Electronically delivered

April 7, 2022

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

RE: CCN: 245293
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 15, 2022, we informed you that we may impose enforcement remedies.

On March 29, 2022, the Minnesota Department of Health completed a survey. 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), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On March 29, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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:

- 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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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. 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.

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 § 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 March 29, 2022. 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.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC for a previous survey conducted on March 3, 2022 (Event ID: M98411), 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 September 3, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F"and/or an E 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

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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 electronic 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 7, 2022

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

Re: Event ID: L2GK11

Dear Administrator:

The above facility survey was completed on March 29, 2022 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 03/29/2022

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 3/29/22, 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 3/21/22, when a cognitively impaired resident climbed out a window and was found on the facility's roof. The administrator and the director of nursing (DON) were notified of the IJ on 3/29/22, at 2:19 p.m. The facility implemented corrective action by 3/22/22, and F689 is being issued at past non-compliance. The above findings constituted substandard quality of care. At the time of the abbreviated survey, onsite investigations were completed, and the following complaint was found to be substantiated: H5293134C (MN81991) with a deficiency cited at F689. 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, the facility must acknowledge receipt of the electronic documents.	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	F 689		

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

Electronically Signed

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 689	Continued From page 1 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 ensure safety and adequate supervision to prevent a resident from climbing out a window and onto the roof for 1 of 3 residents (R1) reviewed for elopement. This resulted in an immediate jeopardy (IJ) for R1 who climbed out of a hallway window, and onto the facility roof. The IJ began on 3/21/22, when R1 climbed through a window onto the second story roof. R1 was brought back into the facility through the second story window without any injuries by RN-A. The administrator and director of nursing (DON) were notified of the IJ on 3/29/22, at 2:19 p.m. The facility implemented corrective action to prevent recurrence by 3/22/22, so F689 was issued at past non-compliance. Findings include: R1's Face Sheet printed on 3/29/22, indicated R1's diagnosis included dementia, left sided hemiparesis (weakness or inability to move one side of the body), and unsteady on feet. R1's quarterly Minimum Data Set (MDS) conducted on 3/17/22, indicated R1 was severely cognitively impaired. R1's most recent wandering assessment 1/25/22, indicated R1 was at moderate risk for elopement, with interventions including WanderGuard (a bracelet placed on the	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

resident that will alarm if a resident tries to go out the door) in place, and placement in the facility's memory care (locked) unit.

The facility's undated description of the incident indicated on 3/21/22, at approximately 10:45 a.m. R2 informed staff that someone was crawling out of the window. Registered nurse (RN)-A went to check, and saw R1 out on the roof. RN-A called for R1 to come back into the building, and R2 came back. When asked what he was doing on the roof, R1 stated some kid had put a ball on the roof and he was trying to get it.

On 3/29/22, at 9:26 a.m. RN-A was interviewed and stated on 3/21/22, she was at the nurse's station when R2 informed her someone had escaped through the window. RN-A stated she went to the window, and saw R1 on the roof, walking away from the window. R1 was near the vents which were approximately 20 feet away from the window. RN-A stated she instructed R1 to come back inside, and after a brief hesitation, he came back and climbed through the window to get back inside. RN-A stated when the incident occurred, she had been at the nurse's station watching three residents who where assessed as high fall risks, and nursing assistant (NA)-A had been assisting another resident with cares. RN-A stated they were the only two staff on the floor for the sixteen residents in the memory care unit.

On 3/29/22, at 9:50 a.m. the director of nursing (DON) was interviewed and stated R1 had crawled out the window onto the roof. The DON stated after R1 was back inside the facility, they checked all windows on the unit, and there were two windows on the memory care unit that could be fully opened. The DON stated although R1

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F 689	Continued From page 3 wore a WanderGuard, this would not have alerted staff, as the windows were not alarmed. The DON stated the memory care unit was staffed with one licensed nurse and one nursing assistant on day shift. On 3/29/22, at 10:29 a.m. nursing assistant (NA)-A stated she was informed by RN-A that R1 had been found outside on the roof. NA-A stated when the incident occurred, she had been in another residents room assisting with personal cares. NA-A stated she and RN-A were the only two staff working on the memory care unit that shift. On 3/29/22, at 1:00 p.m. the administrator was interviewed and stated the height of the roof was approximately 13 feet from the ground. On 3/29/22, at 1:38 p.m. during a follow up interview, the administered stated as part of the weekly building safety checks and monitoring, the maintenance directors' duties included checking to ensure window safety strips where in place and working properly on all windows located on the memory care unit. The administer stated the maintenance director had verified safety checks on the memory care unit had not been completed per policy, and the last time he had checked the windows was more than 6 months ago. The facility Wandering/Elopement Risk Assessment Policy dated 5/19, directed the facility will assess all patients/residents for elopement potential in order to provide a safe and comfortable living environment. A policy on resident safety and supervision was requested and not provided.	F 689		

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F 689	Continued From page 4 The facility implemented corrective action to prevent recurrence by 3/22/22, when the facility implemented a systemic plan that included the following actions: On 3/22/22, the facility reeducated staff on resident's elopement risk and prevention. All windows were checked to ensure window stoppers where in place, and if a window was identified without a stopper it was corrected immediately. All staff were educated to not open a window unless a safety stopper was in place. The interdisciplinary team (IDT) developed and implemented education for all staff related to room readiness which included evaluation of all windows. R1's medications were reviewed by R1's physician, and R1's elopement risk was reassessed. The facility reviewed all residents residing on the memory care unit on their risk for elopement on 3/22/22. Audits where initiated which included interviewing staff to verify staff knowledge related to residents' safety, as well as audits of 15 window stoppers three times a week by IDT to ensure that windows had working stoppers. This was verified through staff interviews on 3/29/22, from approximately 10:20 a.m. through 2:00 p.m. Policies and facility investigative files were reviewed on 3/22/22, which included staff interview notes, education provided to staff, education sign off sheets, elopement risk and prevention policy, IDT meeting notes, and window stopper audits.	F 689		

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	00872	A. BUILDING: _____ B. WING _____	C 03/29/2022

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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 3/29/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: H5293134C (MN81991),	2 000		

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	00872	A. BUILDING: _____ B. WING _____	C 03/29/2022

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2 000	Continued From page 1 however, NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		