Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
September 17, 2021

Administrator
Hopkins Health Services
725 Second Avenue South
Hopkins, MN 55343

RE: CCN: 245293
Cycle Start Date: August 30, 2021

Dear Administrator:

On August 30, 2021, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 2, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 2, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 2, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 30, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Hopkins Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 30, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290

Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING ______ B. WING ______	C 08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

(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
F 000	INITIAL COMMENTS On 8/26/21, through 8/30/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 8/22/21,R1 eloped from the facility on 8/22/21, at 6:00 p.m. and was returned to the facility by the local police department, after being found 1/3 mile away stranded on a major highway. The administrator and director of nursing (DON) were notified of the IJ on 8/27/21, at 11:52 a.m. The IJ was removed on 8/30/21, but non-compliance remained at a lower scope and severity of a D, no actual harm, with potential for more than minimal harm. The above findings constituted substandard quality of care, and an extended survey was conducted on 8/30/21. At the time of the abbreviated survey onsite investigation were completed and the following complaint was found to be SUBSTANTIATED: H5293114C (MN76063) with deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5293115C (MN74444) H5293116C (MN73133) H5293117C (MN72446)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/22/2021

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 000	Continued From page 1 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	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 §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 interview and document review, the facility failed to reassess and provide interventions following attempted elopement for 1 of 3 (R1) residents reviewed for elopements who subsequently eloped from the facility. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. R1 eloped from the facility on 8/22/21, at 6:00 p.m. and was returned to the facility by the local police department, after being found 1/3 mile away stranded on a major highway.	F 689	F 689 This Allegation of Compliance is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Hopkins Health Services as to the accuracy of the surveyor's findings or the conclusions drawn there from. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings are accurate, but that the deficiencies cited are correctly	9/27/21

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F 689	Continued From page 2 The IJ began on 8/22/21. The administrator and director of nursing (DON) were notified of the IJ on 8/27/21, at 11:52 a.m. The IJ was removed on 8/30/21, but non-compliance remained at a lower scope and severity of a D, no actual harm, with potential for more than minimal harm. Findings include: R1's Admission Record printed 8/30/21, included diagnoses of unspecified dementia, unspecified symptoms and signs involving cognitive functions and awareness, and Wernicke's encephalopathy (lesions of the central nervous system). R1's quarterly Minimum Data Set (MDS) dated 7/24/21, indicated R1 had severe cognitive impairment, was independent with ambulation, and required minimal assistance with all activities of daily living (ADLs). R1's care plan dated 7/14/21, identified R1 as an elopement risk. R1's care plan interventions included calmly redirecting to appropriate area, and encouraging socialization with others to provide recreational programming. R1's Wandering Risk Assessment dated 7/22/21, indicated R1 was at high risk for wandering. On 7/2/21, a progress note indicated R1 got off the unit and was found outside of the building. R1 was brought back to the unit. R1's medical record lacked indication a wandering risk assessment was updated, and no new interventions were initiated to prevent elopement. There was no information or investigation into how R1 was able to exit the secured unit.	F 689	applied. R#1 was re-assessed for the risk of wandering on 8/24/2021. Upon completion of the assessment, R#1 had the wandering /elopement care plan updated. R#1 was transferred to the hospital on 8/25/2021 for a mental health evaluation. Residents at risk for unattended exit have the potential to be impacted by the alleged practice. In house residents were re-assessed for risk of wandering or elopement beginning 8/24/2021 with RN review and assessment notes completed on 8/28/2021. The Executive Director or designee validated that the stairwell access o the locked unit is secured and that the keypad code was updated on 8/28/2021. A bulletin board identifying the facility's residents at risk for elopement or wandering was updated on 8/28/2021 and placed in the employee breakroom. Elopement binders were updated with the most recent photo of residents and brief demographic of residents. Signs have been posted on the elevator that goes to the locked unit informing visitors and employees to use the elevator on the east unit to gain access to the second floor. This will reduce the risk for residents getting on the elevator when it arrives on the locked unit. Visitors have been instructed to wait for a staff member to allow them out of the locked unit following visits. Education was provided to staff members by the Director of Nursing or designee on	

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F 689

Continued From page 3

On 8/15/21, a progress note indicated R1 attempted to open the exit doors twice. R1's medical record lacked indication a wandering risk assessment was updated, and no new interventions were initiated to prevent elopement.

On 8/22/21, at 10:04 p.m. a progress note indicated R1 was not in his room at dinner time. A building search was completed and R1 was not found. Staff called 911 at 6:40 p.m. R1 was returned to the facility by the local police at 9:55 p.m. who stated R1 was found stranded along a major highway. Hourly checks were initiated on R1. No other interventions were implemented. There was no information or investigation into how R1 was able to exit the secured unit.

On 8/23/21, a progress note indicated R1 left his unit and was found on the 1st floor stairwell. R1 was returned to his unit. Several attempts were made to place a Wanderguard on R1 without success. There was no information or investigation into how R1 was able to exit the secured unit.

A Wandering Risk assessment was completed on 8/24/21, and indicated R1 was a moderate risk for elopement.

On 8/26/21, at 12:20 p.m. registered nurse (RN)-A was interviewed and stated on 8/23/21, R1 was seen going through the stairwell door and she followed him down. RN-A stated R1 made it to the first floor lobby and was redirected by staff. RN-A stated R1 refused to wear a Wanderguard.
III

On 8/26/21, at 1:06 p.m. RN-B was interviewed and stated she had attempted to put a

F 689

elopement risks, the elopement binder, the elopement bulletin board in the employee breakroom and reporting behavior that includes exit seeking and attempts to leave the facility unattended. Education began on 8/28/2021 and is being presented to casual and on call staff prior to their next scheduled shift.

Elopement drills were implemented starting 8/23/2021 on varying shifts 3 per week for 4 weeks to ensure that facility staff demonstrate understanding of the elopement policy. Audits to be completed of wandering risk assessment and completion of Care Plans. Included in audits are questions directed to staff verifying function of the Wanderguard system starting 8/28/2021. Audits will be completed on varying shifts 5 times per week for 4 weeks or until substantial compliance is maintained. Audits will be submitted to QAPI for review and recommendations. This will be monitored and ensured by the Executive Director and the Director of Nursing.

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F 689	Continued From page 4 Wanderguard on R1 without success. RN-B stated the Wanderguard was put in R1's pants pocket, but R1 took it out. On 8/26/21, at 1:53 p.m. the director of nursing (DON) was interviewed and stated after R1 eloped on 8/22/21, the facility performed elopement drills and training with staff. The DON stated the interventions added for prevention of R1's elopement were placing a Wanderguard, having the family provide 1:1 supervision, or sending R1 to the hospital for a psychological evaluation. The DON stated R1's family could not afford to provide 1:1 supervision, and R1 was refusing the Wanderguard. R1 was sent to the hospital on 8/25/21. On 8/26/21, at 2:05 p.m. R1's family member (FM)-A was interviewed and stated staff at the facility called her on 8/22/21, and informed her that R1 had eloped. FM-A stated the facility told her R1 refused to wear a Wanderguard. On 8/26/21, at 3:08 p.m. the activities assistant (AA)-A was interviewed and stated on 7/2/21, R1 was witnessed going down the stairwell off the unit. AA-A stated staff was alerted and R1 was redirected back onto his unit. On 8/26/21, at 4:20 p.m. the administrator was interviewed and stated that on 8/22/21, R1 may have slipped onto the elevator as a visitor was getting off. The administrator stated there were no cameras in the facility. The administrator stated they were unable to determine how R1 eloped from the facility. On 8/26/21, at 4:31 p.m. licensed practical nurse (LPN)-A was interviewed and stated that he was	F 689		

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F 689	Continued From page 5	F 689		

not working on the unit that R1 eloped from on 8/22/21, but helped with trying to find R1. LPN-A, DON, RN-B, the family and 911 had all been called. LPN-A stated another resident had a family member visiting and that family member indicated that a person had walked onto the elevator as he was getting off on the unit. LPN-A stated he had not seen R1 try to leave the unit since 8/22/21.

The facility implemented corrective action on 8/30/21. Signs were placed on the elevator door to the locked unit indicating visitors must use the other elevator to gain access to locked unit. The stairwell access on the locked unit was secured and the keypad code was changed. All facility in house residents were re-assessed for risk of wandering or elopement. The residents at risk for wandering had care plans updated to identify interventions. Staff were re-educated on the elopement policy and the wandering/elopement risk assessment. Wanderguard door functionality tests were completed. Elopement drills and audits on wandering risk assessments were initiated. Audits will be brought to quality assurance and performance improvement (QAPI) meetings. Binders with residents photographs were updated. A quality assurance (QA) meeting to review the alleged deficiency and complete root cause analysis was completed. These interventions were verified through observation, interview, and document review.

The facility policy Elopement dated 7/7/15, directed to safely and timely redirect patients/residents to a safe environment, a prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill would be held quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING ______ B. WING ______	C 08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

(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
F 689	Continued From page 6 The policy lacked direction for staff on what to do in the event a resident would not wear a Wanderguard.	F 689		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
September 17, 2021

Administrator
Hopkins Health Services
725 Second Avenue South
Hopkins, MN 55343

Re: Event ID: YTNO11

Dear Administrator:

The above facility survey was completed on August 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: ______ B. WING ______	C 08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

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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 8/26/21, through 8/30/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: ______ B. WING ______	C **08/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

(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
2 000	Continued From page 1 SUBSTANTIATED: H5293114C (MN76063), however, no licensing orders were issued. The following complaint(s) were found to be UNSUBSTANTIATED: H5293115C (MN74444) H5293116C (MN73133) H5293117C (MN72446) The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		