per day. This deficient practice had the potential to affect all 21 residents who resided in the facility. Findings include: The PBJ (Payroll Based Journal) Staffing Data Report triggered for no continuous 8-hour RN coverage in 24-hour period for four or more days within 4th quarter. Infraction dates were 7/17/24, 7/18/24, 7/24/24, 7/26/24, 9/21/24 and 9/22/24.	2 810	Corrected.		3/31/25

Minnesota Department of Health

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2 810	Continued From page 10 Document review of the schedule from 10/1/24 - 2/9/25, identified the facility failed to have RN coverage for the dates of: 11/9/24, 11/10/24, 11/28/24, 11/29/24, 12/21/24, 12/25/24, 1/1/25, 1/18/25 and 1/20/25. During interview on 2/10/25 at 9:37 a.m., R12 stated no concerns were reported in resident council. R12 stated the facility was staffed very well with knowledgeable and well-established staff. During interview on 2/13/25 at 1:03 p.m., director of nursing (DON) indicated they were responsible for staffing the facility and submitting the PBJ reports. They confirmed the facility did not have eight hours of continuous RN coverage daily, however, stated there was proper coverage with regularly scheduled competent staff, and stressed the importance of continuity of care of licensed staff for the residents outweighing the title of RN over LPN (licensed practical nurse), and the skill set to care for these residents was met with an LPN. The focus of individual care plans for residents was important, as important to survey to individual care of facilities. A facility' policy on staffing was requested, not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided eight hours per day, seven days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine	2 810			

Minnesota Department of Health

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2 810	Continued From page 11 compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810	Corrected.		3/31/25
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who wished to smoke off facility grounds was properly assessed for safety, and risks of unsupervised smoking were discussed for 1 of 1 resident (R5) reviewed for smoking. The facility further failed to ensure residents at risk for falls were assessed for a root cause and new interventions were put in place to prevent falls for 2 of 3 residents (R10 and R8) reviewed for falls. Findings include: R5	2 830			

Minnesota Department of Health

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2 830	Continued From page 12 R5's quarterly Minimum Data Set (MDS) dated 1/8/25, indicated R5 was cognitively intact. The MDS further indicated R5 utilized a walker for locomotion and was independent with most activities of daily living (ADLs) except bathing. R5's progress note, dated 1/6/25, indicated R5 asked staff if it was okay for her to go outside and walk down the trail. Staff assured R5 it was okay as long as staff knew where she was. That afternoon R5 came back to facility smelling of smoke. R5 confirmed she was aware the care facility was a non-smoking facility but she would like to smoke off property. R5 was also informed that if her decision was to continue smoking, she would need to find alternative placement. R5 verbalized feeling overwhelmed and it was suggested that she take some time to think about what she wanted to do. R5's electronic medical record (EMR) lacked evidence a safe smoking assessment was completed on R5, risks of smoking unsupervised were discussed with R5, and any interventions were care planned to ensure R5's decision to occasionally smoke off campus was as safe as possible (i.e. ensuring staff knew when she was leaving campus, monitoring clothes for burn holes, etc). During an interview on 2/12/25 at 8:54 a.m., R5 stated she wanted to have the right to smoke off campus occasionally but did not want to leave the facility as she liked living there. R5 stated she had gone off campus by walking up the path off the parking lot twice to smoke. R5 stated when she came back the second time the aide had noticed she smelled like smoke and notified the director of nursing (DON). R5 stated she still had a pack of cigarettes and a lighter in her room but had not	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 MINNETONKA, MN 55345		
(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) COMPLETE DATE
2 830	Continued From page 13 smoked since. R5 further stated staff had not assessed her for safe smoking, just told her she could not smoke as it was a non-smoking facility. During an interview on 2/12/25 at 10:30 a.m., registered nurse (RN)-A stated she was aware R5 had, and wanted to continue to smoke off campus, stating the facility had put up signs to indicate there was no smoking on the facility grounds. RN-A stated R5 was "talked to" by the DON and administrator but that a safe smoking assessment was not completed because "they [residents] are not supposed to smoke." RN-A further stated R5 was asked about starting a nicotine patch but was not sure if she wanted one and had not been followed up with. During an interview on 2/13/25 at 12:59 p.m., the DON stated they held a meeting with the ombudsman and R5 had stated she did not want to smoke, however a few days ago she had informed the administrative assistant she did want to smoke. The DON confirmed they had not completed a safe smoking assessment for R5 or put any interventions into place to ensure R5 was as safe as possible if she chose to smoke off campus because they were a non-smoking facility, and she "did not admit smokers". A facility policy on smoking assessments was requested but not received. R10 R10's quarterly MDS dated 12/9/24, indicated R10 had moderate cognitive impairment, was independent with ambulation, and had one fall without injury since last assessment. R10's last two fall assessments, dated 9/10/24 and 11/5/24, both indicated that R10 was at risk	2 830			

Minnesota Department of Health

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2 830	Continued From page 14 for falls. R10's progress notes, dated 8/2/24 - 9/14/24, indicated R10 had three falls in the past 6 months, two out of three of them happening on a Thursday. On 8/2/24, it was documented R10 was found on the floor in her room. On 9/13/24, it was documented R10 was hospitalized after a fall in her bathroom while standing at her sink, resulting in a head strike and laceration above her left eye. On 11/5/24, it was documented R10 was found on the floor in her room and reported hitting her head. R10's care plan, printed 2/14/25, indicated R10 had a history of falls, most current on 11/5/24. R10's care plan indicated several fall interventions dated 2/23/24, and 9/17/24, including monitoring orthostatic blood pressure monthly (checking for blood pressure changes with position changes which may cause dizziness), using a wheelchair while at her bathroom sink and reminding R10 to always have her walker with her. The care plan lacked intervention updates for R10's falls in August and November. R10's Kardex, printed 2/14/25, was utilized by the facility nursing assistants (NA) to know what cares to provide a resident and any special instructions. The Kardex lacked any mention of R10 being a fall risk or any fall interventions. R10's electronic medical record (EMR) indicated the last 2 orthostatic blood pressure that were	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
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2 830	Continued From page 15 taken or recorded was on 6/13/24 and 9/9/24. The facility's Fall Tracking Book lacked any mention of the fall on 8/2/24. R10's EMR identified that R10 was weak after receiving weekly ETC (Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions) on Wednesdays, however failed to implement new, care planned interventions for falls and post ECT monitoring despite R10 almost always falling on the Thursday after ECT. During an interview on 2/15/25 at 8:30 a.m., NA-A stated R10 was independent with most ADLs, including grooming and ambulation. NA-A stated when R10 came back from ECT she was weak and staff would offer her a wheelchair to go to lunch or watch her close at lunch if she refused her wheelchair. NA-A was unaware of any other fall interventions or post ECT monitoring. During an interview on 2/12/25 at 10:30 am, registered nurse (RN)-A stated R10 had ECT every Wednesdays and she would have the NAs keep her in her wheelchair when she arrived back to the facility. RN-A stated that was the only fall intervention or post ECT monitoring she was aware. During an interview on 2/13/25 at 12:59 p.m., the DON stated it would be expected that will each fall the nurse would be implementing a new intervention and writing the fall, root cause and interventions on the fall log. The DON stated at	2 830			

Minnesota Department of Health

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2 830	Continued From page 16 times she would be included in the conversation to help "think outside the box" to ensure a new intervention was always implemented. The DON confirmed R10's care plan and Kardex lacked interventions for post ECT monitoring and while staff were monitoring R10 closer when she returned to the community from ECT, the weakness continued into Thursday when most falls were happening. The DON further confirmed it would be expected that orthostatic blood pressures were monitored monthly as stated in R10's care plan. A facility policy titled Falls/Incidents, dated 8/2021, indicated nursing staff should determine the cause of the fall after each fall and implement and record what new intervention was being implemented to help prevent future falls. R8 R8's quarterly Minimum Data Set (MDS) dated 1/10/25, indicated R8 had intact cognition and no delirium. R8 had delusions, verbal behaviors towards others and wandered one to three days, and did not reject cares. R8 had diagnoses of hypertension (high blood pressure), diabetes mellitus (chronic disease which affects how the body uses sugar for energy), arthritis (general term for conditions which cause joint inflammation, pain, swelling, and stiffness), anxiety disorder, depression, and schizophrenia (chronic mental illness characterized by disruptions in through process, perceptions, emotions, and social interactions). R8 had no upper or lower extremity impairments and used a walker. R8 required partial and/or moderate assistance with toileting hygiene, toilet transfers, and dressing. R8 was independent with footwear	2 830			

Minnesota Department of Health

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2 830	Continued From page 17 application and removal, rolling left and right, and with chair and/or bed-to-chair transfers. R8 was occasionally incontinent of urine. The MDS indicated R8 had one fall with no injury since the last assessment. R8 took antipsychotic, antianxiety, antidepressant, hypoglycemic, and anticonvulsant medication. R8's Care Area Assessment (CAA) worksheet for falls dated 7/16/24, indicated R8 was at risk for falls related to fall history and antianxiety and antidepressant medication use. The CAA noted R8 had a history of falls in their room when getting up from their recliner and using their walker. R8 was at risk for falls, injury, discomfort, increased dependence on staff, decreased leisure, isolation, and further decline. R8's Fall Risk Assessment dated 1/4/25, indicated R8 had one to two falls in the past three months, was ambulatory and continent, had intermittent confusion and/or forgets limitations, required use of assistive device, had systolic blood pressure drop less than 20 mmHg (millimeters of mercury) between lying and standing in three minutes, took three to four of medications the medication classes listed within the past seven days, and had three or more present predisposing conditions or diseases. R8 was "at risk" for falls. R8's Fall Risk Assessment dated 1/28/25, indicated R8 had one to two falls in the past three months, was ambulatory and incontinent, was alert, had normal gait and/or balance, did not have a drop in systolic blood pressure between lying and standing, did not take psychoactive or other listed medication classes in the past seven days, and did not have predisposing conditions or diseases. The assessment indicated R8 was not	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 MINNETONKA, MN 55345		
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2 830	Continued From page 18 "at risk" for falls. R8's fall care plan revised 11/13/24, indicated R8 was at moderate risk for falls related to confusion, gait and/or balance problems, incontinence, poor communication and/or comprehension, psychoactive drug use, and unaware of safety needs. The fall care plan indicated R8's last fall was on 11/13/24. Fall interventions included: -11/13/24, be sure R8's call light within reach and encourage to use call light for assistance as needed. R8 needed prompt response to all requests for assistance. -11/13/24, encourage appropriate use of assistive device. -7/4/24, encourage R8 to sleep in bed and not recliner to promote good sleep and to prevent falls from R8 trying to get out of chair with the footrest up when R8 was confused. -4/13/24, ensure R8 wore appropriate footwear non-skid socks when ambulating or mobilizing in wheelchair. R8's Kardex Report printed 2/12/25, directed staff to keep R8's call light within reach, encourage R8 to use for assistance as needed, and provide prompt response to R8's requests for assistance. Staff were to ensure R8 had an unobstructed path to the bathroom, wore appropriate footwear non-skid socks when ambulating or mobilizing in wheelchair, and encourage R8 to use assistive device. R8's progress note on 1/28/25 at 3:55 a.m., indicated R8 pushed their call light and was found sitting on the floor in front of their recliner in their apartment. The note indicated R8 stated they slid out of the recliner when trying to pick up a blanket which was on the floor. Range of motion of upper and lower extremities were intact and equal, vital	2 830			

Minnesota Department of Health

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2 830	Continued From page 19 signs were stable, and no injuries or pain were noted or reported. R8 used the bathroom and sat in their recliner covered with blankets. The director of nursing was notified. The facility fall book indicated R8 had an unwitnessed fall from their recliner in their room on 1/28/25. The note indicated R8 tried to reach their blankets which were on the floor. Interventions included to remind R8 to use call light all the time to get assistance from staff and encourage R8 to sleep in bed instead of recliner. R8's medical record lacked evidence of fall prevention interventions based on a root cause analysis after the fall on 1/28/25. During interview on 2/12/25 at 10:52 a.m., nursing assistant (NA)-A stated they notified a nurse if they found a resident on the floor, and the nurse completed an assessment and obtained vital signs. Staff asked the resident what happened and what they were trying to do before the fall and assisted the resident back into a wheelchair, recliner, or bathroom. NA-A was unsure of fall interventions for R8. NA-A stated R8 was found on the ground before, and the facility found R8 placed themselves on the floor by reviewing the facility camera footage. NA-A stated R8 had previous falls, and staff helped R8 when needed. During interview on 2/12/25 at 2:53 p.m., NA-B stated fall interventions for R8 were to set up anything they need around them, ensure walker and call light were close by, check on R8 frequently, and remind R8 to use their call light and keep walker close to themselves. During interview on 2/13/25 at 11:55 a.m.,	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
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2 830	Continued From page 20 licensed practical nurse (LPN)-A stated they have a fall tracker sheet which listed interventions to prevent future falls. LPN-A stated they take vitals, assessed for injury, asked the resident what happened, and completed neurological checks for unwitnessed falls. During interview on 2/13/25 at 3:13 p.m., the director of nursing (DON) stated nurses updated resident care plans with new interventions after a fall. DON brought fall information to QA (quality assurance) to discuss. DON stated R8 had two or three falls at night when first admitted and were recliner related. DON stated R8 knew they slept better in bed and talked about sleeping in bed at care conferences. DON reviewed R8's care plan and confirmed R8's fall care plan was not updated after R8's fall on 1/28/25. DON stated the fall interventions were repeated for R8 as they were unsure if the previous fall interventions were followed. DON thought they educated staff on R8's fall interventions or placed a note in their Homebase app (app used by businesses to assist with scheduling, payroll, communication) but did not provide documentation of such. DON stated if staff captured all the needed fall information in the progress notes and fall book, they would not have to write a four-page fall report. DON stated they have a fall book which they have not implemented yet to further analyze resident falls. DON stated creating and implementing fall interventions were important to prevent R8 from future falls and injury. The facility policy Falls/Incident dated 8/2021, directed staff to complete the Fall/Incident report and a progress note detailing the fall/incident, vital signs, and who was notified. The policy directed staff to chart under "Fall Risk Assessments" and in the fall tracking book about	2 830			

Minnesota Department of Health
STATE FORM 6899 24D311 If continuation sheet 22 of 36

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
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21015	Continued From page 22 stayed dry to prevent bacterial growth. In addition, the facility failed to ensure food items were properly labeled and dated, failed to ensure staff covered their hair, assess food temperature during food prep, and to ensure staff followed appropriate infection control technique during food service. This had potential to affect all 21 residents who were served food from the kitchen. Findings include: During the initial kitchen tour on 2/10/25 at 12:26 p.m., a refrigerator in the main kitchen had sliced cheese with no opened date or expiration date and half of Smithfield boneless ham wrapped in plastic with expiration date of February 26, 2025 and no opened date. The freezer in the main kitchen area had a few packages of bratwurst unlabeled and not dated, multiple packaged tortillas with no label or date, and a packaged cheese omelet with white flakes with no date on them. The clean dish area had four stacks of clean cups, and multiple cups had condensation between them. Clean bowls were stacked upright, and condensation was observed in the first, second, and third bowl. During an interview on 2/10/25 at 12:45 p.m., dietary aid (DA)-A, who also cooked, confirmed the observations and stated the ham was used on Saturday, two days prior, and was not sure how long the brats, omelet, or tortillas were in the freezer. DA-A stated dishes needed to be dry before stacking. During observation on 2/11/25 at 11:51 a.m., DA-A wore a headband with two long loose braids halfway down their back and no hair net. DA-A had gloves on and used a knife to cut celery on a cutting board. DA-A removed gloves and stirred	21015			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 MINNETONKA, MN 55345		
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21015	Continued From page 23 the beef in a pan on the stove. DA-A applied gloves and placed the celery in the pan with the beef. DA-A placed the cutting board and knife in the dirty area of the dish machine area, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A prepped one plate with spaghetti and broccoli and gave to staff to serve. DA-A removed gloves, did not perform hand hygiene, applied new gloves, and placed cooked spaghetti noodles in the pan with the beef. DA-A plated multiple plates of the noodles and beef and broccoli and some plates with small pizza circles using tongs and utensils. One pizza circle fell onto the table, and DA-A used utensil to throw the pizza away. DA-A placed broccoli onto the plates of pizza, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A gave plates of food to staff to serve in the dining area, cut pizza in half, continued meal service, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A placed dish soap onto dishes and scrubbed some dishes, rinsed, and placed in dish machine. DA-A removed gloves and placed dirty pan into the dirty area of the dish machine area. DA-A grabbed a package of a small pizza circle from the freezer and placed on the counter by the microwave. DA-A did not perform hand hygiene, applied gloves, put the pizza in the microwave, grabbed a blender from the dish machine, blended and plated the food, placed the blender into the dirty area of the dish room, removed gloves, did not perform hand hygiene, and applied new gloves. DA-A removed the pizza from the microwave, plated the pizza and broccoli, and served. During interview on 2/11/25 at 12:23 p.m., DA-A stated they checked the broccoli temperature but did not take the temperature of the beef served with the meal or the one pizza circle cooked in the	21015			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
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21015	Continued From page 24 microwave. DA-A stated they cooked the pizza in the microwave based on the time frames listed on the package and had prepped the beef for a long enough time for it to be cooked. DA-A verified they had not worn a hair net today or the day prior and did not know where the hair nets were until the previous day. DA-A verified they had not washed their hands and were supposed to wash their hands with every glove change, but indicated they did not unless they touched a food item or had dirty hands for time management purposes. During observation on 2/12/25 at 11:45 a.m., DA-B, who also cooked, temped the food, washed their hand, applied gloves, and dished up salad and barbeque pork. DA-B wore a stocking cap and had a beard. A longer loose hair dangled from DA-B's chin as they scooped salad onto plates. DA-B continued plating food and gave to staff to serve without a beard net. During interview on 2/12/25 at 12:23 p.m., DA-B stated they took the temperature of food before they served. DA-B stated they labeled food when opened and when taken out of its original package, and food was rotated daily so new food was towards the back and older stock would be used first. DA-B stated they changed gloves and wash hands when changing tasks or anytime there was a chance of cross contamination. DA-B stated they had hairnets and needed to wear them, or a hat, when in the kitchen to keep their hair covered. DA-B stated a quarter inch of hair was okay without a beard net and thought the hair on their chin and sides of face was an okay length, but agreed their mustache needed to be covered. During interview on 2/13/25 at 2:27 p.m., the	21015			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER HOPE SPRINGS AT MINNETONKA			STREET ADDRESS, CITY, STATE, ZIP CODE 16913 HIGHWAY 7 MINNETONKA, MN 55345		
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21015	Continued From page 25 administrator expected staff to check the temperature of served food to ensure the food was at appropriate to prevent sickness for those who consumed the food. The administrator expected items to be thrown when expired and products to be labeled when opened and taken out of the original box. Staff was expected to cover their hair in the kitchen, including facial hair. It was also expected dishes would air dry before stacking to ensure no contamination. The administrator expected staff to wash their hands between gloves changes, especially after completion of dirty tasks and before clean tasks with food. The facility policy Food Receiving and Storage dated 1/2023, indicated all food stored in the refrigerator or freezer would be covered, labeled, and dated with "use by" date. The policy indicated all dishes, silverware, pots, and pans were air-dried. The facility policy Dietary Areas- Cleanliness, Safety, Organization, and Regulations dated 2023, directed staff with significant facial beard and/or mustache to wear facial beard nets and hairnets or hats were to be used by all dietary personnel or hair pulled back into secure pony. The policy directed staff to label food with the date it was opened. The facility policy Dietary Gloves and Handwashing dated 1/2023, directed staff to remove gloves, wash hands, and apply new gloves after contact with items such as refrigerator, stove, freezer, and dirty dishes. SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, could ensure appropriate sanitation and storage of dishware	21015			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2025
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(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) COMPLETE DATE	
21015	Continued From page 26 and food items in the kitchen. The facility could educate staff regarding hand hygiene, hair coverings, food temperature monitoring, and food and dish storage The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, or designee could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents who self-administered topical medications creams were assessed for safe and appropriate use for 2 of 3 residents (R11 and R15) reviewed for self-administration of medications. Findings include: R11: R11's quarterly Minimum Data Set (MDS) dated	21565	Corrected.	3/31/25	

Minnesota Department of Health

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21565	Continued From page 27 1/7/25, indicated R11 was admitted to the care facility on 4/6/23 and was cognitively intact. R11's Orders, indicated R11 had an order for Betamethasone Valerate External Cream 0.1% (a steroid cream used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), apply to affected skin as needed for rash unsupervised self-administration. Apply to affected skin twice daily PRN [as needed] for rash up to five days a month and two times a day for rash for two weeks. R11's care plan, dated 6/26/24, indicated for staff to provide medications as ordered, including Betamethasone cream PRN for rash outbreaks. R11's electronic medical record (EMR) indicated R11's last skin observation by a licensed nurse was 11/8/24. R11's EMR lacked evidence that R11 had been assessed for safe self-administration of medication including how to use it, where, and how often. During an interview on 2/13/25 at 10:57 a.m., licensed practical nurse (LPN)-A stated that she did not believe R11 should be able to administer her own medicated cream as she had recently self-declared blindness. LPN-A stated nursing staff should be doing an assessment to ensure residents are visually and cognitively able to self-administer medications. LPN-A further stated it was "questionable" whether R11 had a [neck] rash and although R11 kept the cream in her room, she should be asking staff to assist her with applying the cream. During an interview on 2/13/25 at 11:09 a.m., R11	21565			

Minnesota Department of Health

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21565	Continued From page 28 stated she kept the medicated cream in her bathroom. R11 stated she had been using the cream on her neck twice a day and the rash had cleared up but now she was using it for a rash on her right thigh. R11 stated nursing staff were not assessing her skin and were not offering, or asking, if she needed help applying the cream. She was doing it on her own. During an interview on 2/13/25 at 12:32 p.m., the consultant pharmacist (CP) stated Betamethasone Valerate External Cream 0.1% can cause thinning of the skin which is why it is generally prescribed with a time limit. The CP stated she would want to ensure R11 had the same rash on her thigh the cream was prescribed for on her neck before she used it on the rash on her thigh. During an interview on 2/13/25 at 12:59 p.m., the director of nursing (DON) confirmed R11 had not been assessed for self-administration of her medicated cream. The DON stated she believed R11 had been fine to self-administer medications when they were prescribed but was "not as reliable" now and was unsure if R11 could safely self-administer medications at this time. The DON stated she was unaware of a rash on R11's thigh and she should be assessed for safe and proper use. R15: R15's annual MDS dated 12/4/24, indicated R15 was admitted to the care facility on 12/17/20 and was cognitively intact. R15's Order Summary Report printed 2/14/25, indicated: -Hydrocortisone External Cream 1% (Hydrocortisone (Topical)) (topical corticosteroid	21565			

Minnesota Department of Health

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21565	Continued From page 29 which treats skin conditions). Apply to lower extremities and/or [abdomen] topically as needed for pruritus (itching) unsupervised self-administration apply to lower extremities bid prn (twice daily as needed) for leg rash- may keep at bedside. -Micotrin AP External Powder 2% (Miconazole Nitrate (Topical)) (antifungal medicine used to treat certain kinds of fungal or yeast infections of the skin). Apply to areas of irritation. Apply to under breasts and between skin fold when irritation is present as needed BID. -Terbinafine HCl External Cream 1% (Terbinafine HCl (Topical)) (an antifungal medication which treats fungal infections of the skin). Apply to rash on abdomen topically two times a day for rash unsupervised self-administration. Apply BID until clear. Ok to keep at bedside. -Voltaren Gel 1% (Diclofenac Sodium) (nonsteroidal anti-inflammatory drug which treats joint pain caused by arthritis). Apply to [bilateral] wrists and hands topically every six hours as needed for pain- moderate unsupervised self-administration. Apply 4 grams every six hours prn. May keep at bedside. R15's care plan, indicated the following interventions: -1/29/21, administer analgesia (refers to the relief or absence of pain) as per orders. Give half hour before treatments or care. -8/29/24, R15 self-administered clotrimazole cream under abdominal fold for rash and has as needed for cortisone cream. R15's progress note dated 8/27/24 at 12:23 [12:23 p.m.], indicated R15's providers saw R15 for a continued rash around their abdomen and lower legs and ordered clotrimazole cream twice daily to waist area until rash healed and may	21565			

Minnesota Department of Health

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21565	Continued From page 30 keep clotrimazole and hydrocortisone at bedside to use until healed. R15's progress note dated 11/22/24 at 14:47 [2:47 p.m.], indicated R15's providers saw R15 and ordered micotin antifungal powder to apply under breasts and between skin folds when irritation was present as needed twice daily. R15's EMR lacked evidence that R15 had been assessed for safe self-administration of medication including how to use it, where, and how often. During an interview on 2/13/25 at 11:45 a.m., licensed practical nurse (LPN)-A stated they did not complete self-administration assessments since they were an LPN. LPN-A stated residents were assessed for self-administration when medications first ordered, and R15 cleaned their own skin folds and self-applied needed creams. LPN-A checked with R15 daily to ensure areas cleaned or if R15 had concerns. During observation and interview on 2/13/25 at 12:55 p.m., R15 stated the use voltaren gel once or twice a day for their knees, thumbs joints, and wrists and keep the gel in their room. R15 stated they kept hydrocortisone in their room and used when their skin folds were irritated. R15 stated they also had an antifungal powder in their bathroom which R15 used when they had a rash. R15 stated the doctor ordered the powder, and staff provided R15 the powder and knew about it too. R15 stated they asked the doctor to write they may keep the powder and other treatments at bedside. R15 went to the bathroom to grab their powder, and the powder was miconazole nitrate 2% antifungal powder with a pharmacy label.	21565			

Minnesota Department of Health

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21565	Continued From page 31 During an interview on 2/13/25 at 3:35 p.m., the director of nursing (DON), verified R15 did not have a self-administration assessment and needed an assessment rather than only the doctor's orders. A facility policy titled Self-Administration of Medications Assessments, dated 8/2023, indicated if a resident wished to self-administer medications "the interdisciplinary team must assess the resident's cognitive, physical, visual ability to carry out/administer medications. If resident wishes to self-administer medications/treatments such as insulin's, eye drops, lotions and/or wish medications left for self-administration, resident will be instructed in proper technique and then monitored for 10 days for correct task completion. Staff will document on MAR." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to	21565			

Minnesota Department of Health

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21565	Continued From page 32 QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565	Corrected.		3/31/25
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure provider orders code status [e.g. full code or do not resuscitate (DNR)] were updated, consistent, and accurate throughout the resident's medical record for 1 of 4 residents (R4) reviewed for advance directives. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/30/24, indicated R4 was admitted to the care facility on 6/21/23. The MDS indicated R4 had	21840			

Minnesota Department of Health

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21840	Continued From page 33 intact cognition, disorganized thinking, verbal behavioral symptoms directed toward others, and diagnoses including orthostatic hypotension (condition where blood pressure drops when standing up from a sitting or lying position), dementia and schizophrenia (chronic mental illness characterized by disruptions in thought process, perceptions, emotions, and social interactions). R4's care plan dated 1/31/25, lacked documentation of code status. R4's Health Care Directive dated 12/30/19, indicated they did not want CPR (cardiopulmonary resuscitation; emergency procedure which combined chest compressions and rescue breathing to help someone who is not breathing or whose heart is not beating) attempted if their heart and breathing stopped. R4 wanted a natural death. R4 understood if they chose this option, they would see their health care provider about writing a DNR order. R4's Transfer Orders from Regions Hospital signed 4/11/23, indicated R4's code status was full code. R4's Discharge Orders from Regions Hospital signed 6/21/23, indicated R4's code status was full code. R4's Care Conference note dated 10/18/24, indicated R4, the social workers, and director of nursing attended the care conference. The note indicated R4 wanted CPR in the past and now changed their mind. R4's Admission Record printed 2/14/25, indicated R4 did not want resuscitation and did not want	21840			

Minnesota Department of Health

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21840	Continued From page 34 intubation. R4's orders printed 2/14/25, did not indicate R4's code status. During interview on 2/12/25 at 2:13 p.m., registered nurse (RN)-A stated code statuses were reviewed at care conferences and during admission by the director of nursing (DON). RN-A knew residents' code statuses from the face sheet binder. The face sheet binder had a copy of R4's Admission Record and Health Care Directive, both which did not have a provider signature. During interview on 2/13/25 at 3:31 p.m., the director of nursing (DON) confirmed there was no provider order or involvement in R4's DNR status. The DON preferred everyone to have a POLST and stated not everyone had one, which included R4. The DON stated provider involvement was important to ensure residents were educated about DNR status by a professional with a higher degree. The DON stated they reviewed code status at each care conference. The facility's POLST policy dated 10/2021, directed staff to assist the resident or resident's guardian/representative with completing a Providers Orders for Life Sustaining Treatment (POLST) form. If the resident or guardian/representative chooses to decline CPR, intubation, etc., HSM staff documented on the POLST, and two staff members witnessed the POLST to become effective. The POLST was then faxed to the primary physician for signature. The facility's Advanced Directives/CPR policy dated 1/2023, reflected the same process as the POLST policy. The policy indicated the care plan	21840			

Minnesota Department of Health

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21840	Continued From page 35 reflected resident wishes and whether an advance directive existed. The policy directed staff to reference the Facesheet binder in the event a resident was found without a pulse. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records are consistent and maintained accurately throughout the medical record upon admission, quarterly, and with any significant change. Staff could be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee could audit resident records, and the results of those audits could go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21840			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2025	
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/11/2025. At the time of this survey, Hope Springs At Minnetonka was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hope Springs At Minnetonka is a 2-story building with a partial basement that was built in 2023 and was determined to be built of Type II (111) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.			K 000			

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K 000	Continued From page 2 The facility has a capacity of 21 beds and had a census of 21 at the time of the survey.	K 000			
K 324 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: 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 REQUIREMENT 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,	K 324		3/15/25	
			At the time of the review of the available documentation, the Administrator was out of the country so the inspector did not receive all of the documentation. The kitchen hood suppression system had		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245606	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2025
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(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	
K 324	Continued From page 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. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/11/2025 between 08:45 AM and 10:00 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. 2. On 02/11/2025 at 09:40 AM, it was revealed by observation that the door between the kitchen and the dining room was being held open with a magnet that did not drop with the fire alarm panel. An interview with the Director of Nursing verified these deficient findings at the time of discovery.	K 324	been inspected as required every 6 months by Summit Fire Protection. A copy of the most recent inspection is included with this plan of correction. The magnet holding the door open between the kitchen and the dining room will not be used except during the brief period of time during which food is transported from the kitchen to the dining room. It will not be left propped open unattended. The Administrator will inform the dietary staff in a meeting on March 13th of this directive and routinely check for compliance with this directive.		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		3/15/25	

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K 353	Continued From page 4 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/11/2025 between 08:45 AM and 10:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire sprinkler system has been inspected quarterly. An interview with the Director of Nursing verified this deficient finding at the time of discovery.	K 353	Again, at the time of the review of the available documentation, the Administrator was out of the country so the inspector did not receive all of the documentation. The fire sprinkler system is and has been inspected quarterly and annually for compliance with all applicable Life Safety Codes. A copy of the most recent quarterly inspection of the sprinkler system is included with this plan of correction.		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation.	K 363		3/15/25	

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K 363	Continued From page 5 These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 18.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/11/2025 at 09:44 AM, it was revealed by observation that the basement corridor door that leads to the soiled utility room and storage room was being propped open with a case of water. An interview with the Director of Nursing verified this deficient finding at the time of discovery.	K 363			
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712	The basement corridor door leading to the soiled utility room will not be propped open by any means, but will instead be kept closed by use of the automatic closer on the door. The laundry staff will be instructed individually that this practice is not allowed. The administrator will inspect regularly to ensure compliance with this directive.		3/31/25

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

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K 712	Continued From page 6 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 REQUIREMENT 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 4.7.4, 4.6.1.1 18.7.1.4 and 18.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/11/2025 between 08:45 AM and 10:00 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 third quarter of 2024. 2. On 02/11/2025 between 08:45 AM and 10:00 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 Director of Nursing verified these deficient findings at the time of discovery.			K 712	The Administrator is responsible for conducting quarterly fire drills on each shift throughout the year. The drills will be conducted monthly in a timely manner and will be varied in terms of time of day in which the drill is conducted on each shift so that no regular pattern develops. The administrator will create a grid to ensure that drills are done time and spaced appropriately from the last drill on that shift. The administrator is responsible for implementing this fire drill schedule.		

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K 918 K 918 SS=F	Continued From page 7 Electrical Systems - Essential Electric Syste 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 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 REQUIREMENT is not met as evidenced by:	K 918 K 918			3/31/25

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K 918	Continued From page 8 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, sections 8.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/11/2025 between 08:45 AM and 10:00 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 monthly testing of the emergency generator was completed during October, November, and December of 2024 and January of 2025. 2. On 02/11/2025 between 08:45 AM and 10:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the inspection of the emergency generator was completed the week of 02/03/2025. An interview with the Director of Nursing verified these deficient findings at the time of discovery.	K 918	The documentation for the monthly tests through November of 2024 was shown to the Fire Marshall, but in November the facility hired a maintenance person who had the responsibility for conducting these load tests and documenting them. The maintenance person began documenting December 2024 and January 2025 in a separate log book that he kept. A copy of the monthly tests for December 2024, January 2025 and February 2025 is included with this plan of collection. Going forward the documentation of these monthly tests will be maintained properly and kept in order for easier review. The administrator will be responsible for ensuring that the monthly load tests are completed and documented and available for inspection.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2025

Administrator
Hope Springs At Minnetonka
16913 Highway 7
Minnetonka, MN 55345

RE: CCN: 245606
Cycle Start Date: February 14, 2025

Dear Administrator:

On April 30, 2025, we notified you a remedy was imposed. On May 7, 2025 the Minnesota Department of Health 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 May 6, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 14, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 30, 2025, 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 May 14, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 6, 2025, 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 9, 2025

Administrator
Hope Springs At Minnetonka
16913 Highway 7
Minnetonka, MN 55345

Re: Reinspection Results
Event ID: 24D312

Dear Administrator:

On May 7, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink 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